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Title 26
Internal Revenue

Parts 50 to 299

Revised as of April 1, 2022

Containing a codification of documents
of general applicability and future effect

As of April 1, 2022

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Cite this Code: CFR

To cite the regulations in this volume use title, part and section number. Thus, 26 CFR 50.1 *refers to title 26, part 50, section 1.*

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Each volume of the Code is revised at least once each calendar year and issued on a quarterly basis approximately as follows:

Title 1 through Title 16.....as of January 1
Title 17 through Title 27.....as of April 1
Title 28 through Title 41.....as of July 1
Title 42 through Title 50.....as of October 1

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OLIVER A. POTTS,
Director,
Office of the Federal Register
April 1, 2022

THIS TITLE

Title 26—INTERNAL REVENUE is composed of twenty-two volumes. The contents of these volumes represent all current regulations codified under this title by the Internal Revenue Service, Department of the Treasury, as of April 1, 2022. The first fifteen volumes comprise part 1 (Subchapter A—Income Tax) and are arranged by sections as follows: §§ 1.0–1.60; §§ 1.61–1.139; §§ 1.140–1.169; §§ 1.170–1.300; §§ 1.301–1.400; §§ 1.401–1.409; §§ 1.410–1.440; §§ 1.441–1.500; §§ 1.501–1.640; §§ 1.641–1.850; §§ 1.851–1.907; §§ 1.908–1.1000; §§ 1.1001–1.1400; §§ 1.1401–1.1550; and § 1.1551 to end of part 1. The sixteenth volume containing parts 2–29, includes the remainder of subchapter A and all of Subchapter B—Estate and Gift Taxes. The last six volumes contain parts 30–39 (Subchapter C—Employment Taxes and Collection of Income Tax at Source); parts 40–49; parts 50–299 (Subchapter D—Miscellaneous Excise Taxes); parts 300–499 (Subchapter F—Procedure and Administration); parts 500–599 (Subchapter G—Regulations under Tax Conventions); and part 600 to end (Subchapter H—Internal Revenue Practice).

The OMB control numbers for title 26 appear in § 602.101 of this chapter. For the convenience of the user, § 602.101 appears in the Finding Aids section of the volumes containing parts 1 to 599.

For this volume, Gabrielle E. Burns was Chief Editor. The Code of Federal Regulations publication program is under the direction of John Hyrum Martinez, assisted by Stephen J. Frattini.

Title 26—Internal Revenue

(This book contains parts 50 to 299)

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CHAPTER I—INTERNAL REVENUE SERVICE, DEPARTMENT OF THE TREASURY (CONTINUED)

EDITORIAL NOTE: IRS published a document at 45 FR 6088, Jan. 25, 1980, deleting statutory sections from their regulations. In chapter I, cross references to the deleted material have been changed to the corresponding sections of the IRS Code of 1954 or to the appropriate regulations sections. When either such change produced a redundancy, the cross reference has been deleted. For further explanation, see 45 FR 20795, Mar. 31, 1980.

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SUPPLEMENTARY PUBLICATIONS: *Internal Revenue Service Looseleaf Regulations System.*

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SUBCHAPTER D—MISCELLANEOUS EXCISE TAXES (CONTINUED)

PART 50—REGULATIONS RELATING TO THE TAX IMPOSED WITH RESPECT TO CERTAIN HYDRAULIC MINING

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50.1 Introduction.
50.2 Scope of regulations.
50.3 General definitions and use of terms.
50.4 Rates of tax.
50.5 Liability for the tax.
50.6 Ascertainment of quantity mined.
50.7 Returns.
50.8 Due date and place for filing returns and paying tax.

AUTHORITY: Sec. 23, 27, Stat. 510, as amended; 33 U.S.C. 683.

SOURCE: T.D. 6419, 24 FR 8546, Oct. 22, 1959, unless otherwise noted.

§ 50.1 Introduction.

The Act entitled ''An Act to create the California Debris Commission and regulate hydraulic mining in the State of California'', approved March 1, 1893, as amended, 27 Stat. 507; 34 Stat. 1001; 48 Stat. 1118; 52 Stat. 1040; 61 Stat. 501; 33 U.S.C. 661–687, provides in part as follows:

That a commission is hereby created, to be known as the California Debris Commission, consisting of three members. * * *

SEC. 3. That the jurisdiction of said commission, insofar as the same affects mining carried on by the hydraulic process, shall extend to all such mining in the territory drained by the Sacramento and San Joaquin river systems in the State of California. * * *

SEC. 8. That for the purposes of this act ''hydraulic mining'' and ''mining by the hydraulic process,'' are hereby declared to have the meaning and application given to said terms in said State.

SEC. 9. That the individual proprietor or proprietors, or in the case of a corporation its manager or agent appointed for that purpose, owning mining ground in the territory in the State of California mentioned in section three hereof, which it is desired to work by the hydraulic process, must file with said commission a verified petition, setting forth such facts as will comply with law and the rules prescribed by said commission.

* * * * *

SEC. 13. That in case a majority of the members of said Commission, within thirty days after the time so fixed, concur in the decision in favor of the petitioner or petitioners, the said Commission shall thereupon make an order directing the methods and specifying in detail the manner in which operations shall proceed in such mine or mines; * * *

SEC. 23. Upon the construction by the said commission of dams or other works for the detention of debris from hydraulic mines and the issuing of the order provided for by this Act to any individual, company, or corporation to work any mine or mines by hydraulic process, the individual, company, or corporation operating thereunder working any mine or mines by hydraulic process, the debris from which flows into or is in whole or in part restrained by such dams or other works erected by said commission, shall pay for each cubic yard mined from the natural bank a tax equal to the total capital cost of the dam, reservoir, and rights of way divided by the total capacity of the reservoir for the restraint of debris, as determined in each case by the California Debris Commission, which tax shall be paid annually on a date fixed by said commission and in accordance with regulations to be adopted by the Secretary of the Treasury, and the Treasurer of the United States is hereby authorized to receive the same. * * * The Secretary of the Army is authorized to enter into contracts to supply storage for water and use of outlet facilities from debris storage reservoirs, for domestic and irrigation purposes and power development upon such conditions of delivery, use, and payment as he may approve: *Provided,* That the moneys received from such contracts shall be deposited to the credit of the reservoir project from which the water is supplied, and the total capital cost of said reservoir, which is to be repaid by tax on mining operations as herein provided, shall be reduced in the amount so received.

§ 50.2 Scope of regulations.

(a) *In general.* The regulations in this part relate to the tax imposed with respect to hydraulic mining, the debris from which flows into or is in whole or in part restrained by dams or other works erected for the detention of debris by the California Debris Commission in the area drained by the Sacramento and San Joaquin river systems in the State of California. The regulations have application to taxable years beginning after August 31, 1959.

For definition of the term *taxable year*, see § 50.3(g).

(b) *Extent to which the regulations in this part supersede prior regulations*. The regulations in this part, with respect to the subject matter within the scope thereof, supersede Treasury Decision 4952 (26 CFR (1939) part 317).

§ 50.3 General definitions and use of terms.

As used in the regulations in this part:

(a) The term *Act* means ''An Act to create the California Debris Commission and regulate hydraulic mining in the State of California'' approved March 1, 1893, as amended, 27 Stat. 507; 34 Stat. 1001; 48 Stat. 1118; 52 Stat. 1040; 61 Stat. 501; 33 U.S.C. 661–687.

(b) The term *person* means an individual, a trust, estate, partnership, company, or corporation.

(c) The term *Secretary* means the Secretary of the Treasury.

(d) The term *Commissioner* means the Commissioner of Internal Revenue.

(e) The term *district director* means the district director of internal revenue.

(f) The terms *hydraulic mining* and *mining by the hydraulic process* shall have the meaning and application given said terms in the State of California.

(g) The term *taxable year* means the twelve-month period ending on August 31 of each year for which the tax imposed by the Act is payable.

§ 50.4 Rates of tax.

(a) *Determination of rate*. Under the Act the California Debris Commission will determine and prescribe with respect to each debris dam or other works the rate of tax payable in the area served by the particular debris dam or works. The Secretary of the Army will notify the Secretary of the Treasury of the rate of tax fixed with respect to each debris dam or works as such rate becomes known.

(b) *Measure of tax*. The tax is payable annually on the basis of the number of cubic yards mined from the natural bank by the hydraulic process during the taxable year.

§ 50.5 Liability for the tax.

Liability for tax attaches to any person engaged at any time during the taxable year in hydraulic mining in the area identified in paragraph (a) of § 50.2, if the debris from such mining operations is in whole or in part restrained by any of the debris dams or works constructed by the California Debris Commission.

§ 50.6 Ascertainment of quantity mined.

Each person engaged in hydraulic mining operations within the scope of the tax shall make or cause to be made appropriate surveys of the premises on which such hydraulic mining operations are conducted for the purpose of determining the cubic yardage mined from the natural bank. Such surveys shall be made at the beginning and end of hydraulic mining operations in each taxable year by a licensed engineer or other qualified agency having prior approval of the California Debris Commission, and shall conform to requirements prescribed by the California Debris Commission.

§ 50.7 Returns.

(a) *Form of return*. Every person liable for tax for any taxable year shall prepare for such year a return on Form 1 (California Debris) in accordance with the instructions thereon and in accordance with the regulations in this part.

(b) *Content of return*. The return shall show:

(1) The identity of the particular dam or other works restraining debris from the mine;

(2) The name and location of the mine;

(3) The name and address of the person to whom the California Debris Commission has issued a license to operate the mine;

(4) The number and date of the license;

(5) The name and address of the owner of the mine;

(6) The dates on which hydraulic mining operations began and ended during the taxable year for which the return is made;

(7) The number of cubic yards mined by the hydraulic process at the mine during the taxable year;

(8) The rate of tax per cubic yard determined by the California Debris Commission applicable to the particular mine; and

(9) The amount of tax due and payable (cubic yards mined multiplied by the rate of tax per cubic yard).

(c) *Supporting statement.* With each return there must be submitted a supporting statement of the person who made the surveys at the mine for the mining season covered by the return (see §50.6), stating that such surveys were made in accordance with requirements prescribed by the California Debris Commission.

(d) *Verification of return and supporting statement.* The return and the supporting statement shall be verified by written declarations that they are made under the penalties of perjury.

§50.8 Due date and place for filing returns and paying tax.

The return for a taxable year shall be filed with, and the tax shall be paid to, the district director at San Francisco, California, on or before September 30 of the calendar year in which the taxable year ends. The tax is due and payable on such date without assessment by, or notice from, the district director.

PART 51—BRANDED PRESCRIPTION DRUG FEE

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51.1 Overview.
51.2 Explanation of terms.
51.3 Information requested from covered entities.
51.4 Information provided by the agencies.
51.5 Fee calculation.
51.6 Notice of preliminary fee calculation.
51.7 Dispute resolution process.
51.8 Notification and payment of fee.
51.9 Tax treatment of fee.
51.10 Refund claims.
51.11 Applicability date.
51.6302–1 Method of paying the branded prescription drug fee.

AUTHORITY: 26 U.S.C. 7805; sec. 9008, Pub. L. 111–148, 124 Stat. 119.

Section 51.8 also issued under 26 U.S.C. 6302(a).

Section 51.6302–1 also issued under 26 U.S.C. 6302(a).

SOURCE: T.D. 9544, 76 FR 51249, Aug. 18, 2011, unless otherwise noted.

§51.1 Overview.

(a) The regulations in this part 51 are designated ''Branded Prescription Drug Fee Regulations.''

(b) The regulations in this part 51 provide guidance on the annual fee imposed on covered entities engaged in the business of manufacturing or importing branded prescription drugs by section 9008 of the Patient Protection and Affordable Care Act (ACA), Public Law 111–148 (124 Stat. 119 (2010)), as amended by section 1404 of the Health Care and Education Reconciliation Act of 2010 (HCERA), Public Law 111–152 (124 Stat. 1029 (2010)). All references in these regulations to section 9008 are references to section 9008 of the ACA, as amended by section 1404 of HCERA. Unless otherwise indicated, all other section references are to sections in the Internal Revenue Code. All references to ''fee'' in these regulations are references to the fee imposed by section 9008.

(c) Section 9008(b)(4) sets an applicable fee amount for each year, beginning with 2011, that will be apportioned among covered entities with aggregate branded prescription drug sales of over $5 million to government programs or pursuant to coverage under such programs. Generally, each covered entity is liable for a fee in each fee year that is based on its sales of branded prescription drugs in the sales year that corresponds to the fee year in an amount determined by the Internal Revenue Service (IRS) under the rules of this part.

[T.D. 9684, 79 FR 43639, July 28, 2014]

§51.2 Explanation of terms.

(a) *In general.* This section explains the terms used in this part for purposes of the fee imposed by section 9008 on branded prescription drugs.

(b) *Agencies.* The term *Agencies* means—

(1) The Centers for Medicare and Medicaid Services of the Department of Health and Human Services (CMS);

(2) The Department of Veterans Affairs (VA); and

(3) The Department of Defense (DOD).

(c) *Branded prescription drug*—(1) *In general.* The term *branded prescription drug* means—

(i) Any prescription drug the application for which was submitted under section 505(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)) (FFDCA); or

(ii) Any biological product the license for which was submitted under section 351(a) of the Public Health Service Act (42 U.S.C. 262(a)).

(2) *Prescription drug*. The term *prescription drug* means any drug that is subject to section 503(b) of the FFDCA.

(d) *Branded prescription drug sales*. The term *branded prescription drug sales* means sales of branded prescription drugs to any government program or pursuant to coverage under any such government program. However, the term does not include sales of orphan drugs.

(e) *Covered entity*—(1) *In general*. The term *covered entity* means any manufacturer or importer with gross receipts from branded prescription drug sales including—

(i) A single-person covered entity; or

(ii) A controlled group.

(2) *Single-person covered entity*. The term *single-person covered entity* means a covered entity that is not affiliated with a controlled group.

(3) *Controlled group*. The term *controlled group* means a group of two or more persons, including at least one person that is a covered entity, that is treated as a single employer under section 52(a), 52(b), 414(m), or 414(o).

(4) *Special rules for controlled groups*. For purposes of paragraph (e)(3) of this section (related to controlled groups)—

(i) A foreign entity subject to tax under section 881 is included within a group under section 52(a) or 52(b); and

(ii) A person is treated as being a member of a controlled group if it is a member of the group on the end of the day on December 31st of the sales year.

(5) *Covered entity status*—(i) *Rule*. An entity's status as a covered entity begins in the first fee year in which the entity has branded prescription drug sales and continues each subsequent fee year until there are no remaining branded prescription drug sales for that entity to be taken into account as described in § 51.5(c) or used to calculate the adjustment amount described in § 51.5(e).

(ii) *Example*. The following example illustrates the rule of paragraph (e)(5)(i) of this section:

(A) *Facts*. Entity A is a manufacturer with gross receipts of more than $5 million from branded prescription drugs sales in 2011. Entity A does not have any gross receipts from branded prescription drug sales before or after 2011.

(B) *Analysis*. Entity A is a covered entity beginning in 2011 because it had gross receipts from branded prescription drug sales in 2011. For the 2011 fee year, Entity A does not owe a fee because the 2011 fee is based on sales data from the 2009 sales year. For the 2012 fee year, Entity A does not owe a fee because the 2012 fee is based on sales data from the 2010 sales year. Entity A continues to be a covered entity for the 2012 fee year because its branded prescription drug sales from the 2011 sales year have not yet been taken into account as described in § 51.5(c) and used to calculate the adjustment amount described in § 51.5(e). For the 2013 fee year, Entity A continues to be a covered entity because a portion of its branded prescription drug sales from the 2011 sales year are taken into account as described in § 51.5(c) for purposes of computing the 2013 fee. For the 2013 fee year, Entity A is also liable for the adjustment amount described in § 51.5(e) for the difference between its 2012 fee computed using sales data from the 2010 sales year, which is $0, and what the 2012 fee would have been using sales data from the 2011 sales year. For the 2014 fee year, Entity A continues to be a covered entity because a portion of its branded prescription drug sales for the 2011 sales year are used to calculate the adjustment amount described in § 51.5(e). Therefore, for the 2014 fee year, Entity A will receive an adjustment amount for the difference between its 2013 fee computed using sales data from the 2011 sales year, and what the 2013 fee would have been using sales data from the 2012 sales year, which is $0. After the 2014 fee year, there are no remaining branded prescription drug sales to be taken into account as described in § 51.5(c) or used to calculate the adjustment amount described in § 51.5(e) for Entity A. Accordingly, Entity A is not a covered entity after the 2014 fee year.

(f) *Designated entity*—(1) *In general.* The term *designated entity* means the person within a controlled group that is designated to act for the controlled group regarding the fee by—

(i) Filing Form 8947, ''Report of Branded Prescription Drug Information'';

(ii) Receiving IRS communications about the fee for the group;

(iii) Filing an error report for the group, if applicable, as described in §51.7; and

(iv) Paying the fee to the government.

(2) *Selection of designated entity*—(i) *Controlled group selection of a designated entity*. Except as provided in paragraph (f)(2)(ii) of this section, the controlled group may select a person as the designated entity by filing Form 8947 in accordance with the form instructions. The designated entity must state under penalties of perjury that all members of the controlled group have consented to the selection of the designated entity. The designated entity must maintain a record of all member consents. Each member of a controlled group must maintain a record of its consent to the controlled group's selection of the designated entity.

(ii) *Requirement for affiliated groups; agent for the group.* If the controlled group, without regard to foreign corporations included under section 9008(d)(2)(B), is also an affiliated group whose common parent files a consolidated return for federal income tax purposes, the designated entity is the agent for the group (within the meaning of §1.1502–77 of this title).

(iii) *IRS selection of a designated entity*. Except as provided in paragraph (f)(2)(ii) of this section, if a controlled group does not select a designated entity as provided in paragraph (f)(2)(i) of this section, the IRS will select a member of the controlled group as the designated entity for the controlled group. If the IRS selects the designated entity, then all members of that controlled group will be deemed to have consented to the IRS's selection of the designated entity.

(g) *Fee year*. The term *fee year* means the calendar year in which the fee for a particular sales year must be paid to the government.

(h) *Government programs.* The term *government programs* (collectively ''Programs''), means—

(1) The Medicare Part B program;

(2) The Medicare Part D program;

(3) The Medicaid program;

(4) Any program under which branded prescription drugs are procured by the Department of Veterans Affairs;

(5) Any program under which branded prescription drugs are procured by the Department of Defense; and

(6) The TRICARE retail pharmacy program.

(i) *Manufacturer or importer*. The term *manufacturer or importer* means the person identified in the Labeler Code of the National Drug Code (NDC) for a branded prescription drug.

(j) *NDC*. The term *NDC* means the National Drug Code. The NDC is a unique identifier that is assigned to all drug products approved by the Food and Drug Administration (FDA), including a branded prescription drug. The Labeler Code is the first five numeric characters of the NDC or the first six numeric characters when the available five-character code combinations are exhausted.

(k) *Orphan drugs*—(1) *In general*. Except as provided in paragraph (k)(2) of this section, the term *orphan drug* means any branded prescription drug for which any person claimed a section 45C credit and that credit was allowed for any taxable year.

(2) *Exclusions*. The term *orphan drug* does not include—

(i) Any drug for which there has been a final assessment or court order disallowing the full section 45C credit taken for the drug; or

(ii) Any drug for any sales year after the calendar year in which the FDA approved the drug for marketing for any indication other than the treatment of a rare disease or condition for which a section 45C credit was allowed, regardless of whether a section 45C credit was allowed for the drug before, in the same year as, or after this FDA designation.

(3) *FDA marketing approval for treatment of another rare disease or condition*. If a drug has prior FDA marketing approval for the treatment of a rare disease or condition for which a section 45C credit was allowed, and the FDA

subsequently gives the drug marketing approval for the treatment of another rare disease or condition for which another section 45C credit was also allowed, the drug retains its status as an orphan drug provided the FDA has never approved the drug for marketing for any indication other than the treatment of a rare disease or condition for which a section 45C credit was allowed.

(4) *Examples*. The following examples illustrate the rules of this paragraph (k):

Example 1: Allowance of section 45C credit and later FDA marketing approval of drug for an indication other than the treatment of a rare disease or condition. (i) *Facts*. Drug A is a branded prescription drug that was not on the market before 2011. In 2011, a covered entity claimed a section 45C credit for its qualified clinical testing expenses related to Drug A. There was no final IRS assessment or court order that disallowed the full credit for Drug A. In 2012, the FDA approved Drug A for marketing for an indication other than the treatment of the rare disease or condition for which the section 45C credit was allowed and this indication was not for another rare disease or condition for which a section 45C was allowed.

(ii) *Analysis*. In 2011 and 2012, Drug A is an orphan drug because: first, it was a branded prescription drug for which a person claimed a section 45C credit and for which that credit was allowed for a taxable year; second, there was not a final assessment or court order disallowing the full credit taken for the drug; and third, before 2012, the FDA did not approve the drug for marketing for any indication other than the treatment of a rare disease or condition for which a section 45C credit was allowed. However, Drug A is not an orphan drug for the 2013 sales year or later sales years because in 2012 the FDA approved Drug A for marketing for an indication other than the treatment of the rare disease or condition for which the section 45C credit was allowed and this indication was not for treatment of another rare disease or condition for which a section 45C credit was allowed.

Example 2: FDA marketing approval of drug for an indication other than the treatment of a rare disease or condition and later allowance of section 45C credit. (i) *Facts*. Drug B is a branded prescription drug that was not on the market before 2011. In 2011, FDA approved Drug B for marketing for the treatment of a rare disease or condition and also approved Drug B for marketing for an indication other than the treatment of a rare disease or condition. In 2012, a covered entity claimed a section 45C credit for its qualified clinical testing expenses related to Drug B. There was no final IRS assessment or court order that disallowed the full credit for Drug B.

(ii) *Analysis*. In 2011, Drug B is not an orphan drug because no section 45C credit was allowed and because the FDA approved Drug B for an indication other than the treatment of a rare disease or condition. In 2012, although the covered entity was allowed a section 45C credit for its qualified clinical testing expenses related to Drug B and there was no final IRS assessment or court order that disallowed the full credit, Drug B still is not an orphan drug because the FDA had approved the drug in 2011 for marketing for an indication other than the treatment of a rare disease or condition for which a section 45C credit was allowed in 2012. Thus, Drug B is not an orphan drug for the 2012 sales year or later sales years.

Example 3: Allowance of section 45C credit and subsequent allowance of section 45C credit with no intervening FDA marketing approval of drug for an indication other than the treatment of a rare disease or condition for which a section 45C credit was allowed. (i) *Facts*. Drug C is a branded prescription drug that was not on the market before 2010. In 2010, a covered entity claimed a section 45C credit for its qualified clinical testing expenses related to Drug C. In 2012, a covered entity claimed an additional section 45C credit for its qualified clinical testing expenses related to Drug C for marketing for the treatment of a rare disease or condition different than the one for which the section 45C credit was claimed in 2010. There was no final IRS assessment or court order that disallowed the full credit for Drug C in 2010 or 2012. The FDA has not approved Drug C for an indication other than the treatment of a rare disease or condition for which a section 45C was allowed.

(ii) *Analysis*. In 2010 and 2011, Drug C is an orphan drug because: first, it was a branded prescription drug for which a person claimed a section 45C credit and for which that credit was allowed for a taxable year; second, there was not a final assessment or court order disallowing the full credit taken for the drug; and third, FDA had not approved the drug for marketing for any indication other than the treatment of a rare disease or condition for which a section 45C credit was allowed. In 2012, Drug C retains its orphan drug status because another section 45C credit was allowed and the FDA did not approve Drug C for marketing for any indication other than the treatment of another rare disease or condition for which a section 45C credit was allowed. Thus, Drug C is an orphan drug for the 2013 sales year.

(l) *Sales taken into account*. The term *sales taken into account* means branded prescription drug sales after application of the percentage adjustment table in section 9008(b)(2) (relating to

annual sales less than $400,000,001). See §51.5(a)(3).

(m) *Sales year*. The term *sales year* means the second calendar year preceding the fee year. Thus, for example, for the fee year of 2014, the sales year is 2012.

[T.D. 9684, 79 FR 43639, July 28, 2014, as amended by T.D. 9823, 82 FR 34612, July 26, 2017]

§51.3 Information requested from covered entities.

(a) *In general*. Annually, each covered entity may submit a completed Form 8947, ''Report of Branded Prescription Drug Information,'' in accordance with the instructions for the form. Generally, the form solicits information from covered entities on NDCs, orphan drugs, designated entities, rebates, and other information specified by the form or its instructions.

(b) *Due date*. Form 8947 must be filed by the date prescribed in guidance in the Internal Revenue Bulletin.

[T.D. 9684, 79 FR 43641, July 28, 2014]

§51.4 Information provided by the agencies.

(a) *In general*. For each sales year, the IRS will compile a list of branded prescription drugs by NDC using the data submitted on Forms 8947 and in error reports submitted as part of the dispute resolution process (described in §51.7) and, after applying appropriate due diligence, will provide this list to the Agencies. The Agencies will provide data to the IRS on branded prescription drug sales that occurred during the sales year by Program and NDC. The Agencies will provide data for use in preparing the preliminary fee calculation (described in §§51.5 and 51.6) and may revise or supplement that data following review of error reports submitted as part of the dispute resolution process. The calculation methodology for calculating the sales amounts for each Program, including any reasonable estimation techniques and assumptions that the Agencies expect to use, is described in this section.

(b) *Medicare Part D*—(1) *In general*. CMS will determine branded prescription drug sales under Medicare Part D by aggregating the ingredient cost reported in the ''Ingredient Cost Paid'' field on the Prescription Drug Event (PDE) records at the NDC level, reduced by discounts, rebates, and other price concessions provided by the covered entity, for each sales year. CMS will only include PDE data that Part D sponsors have submitted by the PDE submission deadline (within 6 months after the end of the sales year) and that CMS has approved for inclusion in the Part D payment reconciliation.

(2) *Discounts, rebates, and other price concessions*—(i) *In general*. For purposes of paragraph (b)(1) of this section, the term *discounts, rebates, and other price concessions* means:

(A) Any direct and indirect remuneration (DIR) (within the meaning of paragraph (b)(2)(ii) of this section), which includes any DIR reported on the PDE records at the point of sale and any DIR reported on a Detailed DIR Report (within the meaning of a paragraph (b)(2)(iii) of this section); and

(B) Any coverage gap discount amount (within the meaning of paragraph (b)(2)(iv) of this section).

(ii) *Direct and indirect remuneration*. For purposes of paragraph (b)(2)(i)(A) of this section, the term *direct and indirect remuneration* (DIR) has the same meaning as found in the definition of *actually paid* in 42 CFR 423.308.

(iii) *Detailed DIR Report*. For purposes of paragraph (b)(2)(i)(A) of this section, the term *Detailed DIR Report* means the report containing any DIR (within the meaning of paragraph (b)(2)(ii) of this section) that is collected yearly from Part D sponsors at the NDC level.

(iv) *Coverage gap discount amount*. For purposes of paragraph (b)(2)(i)(B) of this section, the term *coverage gap discount amount* means a 50-percent manufactured-paid discount on certain drugs under the Coverage Gap Discount Program described in section 1860D–14A of the Social Security Act.

(c) *Medicare Part B*—(1) *In general*. CMS will determine branded prescription drug sales under Medicare Part B using the following two data sources:

(i) CMS will use data reported by manufacturers pursuant to section 1847A(c) of the Social Security Act to calculate the annual weighted average sales price (ASP) for each Healthcare

Common Procedure Coding System (HCPCS) code for the sales year.

(ii) CMS will use the Medicare Part B National Summary Data File located at *http://www.cms.gov/NonIdentifiableDataFiles/03_PartBNationalSummaryDataFile.asp* to obtain the number of allowed billing units per HCPCS code for claims incurred during the sales year.

(2) *Calculation*—(i) *In general*. Using the data described in paragraph (c)(1) of this section, CMS will determine branded prescription drugs sales under Medicare Part B as described in paragraphs (c)(3), (4), and (5) of this section. CMS reports sales amounts per HCPCS billing code, not per NDC. Therefore, a covered entity's total Part B sales amounts for all NDCs in a given HCPCS billing code appears under only one NDC in each HCPCS billing code and the covered entity's remaining NDCs in the HCPCS billing code are listed with a sales amount of zero.

(ii) *Example of a Part B sales report:*

HCPCS	NDC	Part B amount
J9876	12345–6789–01	$789,000
	12345–6789–02	0
	12345–6789–03	0
	12345–6800–80	0
	12345–6800–90	0

(3) *HCPCS code; single entity*. For each HCPCS code consisting solely and exclusively of branded prescription drugs (as identified by their respective NDCs) manufactured by a single entity, CMS will multiply the annual weighted ASP by the total number of allowed billing units paid during the sales year to determine the total sales for all NDCs associated with the HCPCS code attributed to Medicare Part B.

(4) *HCPCS code; multiple manufacturers and/or multiple drugs*—(i) *Step one*. For each HCPCS code consisting of a mixture of branded prescription drugs made by different manufacturers and/or a mixture of branded prescription and generic drugs, CMS will determine—

(A) The annual weighted ASP for the HCPCS code;

(B) The total number of allowed billing units paid by Medicare Part B for each HCPCS code during the sales year;

(C) The names of the entities engaged in manufacturing each NDC assigned to the HCPCS code; and

(D) Those entities (if any) identified in paragraph (c)(4)(i)(C) of this section that are manufacturing branded prescription drugs assigned to the HCPCS code.

(ii) *Step two*. Using the information from paragraph (c)(4)(i) of this section, CMS will then do the following:

(A) Calculate the proportion of sales, expressed as a percentage, attributed to each NDC assigned to the HCPCS code by determining the percentage of total sales reported to CMS by each manufacturer of NDC(s) that are assigned to the HCPCS code. For example, if HCPCS code JXXXX contains three drugs with a total of $310,000 sales reported by manufacturers to CMS for the sales year, and $100,000 was reported for Drug A, $200,000 was reported for Drug B, and $10,000 was reported for Drug C, the proportion of sales attributed to each NDC will be 32.26 percent for Drug A, 64.52 percent for Drug B, and 3.22 percent for Drug C; and

(B) For each NDC, multiply the product of the annual weighted ASP and the total allowed billing units paid by Medicare Part B for the HCPCS code by the proportion of sales calculated in paragraph (c)(4)(ii)(A) of this section to determine the sales reportable to the IRS (that is, percentage × (annual weighted ASP × allowed units) = total sales reported to IRS for the NDC). The sales for each manufacturer's NDCs assigned to a HCPCS code are summed and the total sales for each manufacturer's NDCs in a HCPCS code will be reported to the IRS.

(5) *HCPCS code; unable to establish a reliable proportion of sales*. If CMS is unable to establish a reliable proportion of sales attributable to each NDC assigned to the HCPCS code using the method described in paragraph (c)(4)(ii)(A) of this section, CMS will use Medicare Part D utilization percentages in lieu of the proportion of sales determined under paragraph (c)(4)(ii)(A) of this section to perform the calculation described in paragraph (c)(4)(ii)(B) of this section.

(d) *Medicaid*. (1) CMS will determine the branded prescription drug sales for

Medicaid as the per-unit Average Manufacturer Price (AMP) less the Unit Rebate Amounts (URA) that CMS calculates based on manufacturer-reported pricing data multiplied by the number of units reported billed by states to manufacturers. This data will be based on the data reported to CMS for the sales year by covered entities and the states for drugs paid for by the states in the Medicaid Drug Rebate Program for the sales year. The data will include all branded prescription drug units for which the states bill rebates to covered entities under the Medicaid Drug Rebate Program. This program includes, but is not limited to, units paid for under various health care plans such as fee for service, managed care organizations, and drugs administered in a non-retail setting such as drugs administered in a physician's office, clinic, hospital or other setting. The Medicaid Drug Rebate Program's calculated branded prescription drug fee does not include state-only pharmaceutical program sales or rebates.

(2) For any covered entity identified in the first five (or six) digits of an NDC during any of the four quarters of a sales year, CMS will use the following methodology to derive the sales figures that account for third-party payers, such as Medicare Part B:

(i) Report total dollars per NDC for AMP minus URA multiplied by the units reported by a state or states.

(ii) Determine the percentage of the total amount reimbursed that is the Medicaid amount of that reimbursement. For example, if the total amount reimbursed is $100,000, and the Medicaid amount reimbursed is $20,000, then the percentage is 20 percent.

(iii) Multiply the percentage of the Medicaid amount of that reimbursement (in the example in paragraph (d)(2)(ii) of this section, 20 percent) by the dollar figure derived from paragraph (d)(2)(i) of this section (AMP minus URA multiplied by units) to get the new adjusted sales dollar totals.

(e) *Department of Veterans Affairs*. VA will determine branded prescription drug sales to VA by providing, by NDC, the total amount paid (net of refunds and rebates, when they are associated with a specific NDC) for each branded prescription drug procured by VA for its beneficiaries during the sales year. For this purpose, a drug is procured on the invoice (billing) date. The basis of this information will be national procurement data reported during the sales year by VA's Pharmaceutical Prime Vendor to the VA Pharmacy Benefits Management Service and National Acquisition Center. VA sales data includes the Industrial Funding Fee and the Cost Recovery Fee because these amounts are part of the price VA pays to its Pharmaceutical Prime Vendor to procure a drug.

(f) *Department of Defense*. DOD will determine branded prescription drug sales to DOD (for DOD programs other than the TRICARE retail pharmacy program) by providing, by Labeler Code, the manufacturer's name, the NDC, brand name, and the amount paid (net of rebates and or refunds) for each branded prescription drug procured by DOD (for DOD programs other than the TRICARE retail pharmacy program) during the sales year. For DOD programs other than the TRICARE retail pharmacy program, a drug is procured based upon the date it was ordered. DOD includes the Industrial Funding Fee and the Cost Recovery Fee in its drug sales data because these amounts are part of the price DOD pays to procure a drug.

(g) *TRICARE*. DOD will determine branded prescription drug sales to DOD for the TRICARE retail pharmacy program by providing, by Labeler Code, the manufacturer's name, the NDC, brand name, and the amount paid (net of rebates or refunds) for each branded prescription drug procured by DOD through the TRICARE retail pharmacy program during the sales year. For the TRICARE retail pharmacy program, a drug is procured based upon the date it was dispensed. The amount paid is based on the submitted ingredient cost paid, aggregated by NDC, for eligible TRICARE retail pharmacy claims submitted during the program year, minus any refunds or rebates for the corresponding claims.

[T.D. 9684, 79 FR 43641, July 28, 2014; 79 FR 57784, Sept. 26, 2014]

§51.5 Fee calculation.

(a) *Fee components*—(1) *In general*. For every fee year, the IRS will calculate a

covered entity's total fee as described in this section. The IRS will determine a covered entity's total fee by applying, if applicable, the adjustment amount described in paragraph (e) of this section to the entity's allocated fee described in paragraph (d) of this section.

(2) *Calculation of branded prescription drug sales.* Each covered entity's allocated fee for any fee year is equal to an amount that bears the same ratio to the applicable amount as the covered entity's branded prescription drug sales taken into account during the sales year bears to the aggregate branded prescription drug sales of all covered entities taken into account during the sales year.

(3) *Applicable amount.* The applicable amounts for fee years are—

Fee year	Applicable amount
2011	$2,500,000,000
2012	2,800,000,000
2013	2,800,000,000
2014	3,000,000,000
2015	3,000,000,000
2016	3,000,000,000
2017	4,000,000,000
2018	4,100,000,000
2019 and thereafter	2,800,000,000

(4) *Sales taken into account.* A covered entity's branded prescription drug sales taken into account during any calendar year are as follows:

Covered entity's branded prescription drug sales during the calendar year that are:	Percentage of branded prescription drug sales taken into account is:
Not more than $5,000,000	0
More than $5,000,000 but not more than $125,000,000	10
More than $125,000,000 but not more than $225,000,000	40
More than $225,000,000 but not more than $400,000,000	75
More than $400,000,000	100

(b) *Determination of branded prescription drug sales.* The IRS will compile each covered entity's branded prescription drug sales for each Program by NDC. Each NDC will be attributed to the covered entity identified in the Labeler Code as of the end of the day on December 31st of the sales year. For a covered entity that is a controlled group, this includes all NDCs in which a member of the covered entity is identified. For this purpose, the IRS may revise the list of NDCs as a result of information received in the dispute resolution process, and the data the IRS uses to produce the final fee calculation will include any revisions provided by the Agencies at the completion of the dispute resolution process. Each covered entity's branded prescription drug sales will be reduced by its Medicaid state supplemental rebate amounts in the following manner. If CMS has Medicaid state supplemental rebate information for a sales year, CMS will report to the IRS branded prescription drug sales for Medicaid net of Medicaid state supplemental rebates. If CMS does not have complete Medicaid state supplemental rebate information for a sales year, the IRS will reduce the branded prescription drug sales that CMS reported for Medicaid by Medicaid state supplemental rebates reported by the covered entities on Form 8947.

(c) *Determination of sales taken into account.* (1) For each sales year and for each covered entity, the IRS will calculate sales taken into account. The resulting number is the numerator of the ratio described in paragraph (d)(1) of this section.

(2) For each sales year, the IRS will calculate the aggregate branded prescription drug sales taken into account for all covered entities. The resulting number is the denominator of the ratio described in paragraph (d)(2) of this section.

(d) *Allocated fee calculation.* For each covered entity for each fee year, the IRS will calculate the entity's allocated fee by multiplying the applicable amount from paragraph (a)(2) of this section by a fraction—

(1) The numerator of which is the covered entity's branded prescription drug sales taken into account during the sales year (described in paragraph (c)(1) of this section); and

(2) The denominator of which is the aggregate branded prescription drug sales taken into account for all covered entities during the same year (described in paragraph (c)(2) of this section).

(e) *Adjustment amount*—(1) *In general.* In addition to the allocated fee computed under paragraph (d) of this section, the IRS will also automatically calculate for each covered entity an adjustment amount. An adjustment amount reflects the difference between the allocated fee determined for the covered entity in the immediately preceding fee year, using data from the second calendar year preceding that fee year, and what the allocated fee would have been for that entity for the immediately preceding fee year using data from the calendar year immediately preceding that fee year. For example, for 2014, the adjustment amount for a covered entity will be the difference between the entity's 2013 allocated fee, using 2011 data, and what the 2013 allocated fee would have been using 2012 data. Although the adjustment reflects a revision of the prior year's fee based on data from the year immediately preceding the prior fee year, the adjustment is only taken into account by adding it to or subtracting it from the allocated fee computed under paragraph (d) of this section for the current fee year to arrive at the total fee for the current fee year. An adjustment amount is treated as a component of the current year's fee. For purposes of section 6601, any increase in the allocated fee computed under paragraph (d) of this section for the current fee year resulting from any adjustment amount, along with the remainder of the fee, is treated as a fee liability due on the due date for the current year's fee. For purposes of sections 6511 and 6611, any adjustment amount that decreases the allocated fee computed under paragraph (d) of this section for the current fee year is treated as a payment towards the current fee liability made on the due date of the current fee year.

(2) *Amounts paid to a covered entity because of an adjustment amount.* If a covered entity's adjustment amount reduces the fee computed under paragraph (d) of this section below zero and results in an amount due to the covered entity for the fee year, the IRS will pay this amount due to the covered entity. A covered entity does not file Form 843, Claim for Refund and Request for Abatement, to receive this amount owed to a covered entity.

[T.D. 9684, 79 FR 43643, July 28, 2014]

§51.6 Notice of preliminary fee calculation.

(a) *Content of notice.* For each sales year, the IRS will make a preliminary calculation of the fee for each covered entity as described in §51.5. The IRS will notify each covered entity of its preliminary fee calculation for that sales year. The notification to a covered entity of its preliminary fee calculation will include—

(1) The covered entity's allocated fee;

(2) The covered entity's branded prescription drug sales, by NDC, by Program;

(3) The covered entity's branded prescription drug sales taken into account after application of §51.5(a)(4);

(4) The aggregate branded prescription drug sales taken into account for all covered entities;

(5) The covered entity's adjustment amount calculated as described in §51.5(e); and

(6) A reference to the fee dispute resolution procedures set forth in guidance published in the Internal Revenue Bulletin.

(b) *Time of notice.* The IRS will send each covered entity notice of its preliminary fee calculation by the date prescribed in guidance published in the Internal Revenue Bulletin.

[T.D. 9684, 79 FR 43644, July 28, 2014]

§51.7 Dispute resolution process.

(a) *In general.* Upon receipt of its preliminary fee calculation, each covered entity will have an opportunity to dispute this calculation by submitting to the IRS an error report as described in this section. The IRS will provide its final determination with respect to error reports no later than the time the IRS provides a covered entity with a final fee calculation.

(b) *Error report information.* To assert that there have been one or more errors in the drug sales data reported by a Program, the mathematical calculation of the fee, the rebate data, the listing of an NDC for an orphan drug, or any other error, a covered entity must submit an error report with each

asserted error reported on a separate line. The report must include the following information—

(1) Entity name, address, and Employer Identification Number (EIN) as previously reported on the Form 8947;

(2) The name, telephone number, fax number, and email address (if available) of one or more employees or representatives of the entity with whom the IRS may discuss the claimed errors. If the representative is not an employee of the covered entity who is authorized under section 6103 or designated on Form 8947 to discuss the information reported on Form 8947 with the IRS, a Form 2848, ''Power of Attorney and Declaration of Representative,'' must be filed with the error report;

(3) For an error in the drug sales data reported by a Program, the name of the Program that reported the data, the NDC, the specific amount of sales data disputed, the proposed corrected amount, an explanation of why the Agency should use the proposed corrected data instead, and documentation of any Program drug sales data or other information used to establish the existence of any errors.

(4) For a mathematical calculation error, the specific calculation element(s) that the entity disputes and its proposed corrected calculation;

(5) For a rebate data error, the NDC for the drug to which it relates; a discussion of whether the data used in the preliminary fee calculation matches previously reported Form 8947 data on rebates; and, if the data used in the preliminary fee calculation does match the Form 8947 data, an explanation of why the Form 8947 data was erroneous and why the IRS should use the proposed corrected data instead;

(6) For the listing of an NDC for an orphan drug, the name and NDC of the orphan drug; a discussion of whether the data used in the preliminary fee calculation matches previously reported Form 8947 data on orphan drugs; and, if the data used in the preliminary fee calculation does match the Form 8947 data, an explanation of why the Form 8947 data was erroneous and why the IRS should use the proposed corrected data instead;

(7) For any other asserted error, an explanation of the nature of the error, how the error affects the fee calculation, an explanation of how the entity established that an error occurred, the proposed correction to the error, and an explanation of why the IRS or Agency should use the proposed corrected data instead;

(8) If an entity is using data to establish the existence of an error and that data was not reported on Form 8947 or contained in the notification of the preliminary fee calculation, a description of what the data is, how the entity acquired the data, and who maintains it; and

(9) Documentation of any rebate and orphan drug data, or other information used to establish the existence of any errors.

(c) *Form, manner, and timing of submission.* Each covered entity must submit its error report(s) in the form and manner that is prescribed in guidance published in the Internal Revenue Bulletin. This guidance will also prescribe the date by which each covered entity must submit its report(s).

(d) *Finality.* A covered entity must assert any basis for contesting its preliminary fee calculation during the dispute resolution period. In the interest of providing finality to the fee calculation process, the IRS will not accept an error report after the end of the dispute resolution period or alter the final fee calculation on the basis of information provided after the end of the dispute resolution period.

[T.D. 9684, 79 FR 43644, July 28, 2014]

§ 51.8 Notification and payment of fee.

(a) *Notification of final fee calculation.* No later than August 31st of each fee year, the IRS will send each covered entity its final fee calculation for that year. In any fee year, the IRS will base its final fee calculation on data provided to it by the Agencies as adjusted pursuant to the dispute resolution process. The notification to a covered entity of its final fee calculation will include—

(1) The covered entity's allocated fee;

(2) The covered entity's adjustment amount calculated as described in § 51.5;

(3) The covered entity's branded prescription drug sales, by NDC, by Program;

(4) The covered entity's branded prescription drug sales taken into account after application of § 51.5(a)(4);

(5) The aggregate branded prescription drug sales taken into account for all covered entities; and

(6) The final determination with respect to error reports.

(b) *Differences in preliminary fee calculation and final fee calculation*. A covered entity's final fee calculation may differ from the covered entity's preliminary fee calculation because of changes made pursuant to the dispute resolution process described in § 51.7. Even if a covered entity did not file an error report described in § 51.7, a covered entity's final fee may differ from a covered entity's preliminary fee because of a change in data reported by the Agencies after resolution of error reports, including a change in the aggregate prescription drug sales figure. A change in aggregate prescription drug sales data can affect each covered entity's fee because each covered entity's fee is a fraction of the aggregate fee collected from all covered entities. A covered entity's final fee may also differ from its preliminary fee calculation because the data used in the preliminary fee calculation may have contained inaccurate branded prescription drug sales information that was corrected or updated at the conclusion of the dispute resolution process.

(c) *Payment of final fee*. Each covered entity must pay its final fee by September 30th of the fee year. For a controlled group, the payment must be made using the designated entity's EIN as reported on Form 8947. The fee must be paid by electronic funds transfer as required by § 51.6302–1. There is no tax return to be filed for the fee.

(d) *Joint and several liability*. In the case of a controlled group that is liable for the fee, all members of the controlled group are jointly and severally liable for the fee. Accordingly, if a controlled group's fee is not paid, the IRS will separately assess each member of the group for the full amount of the controlled group's fee.

[T.D. 9684, 79 FR 43644, July 28, 2014]

§ 51.9 Tax treatment of fee.

(a) *Treatment as an excise tax*. The fee imposed by section 9008 is treated as an excise tax for purposes of subtitle F of the Internal Revenue Code (Code) (sections 6001–7874). Thus, references in subtitle F to ''taxes imposed by this title,'' ''internal revenue tax,'' and similar references, are also references to the fee imposed by section 9008. For example, the fee imposed by section 9008 is assessed (section 6201), collected (sections 6301, 6321, and 6331), enforced (section 7402 and 7403), subject to examination and summons (section 7602), and subject to confidentiality rules (section 6103) in the same manner as taxes imposed by the Code.

(b) *Deficiency procedures*. The deficiency procedures of sections 6211–6216 do not apply to the fee imposed by section 9008.

(c) *Limitation on assessment*. The IRS must assess the amount of the fee for any fee year within three years of September 30th of that fee year.

(d) *Application of section 275*. The fee is treated as a tax described in section 275(a)(6) (relating to taxes for which no deduction is allowed).

[T.D. 9684, 79 FR 43645, July 28, 2014]

§ 51.10 Refund claims.

Any claim for a refund of the fee must be made by the person that paid the fee to the government and must be made on Form 843, ''Claim for Refund and Request for Abatement,'' in accordance with the instructions for that form.

[T.D. 9684, 79 FR 43645, July 28, 2014]

§ 51.11 Applicability date.

(a) Except as otherwise provided in this section, §§ 51.1 through 51.10 apply on and after July 28, 2014.

(b) Section 51.2(e)(3) applies on and after July 24, 2017.

[T.D. 9684, 79 FR 43645, July 28, 2014, as amended by T.D. 9823, 82 FR 34612, July 26, 2017]

§ 51.6302–1 Method of paying the branded prescription drug fee.

(a) *Fee to be paid by electronic funds transfer*. Under the authority of section

6302(a), the fee imposed on branded prescription drug sales by section 9008 and § 51.5 must be paid by electronic funds transfer as defined in § 31.6302–1(h)(4)(i) of this title, as if the fee were a depository tax. For the time for paying the fee, see § 51.8.

(b) *Effective/applicability date.* This section applies on and after July 28, 2014.

[T.D. 9684, 79 FR 43645, July 28, 2014]

PART 52—ENVIRONMENTAL TAXES

Sec.
52.0–1 Introduction.
52.4681–1 Taxes imposed with respect to ozone-depleting chemicals.
52.4682–1 Ozone-depleting chemicals.
52.4682–2 Qualifying sales.
52.4682–3 Imported taxable products.
52.4682–4 Floor stocks tax.
52.4682–5 Exports.

AUTHORITY: 26 U.S.C. 7805.

Section 52.4682–3 also issued under 26 U.S.C. 4682(c)(2);

Section 52.4682–5 also issued under 26 U.S.C. 4662(e)(4).

§ 52.0–1 Introduction.

The regulations in this part 52 are designated ''Environmental Tax Regulations.'' The regulations relate to the environmental taxes imposed by chapter 38 of the Internal Revenue Code. See part 40 of this chapter for regulations relating to returns, payments, and deposits of taxes imposed by chapter 38.

[T.D. 8442, 57 FR 48186, Oct. 22, 1992]

§ 52.4681–1 Taxes imposed with respect to ozone-depleting chemicals.

(a) *Taxes imposed.* Sections 4681 and 4682 impose the following taxes with respect to ozone-depleting chemicals (ODCs):

(1) *Tax on ODCs.* Section 4681(a)(1) imposes a tax on ODCs that are sold or used by the manufacturer or importer thereof. Except as otherwise provided in § 52.4682–1 (relating to the tax on ODCs), the amount of the tax is equal to the product of—

(i) The weight (in pounds) of the ODC;

(ii) The base tax amount (determined under section 4681(b)(1) (B) or (C)) for the calendar year in which the sale or use occurs; and

(iii) The ozone-depletion factor (determined under section 4682(b)) for the ODC.

(2) *Tax on imported taxable products.* Section 4681(a)(2) imposes a tax on imported taxable products that are sold or used by the importer thereof. Except as otherwise provided in § 52.4682–3 (relating to the tax on imported taxable products), the tax is computed by reference to the weight of the ODCs used as materials in the manufacture of the product. The amount of tax is equal to the tax that would have been imposed on the ODCs under section 4681(a)(1) if the ODCs had been sold in the United States on the date of the sale or use of the imported product. The weight of such ODCs is determined under § 52.4682–3.

(3) *Floor stocks tax*—(i) *Imposition of tax.* Section 4682(h) imposes a floor stocks tax on ODCs that—

(A) Are held by any person other than the manufacturer or importer of the ODC on a date specified in paragraph (a)(3)(ii) of this section; and

(B) Are held on such date for sale or for use in further manufacture.

(ii) Dates on which tax imposed. The floor stocks tax is imposed on January 1 of each calendar year after 1989.

(iii) *Amount of tax.* Except as otherwise provided in § 52.4682–4 (relating to the floor stocks tax), the amount of the floor stocks tax is equal to the excess of—

(A) The tax that would be imposed on the ODC under section 4681(a)(1) if a sale or use of the ODC by its manufacturer or importer occurred on the date the floor stocks tax is imposed (the tentative tax amount), over

(B) The sum of the taxes previously imposed (if any) on the ODC under sections 4681 and 4682.

(b) *Cross-references*—(1) *Tax on ODCs.* Additional rules relating to the tax on ODCs are contained in §§ 52.4682–1 and 52.4682–2.

(2) *Tax on imported taxable products.* Additional rules relating to the tax on imported taxable products are contained in § 52.4682–3.

(3) *Floor stocks tax.* Additional rules relating to the floor stocks tax are contained in § 52.4682–4.

(4) *Returns, payments, and deposits of tax.* Rules requiring returns reporting the taxes imposed by sections 4681 and 4682 are contained in part 40 of this chapter. Part 40 of this chapter also provides rules relating to the use of Government depositaries and to the time for filing returns and making payments of tax.

(c) *Definitions of general application.* The following definitions set forth the meaning of certain terms for purposes of the regulations under sections 4681 and 4682:

(1) *Ozone-depleting chemical.* The term ''ozone-depleting chemical'' (ODC) means any chemical listed in section 4682(a)(2).

(2) *United States.* The term ''United States'' has the meaning given such term by section 4612(a)(4). Under section 4612(a)(4)—

(i) The term ''United States'' means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, any possession of the United States, the Commonwealth of the Northern Mariana Islands, and the Trust Territory of the Pacific Islands; and

(ii) The term includes—

(A) Submarine seabed and subsoil that would be treated as part of the United States (as defined in paragraph (c)(2)(i) of this section) under the principles of section 638 relating to continental shelf areas; and

(B) Foreign trade zones of the United States.

(3) *Manufacture; manufacturer.* The term ''manufacture'' when used with respect to any ODC or imported product includes its production, and the term ''manufacturer'' includes a producer.

(4) *Entry into United States for consumption, use, or warehousing*—(i) *In general.* Except as otherwise provided in this paragraph (c)(4), the term ''entered into the United States for consumption, use, or warehousing'' when used with respect to any goods means—

(A) Brought into the customs territory of the United States (the customs territory) if applicable customs law requires that the goods be entered into the customs territory for consumption, use, or warehousing;

(B) Admitted into a foreign trade zone for any purpose if like goods brought into the customs territory for such purpose would be entered into the customs territory for consumption, use, or warehousing; or

(C) Imported into any other part of the United States (as defined in paragraph (c)(2) of this section) for any purpose if like goods brought into the customs territory for such purpose would be entered into the customs territory for consumption, use, or warehousing.

(ii) *Entry for transportation and exportation.* Goods entered into the customs territory for transportation and exportation are not goods entered for consumption, use, or warehousing.

(iii) *Entries described in two or more provisions.* In the case of any goods with respect to which entries are described in two or more provisions of paragraph (c)(4)(i) of this section, only the first such entry is taken into account. Thus, if the admission of goods into a foreign trade zone is an entry into the United States for consumption, use, or warehousing, the subsequent entry of such goods into the customs territory will not be treated as an entry into the United States for consumption, use, or warehousing.

(iv) *Certain imported products not entered for consumption, use, or warehousing.* Imported products that are entered into the United States for consumption, use, or warehousing do not include any imported products that—

(A) Are entered into the customs territory under Harmonized Tariff Schedule (HTS) heading 9801, 9802, 9803, or 9813;

(B) Would, if entered into the customs territory, be entered under any such heading; or

(C) Are brought into the United States by an individual if the product is brought in for use by the individual and is not expected to be used in a trade or business other than a trade or business of performing services as an employee.

(5) *Importer.* The term ''importer'' means the person that first sells or uses goods after their entry into the United States for consumption, use, or warehousing (within the meaning of paragraph (c)(4) of this section).

(6) *Sale*. The term ''sale'' means the transfer of title or of substantial incidents of ownership (whether or not delivery to, or payment by, the buyer has been made) for consideration which may include money, services, or property. The determination as to the time a sale occurs shall be made under applicable local law.

(7) *Use*—(i) *In general*. Except as otherwise provided in regulations under sections 4681 and 4682, ODCs and imported taxable products are used when they are—

(A) Used as a material in the manufacture of an article, whether by incorporation into such article, chemical transformation, release into the atmosphere, or otherwise; or

(B) Put into service in a trade or business or for production of income.

(ii) *Loss, destruction, packaging, warehousing, and repair*. The loss, destruction, packaging (including repackaging), warehousing, or repair of ODCs and imported taxable products is not a use of the ODC or product lost, destroyed, packaged, warehoused, or repaired.

(iii) *Cross-references to exceptions*. For exceptions to the rule contained in paragraph (c)(7)(i) of this section, see—

(A) Section 52.4682–1(b)(2)(iii) (relating to mixture elections), § 52.4682–1(b)(2)(iv) (relating to mixtures for export), and § 52.4682–1(b)(2)(v) (relating to mixtures for use as a feedstock);

(B) Section 52.4682–3(c)(2) (relating to the election to treat entry of an imported taxable product as use); and

(C) Section 52.4682–3(c)(3) (relating to treating sale of an article incorporating an imported taxable product as the first sale or use of the product).

(8) *Pound*. The term ''pound'' means a unit of weight that is equal to 16 avoirdupois ounces.

(9) *Post-1990 ODC; post-1989 ODC*. The term ''post-1990 ODC'' means any ODC that is listed below Halon–2402 in the table contained in section 4682(a)(2). The term ''post-1989 ODC'' means any ODC other than a post-1990 ODC.

(d) *Effective date*. Sections 52.4681–0, 52.4681–1, 52.4682–1, 52.4682–2, 52.4682–3, and 52.4682–4 are effective as of January 1, 1990, and apply to—

(1) Post-1989 ODCs that the manufacturer or importer thereof first sells or uses after December 31, 1989, and post-1990 ODCs that the manufacturer or importer thereof first sells or uses after December 31, 1990;

(2) Imported taxable products that the importer thereof first sells or uses after December 31, 1989 (but, in the case of products first sold or used before January 1, 1991, by taking into account only the post-1989 ODCs used as materials in their manufacture); and

(3) Post-1989 ODCs held for sale or for use in further manufacture by any person other than the manufacturer or importer thereof on January 1, 1990, and post-1989 and post-1990 ODCs that are so held on January 1 of each calendar year after 1990.

[T.D. 8370, 56 FR 56305, Nov. 4, 1991, as amended by T.D. 8442, 57 FR 48186, Oct. 22, 1992; T.D. 8622, 60 FR 52849, Oct. 11, 1995]

§ 52.4682–1 Ozone-depleting chemicals.

(a) *Overview*. This section provides rules relating to the tax imposed on ozone-depleting chemicals (ODCs) under section 4681, including rules for identifying taxable ODCs and determining when the tax is imposed, and rules prescribing special treatment for certain ODCs. See § 52.4681–1(a)(1) and (c) for general rules and definitions relating to the tax on ODCs.

(b) *Taxable ODCs; taxable event*—(1) *Taxable ODCs*—(i) *In general*. Except as provided in paragraphs (c) through (g) of this section, an ODC is taxable if—

(A) It is listed in section 4682(a)(2) on the date it is sold or used by its manufacturer or importer; and

(B) It is manufactured in the United States or entered into the United States for consumption, use, or warehousing.

(ii) *Storage containers*. An ODC described in paragraph (b)(1)(i) of this section is taxable without regard to the type or size of storage container in which the ODC is held.

(iii) *Example*. The application of this paragraph (b)(1) may be illustrated by the following example:

Example. A brings CFC–12, an ODC listed in section 4682(a)(2), into the customs territory and enters the CFC–12 for transportation and exportation. The ODC is not taxable because it is not entered for consumption, use, or warehousing. The ODC also would not be taxable if it were admitted to a foreign trade

zone (rather than brought into the customs territory) for transportation and exportation.

(2) *Taxable event*—(i) *In general*—(A) *General rule*. The tax on an ODC is imposed when the ODC is first sold or used (as defined in § 52.4681–1(c)(6) and (7)) by its manufacturer or importer.

(B) *Example*. The application of this paragraph (b)(2)(i) may be illustrated by the following example:

Example. A enters CFC–113, an ODC listed in section 4682(a)(2), into the United States for consumption, use, or warehousing. A warehouses the CFC–113 and then decides to ship the ODC to its factory outside the United States (as defined in § 52.4681–1 (c)(2)). The CFC–113 is a taxable ODC because the requirements of paragraph (b)(1)(i) of this section have been met. However, tax is not imposed on the ODC because there is no taxable event. A did not sell the ODC and, under § 52.4681–1(c)(7), warehousing is not a use.

(ii) *Mixtures*. Except as provided in paragraphs (b)(2)(iii), (iv), and (v) of this section, the creation of a mixture containing two or more ingredients is treated as a taxable use of the ODCs contained in the mixture. For this purpose, a mixture cannot be represented by a chemical formula, and an ODC is contained in a mixture only if the chemical identity of the ODC is not changed. Thus, except as provided in paragraphs (b)(2)(iii), (iv), and (v) of this section—

(A) The tax on the post-1989 ODCs (as defined in § 52.4681–1(c)(9)) contained in mixtures created after December 31, 1989, or on the post-1990 ODCs (as defined in § 52.4681–1(c)(9)) contained in mixtures created after December 31, 1990, is imposed when the mixture is created and not on any subsequent sale or use of the mixture; and

(B) No tax is imposed under section 4681 on the post-1989 ODCs contained in mixtures created before January 1, 1990, or on the post-1990 ODCs contained in mixtures created before January 1, 1991.

(iii) *Mixture elections*—(A) *Permitted elections*. The only elections permitted under this paragraph (b)(2)(iii) are—

(*1*) An election for the first calendar quarter beginning after December 31, 1989, and all subsequent periods (the 1990 election); and

(*2*) An election for the first calendar quarter beginning after December 31, 1990, and all subsequent periods (the 1991 election).

(B) *In general*. A manufacturer or importer may elect to treat the sale or use of mixtures containing ODCs as the first sale or use of the ODCs contained in the mixtures. If a 1990 election is made under this paragraph (b)(2)(iii), the tax on post-1989 ODCs contained in a mixture sold or used after December 31, 1989 (including any such mixture created before January 1, 1990) is imposed on the date of such sale or use. Similarly, if a 1991 election is made under this paragraph (b)(2)(iii), the tax on post-1990 ODCs contained in a mixture sold or used after December 31, 1990 (including any such mixture created before January 1, 1991) is imposed on the date of such sale or use.

(C) *Applicability of elections*. An election under this paragraph (b)(2)(iii) applies—

(*1*) In the case of a 1990 election, to all post-1989 ODCs contained in mixtures sold or used by the manufacturer or importer after December 31, 1989 (including any such mixture created before January 1, 1990); and

(*2*) In the case of a 1991 election, to all post-1990 ODCs contained in mixtures sold or used by the manufacturer or importer after December 31, 1990 (including any such mixture created before January 1, 1991).

(D) *Making the election; revocation*. An election under this paragraph (b)(2)(iii) shall be made in accordance with the instructions for the return on which the manufacturer or importer reports liability for tax under section 4681. After October 9, 1990, the election may be revoked only with the consent of the Commissioner.

(iv) *Special rule for exports*. The creation of a mixture for export is not a taxable use of the ODCs contained in the mixture. If a manufacturer or importer sells a mixture for export, § 52.4682–5 applies to the ODCs contained in the mixture. See § 52.4682–5(e) for rules relating to liability of a purchaser for tax if the mixture is not exported.

(v) *Special rule for use as a feedstock*. The creation of a mixture for use as a

feedstock (within the meaning of paragraph (c) of this section) is not a taxable use of the ODCs contained in the mixture.

(c) *ODCs used as a feedstock*—(1) *Exemption from tax*. No tax is imposed on an ODC if the manufacturer or importer of the ODC—

(i) Uses the ODC as a feedstock in the manufacture of another chemical; or

(ii) Sells the ODC in a qualifying sale (within the meaning of paragraph (c)(4) of this section) for use as a feedstock.

(2) *Excess payments*—(i) *In general*. Under section 4682(d)(2)(B), a credit or refund is allowed to a person if—

(A) The person uses an ODC as a feedstock; and

(B) The amount of any tax paid with respect to the ODC under section 4681 or 4682 was not determined under section 4682(d)(2)(A).

(ii) *Procedural rules*. See section 6402 and the regulations thereunder for rules relating to claiming a credit or refund of tax paid with respect to ODCs that are used as a feedstock. A credit against the income tax is not allowed for the amount determined under section 4682(d)(2)(B).

(3) *Definition*. An ODC is used as a feedstock only if the ODC is entirely consumed (except for trace amounts) in the manufacture of another chemical. Thus, the transformation of an ODC into one or more new compounds (such as the transformation of CFC–113 into chlorotrifluoroethylene (CTFE or 1113), of CFC–113 into CFC–115 and CFC–116, or of carbon tetrachloride into hydrochloric acid during petroleum refining or incineration) is treated as use as a feedstock. On the other hand, the ODCs used in a mixture (including an azeotrope such as R–500 or R–502) are not used as a feedstock.

(4) *Qualifying sale*. A sale of ODCs for use as a feedstock is a qualifying sale if the requirements of § 52.4682–2(b)(1) are satisfied with respect to such sale.

(d) *ODCs used in the manufacture of rigid foam insulation*—(1) *Phase-in of tax*—(i) *In general*. The amount of tax imposed on an ODC is determined under section 4682(g) if the manufacturer or importer of the ODC—

(A) Uses the ODC during 1990, 1991, 1992, or 1993 in the manufacture of rigid foam insulation; or

(B) Sells the ODC in a qualifying sale (within the meaning of paragraph (d)(5) of this section) during 1990, 1991, 1992, or 1993.

(ii) *Amount of tax*. Under section 4682(g), ODCs described in paragraph (d)(1)(i) of this section are not taxed if sold or used during 1990 and are taxed at a reduced rate if sold or used during 1991, 1992, or 1993.

(2) *Excess payments*—(i) *In general*. Under section 4682(g)(3), a credit against income tax or a refund is allowed to a person if—

(A) The person uses an ODC during 1990, 1991, 1992, or 1993 in the manufacture of rigid foam insulation; and

(B) The amount of any tax paid with respect to the ODC under section 4681 or 4682 was not determined under section 4682(g).

(ii) *Procedural rules*—(A) The amount determined under section 4682(g)(3) shall be treated as a credit described in section 34(a) (relating to credits for gasoline and special fuels) unless a claim for refund has been filed.

(B) See section 6402 and the regulations thereunder for rules relating to claiming a credit or refund of the tax paid with respect to ODCs that are used in the manufacture of rigid foam insulation.

(3) *Definition*—(i) *Rigid foam insulation*. The term ''rigid foam insulation'' means any rigid foam that is designed for use as thermal insulation in buildings, equipment, appliances, tanks, railcars, trucks, or vessels, or on pipes, including any such rigid foam actually used for purposes other than insulation. Information such as test reports on R-values and advertising material reflecting R-value claims for a particular rigid foam may be used to show that such rigid foam is designed for use as thermal insulation.

(ii) *Rigid foam*—(A) *In general*. The term ''rigid foam'' means any closed cell polymeric foam (whether or not rigid) in which chlorofluorocarbons are used to fill voids within the polymer.

(B) *Examples of rigid foam products*. Rigid foam includes extruded polystyrene foam, polyisocyanurate foam, spray and pour-in-place polyurethane foam, polyethylene foam, phenolic foam, and any other product that the Commissioner identifies as rigid foam

in a pronouncement of general applicability. The form of a product identified under this paragraph (d)(3)(ii)(B) does not affect its character as rigid foam. Thus, such products are rigid foam whether in the form of a board, sheet, backer rod, or wrapping, or in a form applied by spraying, pouring, or frothing.

(4) *Use in manufacture.* An ODC is used in the manufacture of rigid foam insulation if it is incorporated into such product or is expended as a propellant or otherwise in the manufacture or application of such product.

(5) *Qualifying sale.* A sale of an ODC for use in the manufacture of rigid foam insulation is a qualifying sale if the requirements of § 52.4682–2(b)(2) are satisfied with respect to such sale.

(e) *Halons; phase-in of tax.* The amount of tax imposed on Halon-1211, Halon-1301, or Halon-2402 (Halons) is determined under section 4682(g) if the manufacturer or importer of Halons sells or uses Halons during 1990, 1991, 1992, or 1993. Under section 4682(g), Halons are not taxed if sold or used during 1990 and are taxed at a reduced rate if sold or used during 1991, 1992, or 1993.

(f) *Methyl chloroform; reduced rate of tax in 1993.* The amount of tax imposed on methyl chloroform is determined under section 4682(g)(5) if the manufacturer or importer of the methyl chloroform sells or uses it during 1993.

(g) *ODCs used as medical sterilants*—(1) *Phase-in of tax.* The amount of tax imposed on an ODC is determined under section 4682(g)(4) if the manufacturer or importer of the ODC—

(i) Uses the ODC during 1993 as a medical sterilant; or

(ii) Sells the ODC in a qualifying sale (within the meaning of paragraph (g)(4) of this section) during 1993.

(2) *Excess payments*—(i) *In general.* Under section 4682(g)(4)(B), a credit against income tax (without interest) or a refund of tax (without interest) is allowed to a person if—

(A) The person uses an ODC during 1993 as a medical sterilant; and

(B) The amount of any tax paid with respect to the ODC under section 4681 or 4682 exceeds the amount that would have been determined under section 4682(g)(4).

(ii) *Amount of credit or refund.* The amount of credit or refund of tax is equal to the excess of—

(A) The tax that was paid with respect to the ODCs under sections 4681 and 4682; over

(B) The tax that would have been imposed under section 4682(g)(4).

(iii) *Procedural rules.* (A) The amount determined under section 4682(g)(4)(B) and paragraph (g)(2)(ii) of this section is treated as a credit described in section 34(a) (relating to credits for gasoline and special fuels) unless a claim for refund has been filed.

(B) See section 6402 and the regulations under that section for procedural rules relating to claiming a credit or refund of tax.

(3) *Definition of use as a medical sterilant.* An ODC is used as a medical sterilant if it is used in the manufacture of sterilant gas.

(4) *Qualifying sale.* A sale of an ODC for use as a medical sterilant is a qualifying sale if the requirements of § 52.4682–2(b)(3) are satisfied with respect to the sale.

(h) *ODCs used as propellants in metered-dose inhalers*—(1) *Reduced rate of tax.* The amount of tax imposed on an ODC is determined under section 4682(g)(4) if the manufacturer or importer of the ODC—

(i) Uses the ODC after 1992 as a propellant in a metered-dose inhaler; or

(ii) Sells the ODC in a qualifying sale (within the meaning of paragraph (h)(4) of this section) after 1992.

(2) *Excess payments*—(i) *In general.* Under section 4682(g)(4)(B), a credit against income tax (without interest) or a refund of tax (without interest) is allowed to a person if—

(A) The person uses an ODC after 1992 as a propellant in a metered-dose inhaler; and

(B) The amount of any tax paid with respect to the ODC under section 4681 or 4682 exceeds the amount that would have been determined under section 4682(g)(4).

(ii) *Amount of credit or refund.* The amount of credit or refund of tax is equal to the excess of—

(A) The tax that was paid with respect to the ODCs under sections 4681 and 4682; over

(B) The tax that would have been imposed under section 4682(g)(4).

(iii) *Procedural rules*—(A) The amount determined under section 4682(g)(4)(B) and paragraph (h)(2)(ii) of this section is treated as a credit described in section 34(a) (relating to credits for gasoline and special fuels) unless a claim for refund has been filed.

(B) See section 6402 and the regulations under that section for procedural rules relating to claiming a credit or refund of tax.

(3) *Definition of metered-dose inhaler*. A metered-dose inhaler is an aerosol device that delivers a precisely-measured dose of a therapeutic drug.

(4) *Qualifying sale*. A sale of an ODC for use as a propellant for a metered-dose inhaler is a qualifying sale if the requirements of § 52.4682–2(b)(4) are satisfied with respect to the sale.

(i) [Reserved]

(j) *Exports; cross-reference*. For the treatment of exports of ODCs, see § 52.4682–5.

(k) *Recycling*. [Reserved]

[T.D. 8370, 56 FR 56307, Nov. 4, 1991, as amended by T.D. 8622, 60 FR 52849, Oct. 11, 1995]

§ 52.4682–2 Qualifying sales.

(a) *In general*—(1) *Special rules applicable to certain sales*. Special rules apply to sales of ODCs in the following cases:

(i) Under section 4682(d)(2), § 52.4682–1(c), and § 52.4682–4(b)(2)(v) (relating to ODCs used as a feedstock), ODCs sold in qualifying sales are not taxed.

(ii) Under section 4682(g), § 52.4682–1(d), and § 52.4682–4(d)(2) (relating to ODCs used in the manufacture of rigid foam insulation), ODCs sold in qualifying sales are not taxed in 1990 and are taxed at a reduced rate in 1991, 1992, and 1993.

(iii) Under section 4682(g)(4) and § 52.4682–1(g) (relating to ODCs used as medical sterilants), ODCs sold in qualifying sales are taxed at a reduced rate in 1993.

(iv) Under section 4682(g)(4) and § 52.4682–1(h) (relating to ODCs used as propellants in metered-dose inhalers), ODCs sold in qualifying sales are taxed at a reduced rate in years after 1992.

(2) *Qualifying sales*. A sale of ODCs is not a qualifying sale unless the requirements of this section are satisfied. Although registration with the Internal Revenue Service is not required to establish that a sale of ODCs is a qualifying sale, the certificates required by this section shall be made available for inspection by internal revenue agents and officers.

(b) *Requirements for qualification*—(1) *Use as a feedstock*. A sale of ODCs is a qualifying sale for purposes of §§ 52.4682–1(c) and 52.4682–4(b)(2)(v) if the manufacturer or importer of the ODCs—

(i) Obtains a certificate in substantially the form set forth in paragraph (d)(2) of this section from the purchaser of the ODCs; and

(ii) Relies on the certificate in good faith.

(2) *Use in the manufacture of rigid foam insulation*. A sale of ODCs is a qualifying sale for purposes of §§ 52.4682–1(d) and 52.4682–4(d)(2) if the manufacturer or importer of the ODCs—

(i) Obtains a certificate in substantially the form set forth in paragraph (d)(3) of this section from the purchaser of the ODCs; and

(ii) Relies on the certificate in good faith.

(3) *Use as medical sterilants*. A sale of ODCs is a qualifying sale for purposes of § 52.4682–1(g) if the manufacturer or importer of the ODCs—

(i) Obtains a certificate in substantially the form set forth in paragraph (d)(4) of this section from the purchaser of the ODCs; and

(ii) Relies on the certificate in good faith.

(4) *Use as propellants in metered-dose inhalers*. A sale of ODCs is a qualifying sale for purposes of §§ 52.4682–1(h) and 52.4682–4(b)(2)(vii) if the manufacturer or importer of the ODCs—

(i) Obtains a certificate in substantially the form set forth in paragraph (d)(5) of this section from the purchaser of the ODCs; and

(ii) Relies on the certificate in good faith.

(c) *Good faith reliance*—(1) *In general*. The requirements of paragraph (b) of this section are not satisfied with respect to a sale of ODCs and the sale is not a qualifying sale if at the time of the sale—

(i) The manufacturer or importer has reason to believe that the purchaser

will use the ODCs other than for the purpose set forth in the certificate; or

(ii) The Internal Revenue Service has notified the manufacturer or importer that the purchaser's right to provide a certificate has been withdrawn.

(2) *Withdrawal of right to provide a certificate*. The Internal Revenue Service may withdraw the right of a purchaser to provide a certificate to its supplier if such purchaser uses the ODCs to which its certificate applies other than for the purpose set forth in such certificate, or otherwise fails to comply with the terms of the certificate. The Internal Revenue Service may notify the supplier to whom the purchaser provided the certificate that the purchaser's right to provide a certificate has been withdrawn.

(d) *Certificate*—(1) *In general*—(i) *Rules relating to all certificates*. This paragraph (d) sets forth certificates that satisfy the requirements of paragraphs (b)(1) through (4) of this section. The certificate shall consist of a statement executed and signed under penalties of perjury by a person with authority to bind the purchaser. A certificate provided under paragraph (d)(2) or (5) of this section may apply to a single purchase or to multiple purchases and need not specify an expiration date. A certificate provided under paragraph (d)(3) or (4) of this section may apply to a single purchase or multiple purchases, and will expire as of December 31, 1993, unless an earlier expiration date is specified in the certificate. A new certificate must be given to the supplier if any information on the current certificate changes. The certificate may be included as part of any business records normally used to document a sale.

(ii) *Special rule relating to certificates executed before January 1, 1992*. Certificates provided under this paragraph (d)(2) and executed before January 1, 1992, satisfy the requirements of paragraph (b) of this section if they are in substantially the same form as certificates set forth in § 52.4682–2T.

(2) *Certificate relating to ODCs used as a feedstock*—(i) *ODCs that will be resold for use by the second purchaser as a feedstock*. If the purchaser will resell the ODCs to a second purchaser for use by such second purchaser as a feedstock, the certificate provided by the purchaser must be in substantially the following form:

CERTIFICATE OF PURCHASER OF CHEMICALS THAT WILL BE RESOLD FOR USE BY THE SECOND PURCHASER AS A FEEDSTOCK

(To support tax-free sales under section 4682(d)(2) of the Internal Revenue Code.)

Date _____

The undersigned purchaser (''Purchaser'') hereby certifies the following under penalties of perjury:

The following percentage of ozone-depleting chemicals purchased from

_____

(name and address of seller)

will be resold by Purchaser to persons (Second Purchasers) that certify to Purchaser that they are purchasing the ozone-depleting chemicals for use as a feedstock (as defined in § 52.4682–1(c)(3) of the Environmental Tax Regulations).

Product	Percentage
CFC–11.	
CFC–12.	
CFC–113.	
CFC–114.	
CFC–115.	
Carbon tetrachloride.	
Methyl chloroform.	
Other (specify).	

This certificate applies to (check and complete as applicable):

_____ All shipments to Purchaser at the following location(s):

_____

_____

_____

_____ All shipments to Purchaser under the following Purchaser account number(s):

_____

_____

_____

_____ All shipments to Purchaser under the following purchase order(s):

_____

_____

_____

_____ One or more shipments to Purchaser identified as follows:

_____

_____

_____

Purchaser will not claim a credit or refund under section 4682(d)(2)(B) of the Internal Revenue Code for any ozone-depleting chemicals covered by this certificate.

Purchaser understands that any use by Purchaser of the ozone-depleting chemicals

to which this certificate applies other than for the purpose set forth in this certificate may result in the withdrawal by the Internal Revenue Service of Purchaser's right to provide a certificate.

Purchaser will retain the business records needed to document the sales covered by this certificate and will make such records available for inspection by Government officers. Purchaser also will retain and make available for inspection by Government officers the certificates of its Second Purchasers.

Purchaser has not been notified by the Internal Revenue Service that its right to provide a certificate has been withdrawn. In addition, the Internal Revenue Service has not notified Purchaser that the right to provide a certificate has been withdrawn from any Second Purchaser who will purchase ozone-depleting chemicals to which this certificate applies.

Purchaser understands that the fraudulent use of this certificate may subject Purchaser and all parties making such fraudulent use of this certificate to a fine or imprisonment, or both, together with the costs of prosecution.

_____
Signature

_____
Printed or typed name of person signing

_____
Title of person signing

_____
Name of Purchaser

_____
Address

_____

_____
Taxpayer Identifying Number

(ii) *ODCs that will be used by the purchaser as a feedstock.* If the purchaser will use the ODCs as a feedstock, the certificate provided by the purchaser must be in substantially the following form:

CERTIFICATE OF PURCHASER OF CHEMICALS THAT WILL BE USED BY THE PURCHASER AS A FEEDSTOCK

(To support tax-free sales under section 4682(d)(2) of the Internal Revenue Code.)

Date _____

The undersigned purchaser (''Purchaser'') hereby certifies the following under penalties of perjury:

The following percentage of ozone-depleting chemicals purchased from

_____
(name and address of seller)

will be used by Purchaser as a feedstock (as defined in § 52.4682–1(c)(3) of the Environmental Tax Regulations).

Product	Percentage	Kilograms to be transformed
CFC–11.		
CFC–12.		
CFC–113.		
CFC–114.		
CFC–115.		
Carbon tetrachloride.		
Methyl chloroform.		
Other (specify).		

This certificate applies to (check and complete as applicable):

_____ All shipments to Purchaser at the following location(s):

_____

_____

_____

_____ All shipments to Purchaser under the following Purchaser account number(s):

_____

_____

_____

_____ All shipments to Purchaser under the following purchase order(s):

_____

_____

_____

_____ One or more shipments to Purchaser identified as follows:

_____

_____

_____

Purchaser will not claim a credit or refund under section 4682(d)(2)(B) of the Internal Revenue Code for any ozone-depleting chemicals covered by this certificate.

Purchaser understands that any use of the ozone-depleting chemicals to which this certificate applies other than as a feedstock may result in the withdrawal by the Internal Revenue Service of Purchaser's right to provide a certificate.

Purchaser will retain the business records needed to document the use as a feedstock of the ozone-depleting chemicals to which this certificate applies and will make such records available for inspection by Government officers.

Purchaser has not been notified by the Internal Revenue Service that its right to provide a certificate has been withdrawn.

Purchaser understands that the fraudulent use of this certificate may subject Purchaser and all parties making such fraudulent use of this certificate to a fine or imprisonment, or both, together with the costs of prosecution.

_____
Signature

_____
Printed or typed name of person signing

Title of person signing

Name of Purchaser

Address

Taxpayer Identifying Number

(3) *Certificate relating to ODCs used in the manufacture of rigid foam insulation*—(i) *ODCs that will be resold to a second purchaser for use by the second purchaser in the manufacture of rigid foam insulation*. If the purchaser will resell the ODCs to a second purchaser for use by such second purchaser in the manufacture of rigid foam insulation, the certificate provided by the purchaser must be in substantially the following form:

CERTIFICATE OF PURCHASER OF CHEMICALS THAT WILL BE RESOLD FOR USE BY THE SECOND PURCHASER IN THE MANUFACTURE OF RIGID FOAM INSULATION

(To support tax-free or tax-reduced sales under section 4682(g) of the Internal Revenue Code.)

Effective Date _____

Expiration Date _____

(not after 12/31/93)

The undersigned purchaser (''Purchaser'') hereby certifies the following under penalties of perjury:

The following percentage of ozone-depleting chemicals purchased from

(name and address of seller)

will be resold by Purchaser to persons (Second Purchasers) that certify to Purchaser that they are purchasing the ozone-depleting chemicals for use in the manufacture of rigid foam insulation (as defined in § 52.4682–1(d)(3) and (4) of the Environmental Tax Regulations).

Product	Percentage
CFC–11.	
CFC–12.	
CFC–113.	
CFC–114.	
CFC–115.	
Carbon tetrachloride.	
Methyl chloroform.	
Other (specify).	

This certificate applies to (check and complete as applicable):

_____ All shipments to Purchaser at the following location(s):

_____ All shipments to Purchaser under the following Purchaser account number(s):

_____ All shipments to Purchaser under the following purchase order(s):

_____ One or more shipments to Purchaser identified as follows:

Purchaser will not claim a credit or refund under section 4682(g)(3) of the Internal Revenue Code for any ozone-depleting chemicals covered by this certificate.

Purchaser understands that any use by Purchaser of the ozone-depleting chemicals to which this certificate applies other than for the purpose set forth in this certificate may result in the withdrawal by the Internal Revenue Service of Purchaser's right to provide a certificate.

Purchaser will retain the business records needed to document the sales covered by this certificate and will make such records available for inspection by Government officers. Purchaser also will retain and make available for inspection by Government officers the certificates of its Second Purchasers.

Purchaser has not been notified by the Internal Revenue Service that its right to provide a certificate has been withdrawn. In addition, the Internal Revenue Service has not notified Purchaser that the right to provide a certificate has been withdrawn from any Second Purchaser who will purchase ozone-depleting chemicals to which this certificate applies.

Purchaser understands that the fraudulent use of this certificate may subject Purchaser and all parties making such fraudulent use of this certificate to a fine or imprisonment, or both, together with the costs of prosecution.

Signature

Printed or typed name of person signing

Title of person signing

Name of Purchaser

Address

Taxpayer Identifying Number

(ii) *ODCs that will be used by the purchaser in the manufacture of rigid foam insulation*. If the purchaser will use the ODCs in the manufacture of rigid foam insulation, the certificate provided by the purchaser must be in substantially the following form:

CERTIFICATE OF PURCHASER OF CHEMICALS THAT WILL BE USED BY THE PURCHASER IN THE MANUFACTURE OF RIGID FOAM INSULATION

(To support tax-free or tax-reduced sales under section 4682(g) of the Internal Revenue Code.)

Effective Date _____
Expiration Date _____
(not after 12/31/93)

The undersigned purchaser (''Purchaser'') hereby certifies the following under penalties of perjury:

The following percentage of ozone-depleting chemicals purchased from

_____
(name and address of seller)

will be used by Purchaser in the manufacture of rigid foam insulation (as defined in § 52.4682–1(d) (3) and (4) of the Environmental Tax Regulations).

Product	Percentage
CFC–11.	
CFC–12.	
CFC–113.	
CFC–114.	
CFC–115.	
Carbon tetrachloride.	
Methyl chloroform.	
Other (specify).	

This certificate applies to (check and complete as applicable):

_____ All shipments to Purchaser at the following location(s):

_____ All shipments to Purchaser under the following Purchaser account number(s):

_____ All shipments to Purchaser under the following purchase order(s):

_____ One or more shipments to Purchaser identified as follows:

Purchaser will not claim a credit or refund under section 4682(g)(3) of the Internal Revenue Code for any ozone-depleting chemicals covered by this certificate.

Purchaser understands that any use by Purchaser of the ozone-depleting chemicals to which this certificate applies other than in the manufacture of rigid foam insulation may result in the withdrawal by the Internal Revenue Service of Purchaser's right to provide a certificate.

Purchaser will retain the business records needed to document the use in the manufacture of rigid foam insulation of the ozone-depleting chemicals to which this certificate applies and will make such records available for inspection by Government officers.

Purchaser has not been notified by the Internal Revenue Service that its right to provide a certificate has been withdrawn.

Purchaser understands that the fraudulent use of this certificate may subject Purchaser and all parties making such fraudulent use of this certificate to a fine or imprisonment, or both, together with the costs of prosecution.

_____
Signature

_____
Printed or typed name of person signing

_____
Title of person signing

_____
Name of Purchaser

_____
Address

_____

_____
Taxpayer Identifying Number

(4) *Certificate relating to ODCs used as medical sterilants*—(i) *ODCs that will be resold for use by the second purchaser as medical sterilants*. If the purchaser will resell the ODCs to a second purchaser for use by such second purchaser as medical sterilants, the certificate provided by the purchaser must be in substantially the following form:

CERTIFICATE OF PURCHASER OF CHEMICALS THAT WILL BE RESOLD FOR USE BY THE SECOND PURCHASER AS MEDICAL STERILANTS

(To support tax-reduced sales under section 4682(g)(4) of the Internal Revenue Code.)

Effective Date _____
Expiration Date _____
(not after 12/31/93)

The undersigned purchaser (Purchaser) certifies the following under penalties of perjury:

The following percentage of ozone-depleting chemicals purchased from:

_____

(Name of seller)

_____

(Address of seller)

will be resold by Purchaser to persons (Second Purchasers) that certify to Purchaser that they are purchasing the ozone-depleting chemicals for use as medical sterilants (as defined in § 52.4682–1(g)(3) of the Environmental Tax Regulations).

Product	Percentage
CFC–12	_____

This certificate applies to (check and complete as applicable):

_____ All shipments to Purchaser at the following location(s):

_____

_____

_____

_____ All shipments to Purchaser under the following Purchaser account number(s):

_____

_____

_____

_____ All shipments to Purchaser under the following purchase order(s):

_____

_____

_____

_____ One or more shipments to Purchaser identified as follows:

_____

_____

_____

Purchaser will not claim a credit or refund under section 4682(g)(4) of the Internal Revenue Code for any ozone-depleting chemicals covered by this certificate.

Purchaser understands that any use by Purchaser of the ozone-depleting chemicals to which this certificate applies other than for the purpose set forth in this certificate may result in the withdrawal by the Internal Revenue Service of Purchaser's right to provide a certificate.

Purchaser will retain the business records needed to document the sales covered by this certificate and will make such records available for inspection by Government officers. Purchaser also will retain and make available for inspection by Government officers the certificates of its Second Purchasers.

Purchaser has not been notified by the Internal Revenue Service that its right to provide a certificate has been withdrawn. In addition, the Internal Revenue Service has not notified Purchaser that the right to provide a certificate has been withdrawn from any Second Purchaser who will purchase ozone-depleting chemicals to which this certificate applies.

Purchaser understands that the fraudulent use of this certificate may subject Purchaser and all parties making such fraudulent use of this certificate to a fine or imprisonment, or both, together with the costs of prosecution.

_____

Name of Purchaser

_____

Address of Purchaser

_____

_____

Taxpayer Identifying Number of Purchaser

_____

Title of person signing

_____

Printed or typed name of person signing

_____

Signature

(ii) *ODCs that will be used by the purchaser as medical sterilants.* If the purchaser will use the ODCs as medical sterilants, the certificate provided by the purchaser must be in substantially the following form:

CERTIFICATE OF PURCHASER OF CHEMICALS THAT WILL BE USED BY THE PURCHASER AS MEDICAL STERILANTS

(To support tax-reduced sales under section 4682(g)(4) of the Internal Revenue Code.)

Effective Date _____

Expiration Date _____

(not after 12/31/93)

The undersigned purchaser (Purchaser) certifies the following under penalties of perjury:

The following percentage of ozone-depleting chemicals purchased from:

_____

(Name of seller)

_____

(Address of seller)

will be used by Purchaser as medical sterilants (as defined in § 52.4682–1(g)(3) of the Environmental Tax Regulations).

Product	Percentage
CFC–12	_____

This certificate applies to (check and complete as applicable):

_____ All shipments to Purchaser at the following location(s):

_____

_____

_____

_____ All shipments to Purchaser under the following Purchaser account number(s):

_____

_____

_____

_____ All shipments to Purchaser under the following purchase order(s):

_____ One or more shipments to Purchaser identified as follows:

Purchaser will not claim a credit or refund under section 4682(g)(4) of the Internal Revenue Code for any ozone-depleting chemicals covered by this certificate.

Purchaser understands that any use by Purchaser of the ozone-depleting chemicals to which this certificate applies other than as medical sterilants may result in the withdrawal by the Internal Revenue Service of Purchaser's right to provide a certificate.

Purchaser will retain the business records needed to document the use as medical sterilants of the ozone-depleting chemicals to which this certificate applies and will make such records available for inspection by Government officers.

Purchaser has not been notified by the Internal Revenue Service that its right to provide a certificate has been withdrawn.

Purchaser understands that the fraudulent use of this certificate may subject Purchaser and all parties making such fraudulent use of this certificate to a fine or imprisonment, or both, together with the costs of prosecution.

Name of Purchaser

Address of Purchaser

Taxpayer Identifying Number of Purchaser

Title of person signing

Printed or typed name of person signing

Signature

(5) *Certificate relating to ODCs used as propellants in metered-dose inhalers*—(i) *ODCs that will be resold for use by the second purchaser as propellants in metered-dose inhalers.* If the purchaser will resell the ODCs to a second purchaser for use by such second purchaser as propellants in metered-dose inhalers, the certificate provided by the purchaser must be in substantially the following form:

CERTIFICATE OF PURCHASER OF CHEMICALS THAT WILL BE RESOLD FOR USE BY THE SECOND PURCHASER AS PROPELLANTS IN METERED-DOSE INHALERS

(To support tax-reduced sales under section 4682(g)(4) of the Internal Revenue Code.)

Date _____

The undersigned purchaser (Purchaser) certifies the following under penalties of perjury:

The following percentage of ozone-depleting chemicals purchased from:

(Name of seller)

(Address of seller)

will be resold by Purchaser to persons (Second Purchasers) that certify to Purchaser that they are purchasing the ozone-depleting chemicals for use as propellants in metered-dose inhalers (as defined in § 52.4682–1(h)(3) of the Environmental Tax Regulations).

Product	Percentage
CFC–11	_____
CFC–12	_____
CFC–114	_____

This certificate applies to (check and complete as applicable):

_____ All shipments to Purchaser at the following location(s):

_____ All shipments to Purchaser under the following Purchaser account number(s):

_____ All shipments to Purchaser under the following purchase order(s):

_____ One or more shipments to Purchaser identified as follows:

Purchaser will not claim a credit or refund under section 4682(g)(4) of the Internal Revenue Code for any ozone-depleting chemicals covered by this certificate.

Purchaser understands that any use by Purchaser of the ozone-depleting chemicals to which this certificate applies other than for the purpose set forth in this certificate may result in the withdrawal by the Internal Revenue Service of Purchaser's right to provide a certificate.

Purchaser will retain the business records needed to document the sales covered by this

certificate and will make such records available for inspection by Government officers. Purchaser also will retain and make available for inspection by Government officers the certificates of its Second Purchasers.

Purchaser has not been notified by the Internal Revenue Service that its right to provide a certificate has been withdrawn. In addition, the Internal Revenue Service has not notified Purchaser that the right to provide a certificate has been withdrawn from any Second Purchaser who will purchase ozone-depleting chemicals to which this certificate applies.

Purchaser understands that the fraudulent use of this certificate may subject Purchaser and all parties making such fraudulent use of this certificate to a fine or imprisonment, or both, together with the costs of prosecution.

_____
Name of Purchaser

_____
Address of Purchaser

_____
_____
Taxpayer Identifying Number of Purchaser

_____
Title of person signing

_____
Printed or typed name of person signing

_____
Signature

(ii) *ODCs that will be used by the purchaser as propellants in metered-dose inhalers.* If the purchaser will use the ODCs as propellants in metered-dose inhalers, the certificate provided by the purchaser must be in substantially the following form:

CERTIFICATE OF PURCHASER OF CHEMICALS THAT WILL BE USED BY THE PURCHASER AS PROPELLANTS IN METERED-DOSE INHALERS

(To support tax-reduced sales under section 4682(g)(4) of the Internal Revenue Code.)

Date _____

The undersigned purchaser (Purchaser) certifies the following under penalties of perjury:

The following percentage of ozone-depleting chemicals purchased from:

_____
(Name of seller)

_____
(Address of seller)

will be used by Purchaser as propellants in metered-dose inhalers (as defined in § 52.4682–1(h)(3) of the Environmental Tax Regulations).

Product	Percentage
CFC–11	_____
CFC–12	_____
CFC–114	_____

This certificate applies to (check and complete as applicable):

_____ All shipments to Purchaser at the following location(s):

_____
_____
_____

_____ All shipments to Purchaser under the following Purchaser account number(s):

_____
_____
_____

_____ All shipments to Purchaser under the following purchase order(s):

_____
_____
_____

_____ One or more shipments to Purchaser identified as follows:

_____
_____
_____

Purchaser will not claim a credit or refund under section 4682(g)(4) of the Internal Revenue Code for any ozone-depleting chemicals covered by this certificate.

Purchaser understands that any use by Purchaser of the ozone-depleting chemicals to which this certificate applies other than as propellants in metered-dose inhalers may result in the withdrawal by the Internal Revenue Service of Purchaser's right to provide a certificate.

Purchaser will retain the business records needed to document the use as propellants in metered-dose inhalers of the ozone-depleting chemicals to which this certificate applies and will make such records available for inspection by Government officers.

Purchaser has not been notified by the Internal Revenue Service that its right to provide a certificate has been withdrawn.

Purchaser understands that the fraudulent use of this certificate may subject Purchaser and all parties making such fraudulent use of this certificate to a fine or imprisonment, or both, together with the costs of prosecution.

_____
Name of Purchaser

_____
Address of Purchaser

_____
_____
Taxpayer Identifying Number of Purchaser

_____
Title of person signing

_____
Printed or typed name of person signing

_____

Signature

[T.D. 8370, 56 FR 56308, Nov. 4, 1991, as amended by T.D. 8622, 60 FR 52850, Oct. 11, 1995]

§ 52.4682–3 Imported taxable products.

(a) *Overview; references to Tables; special rule for 1990*—(1) *Overview*. This section provides rules relating to the tax imposed on imported taxable products under section 4681, including rules for identifying imported taxable products, determining the weight of the ozone-depleting chemicals (ODCs) used as materials in the manufacture of such products, and computing the amount of tax on such products. See § 52.4681–1(a)(2) and (c) for general rules and definitions relating to the tax on imported taxable products.

(2) *References to Tables*. When used in this section—

(i) The term *Imported Products Table* (Table) refers to the Table set forth in paragraph (f)(6) of this section; and

(ii) The term *current Imported Products Table* (current Table) used with respect to a product refers to the Table in effect on the date such product is first sold or used by the importer thereof.

(3) *Special rule for 1990*. In the case of products first sold or used before January 1, 1991, post-1990 ODCs (as defined in § 52.4681–1(c)(9)) shall not be taken into account in applying the rules of this section.

(b) *Imported taxable products*—(1) *In general*—(i) *Rule*. Except as provided in paragraph (b)(2) of this section, the term ''imported taxable product'' means any product that—

(A) Is entered into the United States for consumption, use, or warehousing; and

(B) Is listed in the current Table.

(ii) *Example*. The application of this paragraph (b)(1) may be illustrated by the following example:

Example. A brings a light truck with a Harmonized Tariff Schedule classification of 8704 into the customs territory and enters the truck for transportation and exportation. Although the truck is listed in the current Table, it is not an imported taxable product because it is not entered for consumption, use, or warehousing. The truck also would not be an imported taxable product if it were admitted to a foreign trade zone (rather than brought into the customs territory) for transportation and exportation.

(2) *Exceptions*—(i) *In general*. A product is not treated as an imported taxable product if—

(A) The product is listed in Part I of the current Table and the adjusted tax with respect to the product is *de minimis* (within the meaning of paragraph (b)(2)(ii) of this section); or

(B) The product is listed in Part II of the current Table, the adjusted tax with respect to the product is *de minimis* (within the meaning of paragraph (b)(2)(ii) of this section), and the ODCs (other than methyl chloroform) used as materials in the manufacture of the product were not used for purposes of refrigeration or air conditioning, creating an aerosol or foam, or manufacturing electronic components.

(ii) *De minimis adjusted tax*. The adjusted tax with respect to a product is *de minimis* if such tax is less than one/tenth of one percent of the importer's cost of acquiring such product. The term *adjusted tax* means the tax that would be imposed under section 4681 on the ODCs used as materials in the manufacture of such product if such ODCs were sold in the United States and the base tax amount were $1.00.

(c) *Taxable event*—(1) *In general*. Except as otherwise provided in paragraphs (c) (2) and (3) of this section, the tax on an imported taxable product is imposed when the product is first sold or used (as defined in § 52.4681–1(c) (6) and (7)) by its importer. Thus, for example, imported taxable products that are warehoused or repackaged after entry and then exported without being sold or used in the United States are not subject to tax.

(2) *Election to treat importation as use*—(i) *In general*. An importer may elect to treat the entry of products into the United States as the use of such products. In the case of imported taxable products to which an election under this paragraph (c)(2) applies—

(A) Tax is imposed on the products on the date of entry (as determined under paragraph (c)(2)(ii) of this section) if the products are entered into the United States after the election becomes effective;

(B) Tax is imposed on the products on the date the election becomes effective if the products were entered into the United States after December 31, 1989,

and before the election becomes effective; and

(C) No tax is imposed if the products were entered into the United States before January 1, 1990.

(ii) *Date of entry*. The date of entry is determined by reference to customs law. If the actual date is unknown, the importer may use any reasonable and consistent method to determine the date of entry, provided that such date is within 10 business days of arrival of products in the United States.

(iii) *Applicability of election*. An election under this paragraph (c)(2) applies to all imported taxable products that are owned (and have not been used) by the importer at the time the election becomes effective and all imported taxable products that are entered into the United States by the importer after the election becomes effective. An election under this paragraph (c)(2) becomes effective at the beginning of the first calendar quarter to which the election applies. After October 9, 1990, the election may be revoked only with the consent of the Commissioner.

(iv) *Making the election*. An election under this paragraph (c)(2) shall be made in accordance with the instructions for the return on which the importer is required to report liability for tax under section 4681.

(3) *Treating the sale of an article incorporating an imported taxable product as the first sale or use of such product*—(i) *In general*. In the case of articles to be sold, an importer may treat the sale of an article manufactured or assembled in the United States as the first sale or use of an imported taxable product incorporated in such article, but only if the importer—

(A) Has consistently treated the sale of similar articles as the first sale or use of similar imported taxable products; and

(B) Has not made an election under paragraph (c)(2) of this section.

(ii) *Similar articles and imported taxable products*. An importer may establish any reasonable criteria for determining whether articles or imported taxable products are similar for purposes of this paragraph (c)(3).

(iii) *Establishment of consistent treatment*. An importer has consistently treated the sale of similar articles as the first sale or use of similar imported taxable products only if such treatment is reflected in the computation of tax on the importer's returns for all prior calendar quarters in which such treatment would affect tax liability.

(iv) *Example*. The application of this paragraph (c)(3) may be illustrated by the following example:

Example. (a) An importer of printed circuits and other electronic components uses those products in assembling television receivers in the United States and also uses the printed circuits in assembling VCRs in the United States. Under the importer's criteria for determining similarity, printed circuits are similar to other printed circuits, but not to the other electronic components. In addition, television receivers are similar to other television receivers, but not to VCRs. The importer has not made an election under paragraph (c)(2) of this section.

(b) Under this paragraph (c)(3), the importer may treat the sale of the television receivers as the first sale or use of the imported printed circuits incorporated into the television receivers. In that case, the tax on the printed circuits would be imposed when the television receivers are sold rather than when the printed circuits are used in assembling the television receivers.

(c) The importer may treat the sale of the television receivers as the first sale or use of the printed circuits incorporated into the television receivers even if the sale of the television receivers is not treated as the first sale or use of the other electronic components incorporated into the television receivers and even if the sale of VCRs is not treated as the first sale or use of the printed circuits incorporated into the VCRs. Under paragraph (c)(3)(i)(A) of this section, however, the importer must have consistently treated the sale of television receivers as the first sale or use of printed circuits incorporated into the receivers. Thus, in the case of television receivers that were assembled before January 1, 1990, and sold after December 31, 1989, the importer must have treated the sale of the television receivers as the first sale or use of the printed circuits incorporated into the television receivers when reporting tax under section 4681 with respect to such printed circuits.

(d) *ODCs used as materials in the manufacture of imported taxable products*—(1) *ODC weight*. The tax imposed on an imported taxable product under section 4681 is computed by reference to the weight of the ODCs used as materials in the manufacture of the product (ODC weight). The ODC weight of a product includes the weight of ODCs

used as materials in the manufacture of any components of the product.

(2) *ODCs used as materials in the manufacture of a product.* Except as provided in paragraph (d)(3) of this section, an ODC is used as a material in the manufacture of a product if the ODC is—

(i) Incorporated into the product;

(ii) Released into the atmosphere in the process of manufacturing the product; or

(iii) Otherwise used in the manufacture of the product (but only to the extent the cost of the ODC is properly allocable to the product).

(3) *Protective packaging.* ODCs used in the manufacture of the protective material in which a product is packaged are not treated as ODCs used as materials in the manufacture of such product.

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

Example 1. A, a manufacturer located outside the United States, uses ODCs as a solvent to clean the printed circuits it manufactures and as a coolant in the air-conditioning system of the factory in which the printed circuits are manufactured. The ODCs used as a solvent are released into the atmosphere, and, under paragraph (d)(2)(ii) of this section, are used as materials in the manufacture of the printed circuits. The ODCs used as a coolant in the air-conditioning system are also used in the manufacture of the printed circuits. Under paragraph (d)(2)(iii) of this section, these ODCs are used as materials in the manufacture of the printed circuits only to the extent the cost of the ODCs is properly allocable to the printed circuits.

Example 2. B manufactures television receivers outside the United States and wraps them for shipping in a protective packing material manufactured with ODCs. Under paragraph (d)(3) of this section, the ODCs used in the manufacture of the protective packing material are not treated as ODCs used as a material in the manufacture of the television receivers.

(e) *Methods of determining ODC weight; computation of tax*—(1) *In general.* This paragraph (e) sets forth the methods to be used for determining the ODC weight of an imported taxable product and a method to be used in computing the tax when the ODC weight cannot be determined. The amount of tax is computed separately for each imported taxable product and the method to be used in determining the ODC weight or otherwise computing the tax is separately determined for each such product. Thus, an importer may use one method in computing the tax on some imported taxable products and different methods in computing the tax on other products. For example, an importer of telephone sets may compute the tax using the exact method described in paragraph (e)(2) of this section for determining the ODC weight of telephone sets supplied by one manufacturer and using the Table method described in paragraph (e)(3) of this section for telephone sets supplied by other manufacturers that have not provided sufficient information to allow the importer to use the exact method.

(2) *Exact method.* If the importer determines the weight of each ODC used as a material in the manufacture of an imported taxable product and supports that determination with sufficient and reliable information, the ODC weight of the product is the weight so determined. Under this method, the ODC weight of a mixture is equal to the weight of the ODCs contained in the mixture. Representations by the manufacturer of the product to the importer as to the weight of the ODCs used as materials in the manufacture of the product may be sufficient and reliable information for this purpose. Thus, a letter to the importer signed by the manufacturer may constitute sufficient and reliable information if the letter adequately identifies the product and states the weight of each ODC used as a material in the product's manufacture.

(3) *Table method*—(i) *In general.* If the ODC weight of an imported taxable product is not determined using the exact method described in paragraph (e)(2) of this section and the current Table specifies an ODC weight for the product, the ODC weight of the product is the Table ODC weight, regardless of what ODCs were used in the manufacture of the product. In computing the amount of tax, the Table ODC weight shall not be rounded.

(ii) *Special rules*—(A) *Articles assembled in the United States.* An importer that assembles finished articles in the United States may compute the

amount of tax imposed on the imported taxable products incorporated into the finished article by using the Table ODC weight specified for the article instead of the Table ODC weights specified for the components. In order to compute the tax under this special rule, the importer must determine the actual number of articles manufactured. For example, if an importer manufactures 100 camcorders using imported subassemblies, the importer may compute the amount of tax on the subassemblies by using the Table ODC weight specified for camcorders. Thus, the tax imposed on the subassemblies is equal to the tax that would be imposed on 100 camcorders.

(B) *Combination method.* This paragraph (e)(3)(ii)(B) applies to an imported taxable product if the current Table specifies weights for two or more ODCs with respect to the product and the importer of the product can determine the weight of any such ODC (and of any ODC used as a substitute for such ODC) and can support such determination with sufficient and reliable information. In determining the ODC weight of any such product, the importer may replace the weight specified in the Table for such ODC with the weight (as determined by the importer) of such ODC and its substitutes. For example, if an importer has sufficient and reliable information to determine the amount of CFC–12 included in a product as a coolant (and to determine that no ODCs have been used as substitutes for CFC–12) but cannot determine the amount of CFC–113 used in manufacturing the product's electronic components, the importer may use the weight specified in the Table for CFC–113 and the actual weight determined by the importer for CFC–12 in determining the ODC weight of the product.

(C) *ODCs used in the manufacture of rigid foam insulation.* In computing the tax using the method described in this paragraph (e)(3), any ODC for which the Table specifies a weight followed by an asterisk (*) shall be treated as an ODC used in the manufacture of rigid foam insulation (as defined in § 52.4682–1(d)(3) and (4)).

(4) *Value method*—(i) *General rule.* If the importer cannot determine the ODC weight of an imported taxable product under the exact method described in paragraph (e)(2) of this section and the Table ODC weight of the product is not specified, the tax imposed on the product under section 4681 is one percent of the entry value of the product.

(ii) *Special rule for mixtures.* If, in the case of an imported taxable product that is a mixture, the tax was determined under the method described in this paragraph (e)(4), the Commissioner may redetermine the tax based on the ODC weight of the mixture.

(5) *Adjustment for prior taxes*—(i) *In general.* If any manufacture with respect to an imported taxable product occurred in the United States or the product incorporates a taxed component or a taxed chemical was used in its manufacture, the product's ODC weight (or value) attributable to manufacture within the United States or to taxed components or taxed chemicals shall be disregarded in computing the tax on such product using a method described in paragraph (e) (2), (3), or (4) of this section.

(ii) *Taxed component.* The term ''taxed component'' means any component that previously was subject to tax as an imported taxable product or that would have been so taxed if section 4681 had been in effect for periods before January 1, 1990.

(iii) *Taxed chemical.* The term ''taxed chemical'' means any ODC that previously was subject to tax.

(6) *Examples.* The application of this paragraph (e) may be illustrated by the following examples:

Example 1. A is an importer (as defined in § 52.4681–1(c)(5)) of VCRs. The HTS classification for the VCRs is 8528.10.40. VCRs classified under HTS heading 8528.10.40 are imported taxable products because they are listed in the Table (contained in paragraph (f)(6) of this section) by name and HTS heading (as described in paragraph (f)(3)(i) of this section). Each VCR is wrapped in protective packing material manufactured with ODCs. A imports and sells 100 VCRs during the first calendar quarter of 1991. A may determine the ODC weight for the VCRs by reference to the Table. The Table ODC weight specified for VCRs classified under HTS heading 8528.10.40 is 0.0586 pound of CFC–113. This weight does not take protective packaging into account. The amount of tax for the first quarter of 1991 is $6.42 (0.0586 (the ODC weight) × 100 (the number of VCRs sold in the

quarter) × $1.37 (the base tax amount for CFC–113 in 1991) × 0.8 (the ozone-depletion factor for CFC–113)). If A uses the exact method (as described in paragraph (e)(2) of this section) to determine the ODC weight for the VCRs, A does not take into account the ODCs used in the manufacture of the protective packaging. (Imported protective packaging containing foams made with ODCs other than foams defined in § 52.4682–1(d)(3) is subject to tax, however, if the packaging is sold as packaging or first used as packaging in the United States.)

Example 2. The facts are the same as in *Example 1*, except that A's VCRs are manufactured using methyl chloroform as the solvent instead of CFC–113. If A does not use the exact method to determine the weight of the methyl chloroform used in the manufacture of the VCRs, A must, under paragraphs (e)(3)(i) and (e)(4)(i) of this section, determine the ODC weight by reference to the Table. If A uses the Table ODC weight, the computation of tax is the same as in *Example 1*, using the base tax amount and ozone-depletion factor for CFC–113. A does not substitute the base tax amount and ozone-depletion factor of methyl chloroform for those of CFC–113.

Example 3. B imports and sells mixtures of ethylene oxide and CFC–12. The mixture is 88 percent CFC–12 by weight. B also imports and sells R–502. The R–502 is 51 percent CFC–115 by weight. In the first calendar quarter of 1991 B sells 100 pounds of imported ethylene oxide/CFC–12 mixture and 10,000 pounds of imported R–502. The ethylene/CFC–12 mixture and the R–502 are imported taxable products because they are listed in Part I of the Table (contained in paragraph (f)(6) of this section). Under the exact method described in paragraph (e)(2) of this section, B computes the tax based on 88 pounds of CFC–12, the amount of ODCs contained in the imported ethylene oxide mixture, and based on 5100 pounds of CFC–115, the amount of ODCs in the imported R–502.

(f) *Imported Products Table*—(1) *In general*. This paragraph (f) contains rules relating to the Imported Products Table (Table) and sets forth the Table. The Table lists all the products that are subject to the tax on imported taxable products and specifies the Table ODC weight of each product for which such a weight has been determined.

(2) *Applicability of Table*—(i) *In general*. Except as provided in paragraph (f)(2)(ii) of this section, the Table contained in paragraph (f)(6) of this section is effective on January 1, 1990.

(ii) *Treatment of certain products*—(A) Products included in a listing that is preceded by a double asterisk (**) in the Table shall not be treated as imported taxable products until October 1, 1990.

(B) Products included in a listing that is preceded by a triple asterisk (***) in the Table shall not be treated as imported taxable products until January 1, 1992.

(3) *Identification of products*—(i) *In general*. Each listing in the Table identifies a product by name and includes only products that are described by that name. Most listings (other than listings for mixtures) identify a product by both name and HTS heading. In such cases, a product is included in that listing only if the product is described by that name and the rate of duty on the product is determined by reference to that HTS heading. However, the product is included in that listing even if it is manufactured with or contains a different ODC than the ODC specified in the Table.

(ii) *Electronic items not listed by specific name*—(A) *In general*. Part II of the Table contains listings for electronic items that are not included within any other listing in the Table. An imported product is included in these listings only if such imported product—

(*1*) Is an electronic component listed in chapters 84, 85, or 90 of the Harmonized Tariff Schedule; or

(*2*) Contains components described in paragraph (f)(3)(ii)(A)(*1*) of this section and more than 15 percent of the cost of the imported product is attributable to such components.

(B) *Electronic component*. For purposes of this paragraph (f)(3)(ii), an electronic component is a component whose operation involves the use of nonmechanical amplification or switching devices such as tubes, transistors, and integrated circuits. Such components do not include passive electrical devices such as resistors and capacitors.

(C) *Certain items not included*. Items such as screws, nuts, bolts, plastic parts, and similar specially fabricated parts that may be used to construct an electronic item are not themselves included in the listing for electronic items not otherwise listed in the Table.

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

Example 1. The Table lists ''electronic integrated circuits and microassemblies; HTS heading 8542.'' A bipolar transistor under HTS heading 8542.11.00.05 is included in this listing because a bipolar transistor is a type of electronic integrated circuit and HTS heading 8542.11.00.05 is included within HTS heading 8542.

Example 2. The Table lists ''radios; HTS heading 8527.19,'' ''radio combinations; HTS heading 8527.11'' and ''radio combinations; HTS heading 8527.31.'' A radio classified under HTS heading 8527.19 is not included within either listing for radio combinations. However, a radio classified under HTS heading 8527.19.00.20 is included within the listing for radios; HTS heading 8527.19. A radio combination classified under HTS heading 8527.11.20 is included within the listing for radio combinations; HTS heading 8527.11 but not the listing for radio combinations; HTS heading 8527.31. Any radio or radio combination not classified under the HTS heading for any other listing is included in the listing for electronic items not otherwise listed.

(4) *Rules for listing products*. Products are listed in the Table in accordance with the following rules:

(i) *Listing in part I*. A product is listed in part I of the Table if it is a mixture containing ODCs. In addition, a product other than a mixture containing ODCs will be listed in part I of a revised Table if the Commissioner has determined that—

(A) The ODC weight of the product is not *de minimis* when the product is produced using the predominant method of manufacturing the product; and

(B) None of the ODCs used as materials in the manufacture of the product under the predominant method are used for purposes of refrigeration or air conditioning, creating an aerosol or foam, or manufacturing electronic components.

(ii) *Listing in part II*. A product is listed in part II of the Table if the Commissioner has determined that the ODCs used as materials in the manufacture of the product under the predominant method are used for purposes of refrigeration or air conditioning, creating an aerosol or foam, or manufacturing electronic components.

(iii) *Listing in part III*. A product is listed in part III of the Table if the Commissioner has determined that the product is not an imported taxable product and the product would otherwise be included within a listing in part II of the Table. For example, floppy disk drive units are listed in part III because they are not imported taxable products and they would, but for their listing in part III, be included within the part II listing for electronic items not specifically identified.

(5) *Table ODC weight*. The Table ODC weight of a product is the weight, determined by the Commissioner, of the ODCs that are used as materials in the manufacture of the product under the predominant method of manufacturing. The Table ODC weight is given in pounds per single unit of product unless otherwise specified.

(6) *Table*. The Table is set forth below:

IMPORTED PRODUCTS TABLE

Product name	Harmonized tariff schedule heading	ODC	ODC weight
Part I—Products that are mixtures containing ODCs:			
Mixtures containing ODCs, including but not limited to:			
—anti-static sprays.			
—automotive products such as "carburetor cleaner," "stop leak," and "oil charge".			
—cleaning solvents.			
—contact cleaners.			
—degreasers.			
—dusting sprays.			
—electronic circuit board coolants.			
—electronic solvents.			
—ethylene oxide/CFC–12.			
—fire extinguisher preparations and charges.			
—flux removers for electronics.			
—insect and wasp sprays.			
—mixtures of ODCs.			
—propellants.			
—refrigerants			

Product name	Harmonized tariff schedule heading	ODC	ODC weight
Part II—Products in which ODCs are used for purposes of refrigeration or air conditioning, creating an aerosol or form or manufacturing electronic components:			
Rigid foam insulation defined in § 52.4682–1(d)(3)			
Foams made with ODCs, other than foams defined in § 52.4682–1(d)(3).			
Scrap flexible foams made with ODCs			
Medical products containing ODCs:			
Surgical staplers			
Cryogenic medical instruments			
Drug delivery systems			
Inhalants			
Dehumidifiers, household	8415.82.00.50	CFC–12	0.344
Chillers:	8415.82.00.65		
Charged with CFC–12		CFC–12	1600.
Charged with CFC–114		CFC–114	1250.
Charged with R–500		CFC–12	1920.
Refrigerator-freezers, household:			
Not >184 liters	8418.10.00.10	CFC–11	[1]1.08
		CFC–12	0.13
>184 liters but not >269 liters	8418.10.00.20	CFC–11	[1]1.32
		CFC–12	0.26
>269 liters but not >382 liters	8418.10.00.30	CFC–11	[1]1.54
		CFC–12	0.35
>382 liters	8418.10.00.40	CFC-11	[1]1.87
		CFC–12	0.35
Refrigerators, household:			
Not >184 liters	8418.21.00.10	CFC–11	[1]1.08
		CFC–12	0.13
>184 liters but not >269 liters	8418.21.00.20	CFC–11	[1]1.32
		CFC–12	0.26
>269 liters but not >382 liters	8418.21.00.30	CFC–11	[1]1.54
		CFC–12	0.35
>382 liters	8418.21.00.90	CFC–11	[1]1.87
		CFC–12	0.35
Freezers, household	8418.30	CFC–11	[1]2.0
		CFC–12	0.4
Freezers, household	8418.40	CFC–11	[1]2.0
		CFC–12	0.4
Refrigerating display counters not >227 kg	8418.50	CFC–11	[1]50.0
		CFC–12	260.0
Icemaking machines	8418.69		
Charged with CFC–12		CFC–12	1.4
Charged with R–502		CFC–115	3.39
Drinking water coolers	8418.69		
Charged with CFC–12		CFC–12	0.21
Charged with R–500		CFC–12	0.22
Centrifugal chillers, hermetic	8418.69		
Charged with CFC–12		CFC–12	1600.
Charged with CFC–114		CFC–114	1250.
Charged with R–500		CFC–12	1920.
Reciprocating chillers	8418.69		
Charged with CFC–12		CFC–12	200.
Mobile refrigeration systems	8418.99		
Containers		CFC–12	15.
Trucks		CFC–12	11.
Trailers		CFC–12	20.
Refrigeration condensing units:			
not >746W	8418.99.00.05	CFC–12	0.3
>746W but not >2.2KW	8418.99.00.10	CFC–12	1.0
>2.2KW but not >7.5KW	8418.99.00.15	CFC–12	3.0
>7.5KW but not >22.3KW	8418.99.00.20	CFC–12	8.5
>22.3 KW	8418.99.00.25	CFC–12	17.0
Fire extinguishers, charged w/ODCs	8424		
Electronic typewriters and word processors	8469	CFC–113	0.2049
Electronic calculators	8470.10	CFC–113	0.0035
Electronic calculators w/printing device	8470.21	CFC–113	0.0057
Electronic calculators	8470.29	CFC–113	0.0035
Account machines	8470.40	CFC–113	0.1913
Cash registers	8470.50	CFC–113	0.1913
Digital automatic data processing machines w/cathode ray tube, not included in subheading 8471.20.00.90.	8471.20	CFC–113	0.3663

Product name	Harmonized tariff schedule heading	ODC	ODC weight
Laptops, notebooks, and pocket computers	8471.20.00.90	CFC–113	0.03567
Digital processing units w/entry value:			
Not >$100K	8471.91	CFC–113	0.4980
>$100K	8471.91	CFC–113	27.6667
Combined input/output units (terminals)	8471.92	CFC–113	0.3600
Keyboards	8471.92	CFC–113	0.0742
Display units	8471.92	CFC–113	0.0386
Printer units	8471.92	CFC–113	0.1558
Input or output units	8471.92	CFC–113	0.1370
Hard magnetic disk drive units not included in subheading 8471.93.10 for a disk of a diameter:			
Not >9 cm (3½ inches)	8471.93	CFC–113	0.2829
>9 cm (3½ inches) but not >21 cm (8¼ inches)	8471.93	CFC–113	1.1671
Nonmagnetic storage units w/ entry value >$1,000	8471.93	CFC–113	2.7758
Magnetic disk drive units for a disk of a diameter over 21 cm (8¼ inches).	8471.93.10	CFC–113	4.0067
Power supplies	8471.99.30	CFC–113	0.0655
Electronic office machines	8472	CFC–113	0.001
Populated cards for digital processing units in subheading 8471.91 w/value:			
Not >$100K	8473.30	CFC–113	0.1408
>$100K	8473.30	CFC–113	4.82
Automatic goods-vending machines with refrigerating device	8476.11	CFC–12	0.45
Microwave ovens with electronic controls, with capacity of	8516.50		
0.99 cu. ft. or less		CFC–113	0.0300
1.0 through 1.3 cu. ft		CFC–113	0.0441
1.31 cu. ft. or greater		CFC–113	0.0485
Microwave oven combinations with electronic controls	8516.60.40.60	CFC–113	0.0595
Telephone sets w/entry value:			
Not >$11.00	8517.10	CFC–113	0.0225
>$11.00	8517.10	CFC–113	0.1
Teleprinters and teletypewriters	8517.20	CFC–113	0.1
Switching equipment not included in subheading 8517.30.20	8517.30	CFC–113	0.1267
Private branch exchange switching equipment	8517.30.20	CFC–113	0.0753
Modems	8517.40	CFC–113	0.0225
Intercoms	8517.81	CFC–113	0.0225
Facsimile machines	85l7.82	CFC–113	0.0225
Loudspeakers, microphones, headphones, and electric sound amplifier sets, not included in subheading 8518.30.10.	8518	CFC–113	0.0022
Telephone handsets	8518.30.10	CFC–113	0.042
Turntables, record players, cassette players, and other sound reproducing apparatus.	8519	CFC–113	0.0022
Magnetic tape recorders and other sound recording apparatus, not included in subheading 8520.20.	8520	CFC–113	0.0022
Telephone answering machines	8520.20	CFC–113	0.1
Color video recording/reproducing apparatus	8521.10.00.20	CFC–113	0.0586
Videodisc players	8521.90	CFC–113	0.0106
Cordless handset telephones	8525.20.50	CFC–113	0.1
Cellular communication equipment	8525.20.60	CFC–113	0.4446
TV cameras	8525.30	CFC–113	1.423
Camcorders	8525.30	CFC–113	0.0586
Radio combinations	8527.11	CFC–113	0.0022
Radios	8527.19	CFC–113	0.0014
Motor Vehicle radios with or w/o tape player	8527.21	CFC–113	0.0021
Radio combinations	8527.31	CFC–113	0.0022
Radios	8527.32	CFC–113	0.0014
Tuners w/o speaker	8527.39.00.20	CFC–113	0.0022
Television receivers	8528	CFC–113	0.0386
VCRs	8528.10.40	CFC–113	0.0586
Home satellite earth stations	8528.10.80.55	CFC–113	0.0106
Electronic assemblies for HTS headings 8525, 8527, & 8528	8529.90	CFC–113	0.0816
Indicator panels incorporating liquid crystal devices or light emitting diodes.	8531.20	CFC–113	0.0146
Printed circuits	8534	CFC–113	0.001
Computerized numerical controls	8537.10.00.30	CFC–113	0.1306
Diodes, crystals, transistors and other similar discrete semiconductor devices.	8541	CFC–113	0.0001
Electronic integrated circuits and microassemblies	8542	CFC–113	0.0002
Signal generators	8543.20	CFC–113	0.6518
Avionics	8543.90.40	CFC–113	0.915
Signal generators subassemblies	8543.90.80	CFC–113	0.1265
Insulated or refrigerated railway freight cars	8606	CFC–11	[1]100.

Product name	Harmonized tariff schedule heading	ODC	ODC weight
Passenger automobiles	8703		
Foams (interior)		CFC–11	0.8
Foams (exterior)		CFC–11	0.7
With charged a/c		CFC–12	2.0
Without charged a/c		CFC–12	0.2
Electronics		CFC–113	0.5
Light trucks	8704		
Foams (interior)		CFC–11	0.6
Foams (exterior)		CFC–11	0.1
With charged a/c		CFC–12	2.0
Without charged a/c		CFC–12	0.2
Electronics		CFC–113	0.4
Heavy trucks and tractors, GVW 33,001 lbs or more:[2]	8704		
Foams (interior)		CFC–11	0.6
Foams (exterior)		CFC–11	0.1
With charged a/c		CFC–12	3.0
Without charged a/c		CFC–12	0.2
Electronics		CFC–113	0.4
Motorcycles with seat foamed with ODCs	8711	CFC–11	0.04
Bicycles with seat foamed with ODCs	8712	CFC–11	0.04
Seats foamed with ODCs	8714.95	CFC–11	0.04
Aircraft	8802	CFC–12	0.25 lb/1000 lbs Operating Empty Weight (OEW).
		CFC–113	30.0 lbs./1000 lbs.OEW
Optical fibers	9001	CFC–12	0.005 lb/thousand feet.
Electronic cameras	9006	CFC–113	0.01
Photocopiers	9009	CFC–113	0.0426
Avionics	9014.20	CFC–113	0.915
Electronic drafting machines	9017	CFC–113	0.12
Complete patient monitoring systems	9018.19.80	CFC–12	0.94
		CFC–113	3.4163
Complete patient monitoring systems; subassemblies thereof	9018.19.80.60	CFC–113	1.9320
Physical or chemical analysis instruments	9027	CFC–12	0.0003
		CFC–113	0.0271
Oscilloscopes	9030	CFC–11	0.49
		CFC–12	0.5943
		CFC–113	0.2613
Foam chairs	9401	CFC–11	0.30
Foam sofas	9401	CFC–11	0.75
Foam mattresses	9404.21	CFC–11	1.60
Electronic games and electronic components thereof	9504	CFC-113	
Electronic items not otherwise listed in the Table:			
Included in HTS chapters 84, 85, 90		CFC–113	0.0004 pound/$1.00 of entry value.
Not included in HTS chapters 84, 85, 90[3]		CFC–113	0.0004 pound/$1.00 of entry value.
PART III—Products that are not Imported Taxable Products:			
Room air conditioners	8415.10.00.60		
Dishwashers	8422.11		
Clothes washers	8450.11		
Clothes dryers	8451.21		
Floppy disk drive units	8471.93		
Transformers and inductors	8504		
Toasters	8516.72		
Unrecorded media	8523		
Recorded media	8524		
Capacitors	8532		
Resistors	8533		
Switching apparatus	8536		
Cathode tubes	8540		

[1] See paragraph (e)(3)(ii)(C) of this section. Denotes an ODC used in the manufacture of rigid foam insulation.
[2] See paragraph (f)(2)(ii)(A) of this section. Denotes product for which the effective date is October 1, 1990.
[3] See paragraph (f)(2)(ii)(B) of this section. Denotes products for which the effective date is January 1, 1992.

(g) *Requests for modification of Table*—(1) *In general*. Any manufacturer or importer of a product may request that

the Secretary modify the Table in any of the following respects:

(i) Adding a product to the Table and specifying its Table ODC weight.

(ii) Removing a product from the Table.

(iii) Changing or specifying the Table ODC weight of a product.

(2) *Form of request*. The Secretary will consider a request for modification that includes the following:

(i) The name, address, taxpayer identifying number, and principal place of business of the requester.

(ii) For each product with respect to which a modification is requested:

(A) The name of the product;

(B) The HTS heading or subheading;

(C) The type of modification requested;

(D) The Table ODC weight that should be specified for the product if the request relates to adding a product or changing or specifying its Table ODC weight; and

(E) The data supporting the request.

(3) *Address*. The address for submission of requests under this paragraph (g) is: Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Attn: CC:CORP:T:R (Imported Products Table), room 5228, Washington, DC 20044.

(4) *Public inspection and copying*. Requests submitted under this paragraph (g) will be available in the Internal Revenue Service Freedom of Information Reading Room for public inspection and copying.

[T.D. 8370, 56 FR 56311, Nov. 4, 1991, as amended by T.D. 8370, 58 FR 14518, Mar. 18, 1993]

§ 52.4682–4 Floor stocks tax.

(a) *Overview*. This section provides rules for identifying ozone-depleting chemicals (ODCs) that are subject to the floor stocks tax imposed by section 4682(h)(1), determining the person that is liable for the tax, and computing the amount of the tax. See § 52.4681–1(a)(3) and (c) for general rules and definitions relating to the floor stocks tax.

(b) *Identifying rules*—(1) *ODCs subject to floor stocks tax; ODCs held for sale or for use in further manufacture*—(i) *In general*. The floor stocks tax is imposed only on an ODC that is held for sale or for use in further manufacture on the date the tax is imposed. This paragraph (b)(1) provides rules for identifying ODCs held for sale or for use in further manufacture.

(ii) *Held for sale*—(A) *In general*. For purposes of determining whether an ODC is held for sale, the term *sale* shall have the meaning set forth in § 52.4681–1(c)(6). ODCs held for sale include ODCs that will be sold in connection with the provision of services or in connection with the sale of a manufactured article and, in such cases, include ODCs that will be sold without the statement of a separate charge for those ODCs.

(B) *ODCs held by a government*. An ODC that is held by a government for its own use is not held for sale even if the ODC will be transferred between agencies or other subdivisions that have or are required to have different employer identification numbers.

(iii) *Held for use in further manufacture*. Except as otherwise provided in paragraph (b)(2)(v) of this section, an ODC is held for use in further manufacture if—

(A) The ODC will be used as a material (within the meaning of paragraph (b)(1)(iv) of this section) in the manufacture of an article; and

(B) Such article will be held for sale.

(iv) *Use as material*—(A) *In general*. Except as provided in paragraph (b)(1)(iv)(B) of this section, an ODC will be used as a material in the manufacture of an article if the ODC will be—

(*1*) Incorporated into the article; or

(*2*) Released into the atmosphere in the process of manufacturing the article.

(B) *ODCs used in equipment*. For purposes of the floor stocks tax, an ODC is not used as a material in the manufacture of an article if the ODC is (or will be) contained in equipment used in such manufacture and the ODC will be used for its intended purpose without being released from such equipment. Thus, ODCs that are (or will be) used as coolants in a factory's air-conditioning system are not used as materials in the manufacture of articles produced in the factory.

(v) *Storage containers*. The floor stocks tax is imposed on an ODC without regard to the type or size of the storage container in which the ODC is held. Thus, the tax may apply to an

ODC whether it is in a 14-ounce can or a 30-pound tank.

(vi) *Examples*. The provisions of this paragraph (b)(1) may be illustrated by the following examples:

Example 1. A, a manufacturer of air conditioners, holds an ODC for use in air conditioners that it will manufacture and sell. A holds the ODC for use in further manufacture.

Example 2. B, a manufacturer of electronic components, holds an ODC for use as a solvent to clean printed circuits that it will sell to computer manufacturers. B holds the ODC for use in further manufacture.

Example 3. C, an automobile dealer, holds an ODC for use in charging air conditioners installed in automobiles that it sells to retail customers. C does not hold the ODC for use in further manufacture. C does, however, hold the ODC for sale, even if the customers are not separately charged for ODCs used in the automobile air conditioners.

Example 4. D operates an air-conditioning repair service and holds an ODC for use in repairing air conditioners for its customers. D holds the ODC for sale even if the customers are not separately charged for ODCs used in the repairs.

Example 5. E, a grocery-store chain, holds an ODC for use in its refrigeration units. E does not hold the ODC for sale or for use in further manufacture.

Example 6. F, a bank, holds an ODC for use in its fire extinguishers to protect the computer system. F does not hold the ODC for sale or for use in further manufacture.

Example 7. G, a government agency, holds an ODC for use in the refrigeration equipment of its various units. The units have separate employer identification numbers. The ODC is stored in a central warehouse until needed by a unit and then transferred to the unit upon request. G does not hold the ODC for sale or for use in further manufacture.

(2)(i) *Mixtures*—(A) *Tax imposed on January 1, 1990*. In the case of the floor stocks tax imposed on January 1, 1990, the tax is not imposed on an ODC that has been mixed with any other ingredients.

(B) *Taxes imposed after 1990*—(*1*) *In general*. In the case of the floor stocks tax imposed on January 1 of a calendar year after 1990, the tax is not imposed on an ODC that has been mixed with any other ingredients, but only if it is established that such ingredients contribute to the accomplishment of the purpose for which the mixture will be used. A mixture is not exempt from tax under this paragraph (b)(2)(i)(B), however, if it contains only an ODC and an inert ingredient that does not contribute to the accomplishment of the purpose for which the mixture will be used.

(*2*) *Exception*. In the case of a floor stocks tax imposed on or after January 1, 1992, a mixture is not exempt from floor stocks tax under this paragraph (b)(2)(i)(B) if it contains only ODCs and one or more stabilizers. For this purpose, the term *stabilizer* means an ingredient needed to maintain the chemical integrity of the ODC.

(C) *Examples*. The provisions of this paragraph (b)(2)(i) may be illustrated by the following examples:

Example 1. The floor stocks tax is not imposed on the ODCs contained in refrigerants such as R–500 and R–502 because such products are mixtures of ODCs and other chemicals that contribute to the accomplishment of the purpose for which the mixture will be used.

Example 2. The floor stocks tax is not imposed on the ODCs contained in automotive products used for checking for leaks because such products are a mixture of ODCs and small amounts of dyes and oils that contribute to the accomplishment of the purpose for which the mixture will be used.

Example 3. The floor stocks tax is not imposed on Halon 1301 pressurized with nitrogen. Although nitrogen is an inert ingredient, it contributes to the accomplishment of the purpose for which the mixture will be used.

Example 4. On January 1, 1993, the floor stocks tax is imposed on methyl chloroform that is stabilized to prevent hydrolization or chemical reaction during transportation or use, unless the stabilized methyl chloroform has also been mixed with other ingredients that contribute to the accomplishment of the purpose for which the mixture will be used.

(ii) *Manufactured articles*. The floor stocks tax is not imposed on an ODC that is contained in a manufactured article in which the ODC will be used for its intended purpose without being released from such article. For example, the tax is not imposed on the ODCs contained in the cooling coils of a refrigerator even if the refrigerator is held for sale. However, the tax is imposed on a can of ODC used to recharge an air conditioning unit because the ODC must be expelled from the can in order to be used. Similarly, beginning in 1991, the tax is imposed on Halons

contained in a fire extinguisher held for sale because such ODCs must be expelled from the fire extinguisher in order to be used.

(iii) *Recycled ODCs*. The floor stocks tax is not imposed on ODCs that have been reclaimed or recycled. For example, the tax is not imposed on an ODC that is held for use in further manufacture after being used as a solvent and recycled.

(iv) *ODCs held by the manufacturer or importer*. The floor stocks tax is not imposed on ODCs held by their manufacturer or importer.

(v) *ODCs used as a feedstock*—(A) *In general*. The floor stocks tax is not imposed on any ODC that was sold in a qualifying sale for use as a feedstock (as defined in § 52.4682–1(c)).

(B) *Post-1989 ODCs sold before January 1, 1990; post-1990 ODCs sold before January 1, 1991*. A post-1989 ODC that was sold by its manufacturer or importer before January 1, 1990, or a post-1990 ODC that was sold by its manufacturer or importer before January 1, 1991, shall be treated, for purposes of this paragraph (b)(2)(v), as an ODC that was sold in a qualifying sale for purposes of § 52.4682–1(c) if the ODC will be used as a feedstock (within the meaning of § 52.4682–2(c)(3)).

(vi) *ODCs to be exported*—(A) *In general*. The floor stocks tax is not imposed on any ODC that was sold in a qualifying sale for export (as defined in § 52.4682–5(d)(1)).

(B) *ODCs sold before January 1, 1993*. An ODC that was sold by its manufacturer or importer before January 1, 1993, is treated, for purposes of this paragraph (b)(2)(vi), as an ODC that was sold in a qualifying sale for export for purposes of § 52.4682–5(d)(1) if the ODC will be exported.

(vii) *ODCs used as propellants in metered-dose inhalers; years after 1992*—(A) *In general*. The floor stocks tax is not imposed on January 1 of calendar years after 1992 on any ODC that was sold in a qualifying sale for use as a propellant in a metered-dose inhaler (as defined in § 52.4682–1(h)).

(B) *ODCs sold before January 1, 1993*. An ODC that was sold by its manufacturer or importer before January 1, 1993, is treated, for purposes of this paragraph (b)(2)(vii), as an ODC that was sold in a qualifying sale for purposes of § 52.4682–1(h) if the ODC will be used as a propellant in a metered-dose inhaler (within the meaning of § 52.4682–1(h)).

(viii) *ODCs used as medical sterilants; 1993*. The floor stocks tax is not imposed in 1993 on any ODC held for use as a medical sterilant (as defined in § 52.4682–1(g)).

(c) *Person liable for tax*—(1) *In general*. The person liable for the floor stocks tax on an ODC is the person that holds the ODC on a date on which the tax is imposed. The person who holds the ODC is the person who has title to the ODC (whether or not delivery to such person has been made) as of the first moment of such date. The person who has title at such time is determined under applicable local law.

(2) *Special rule*. Each business unit that has, or is required to have, its own employer identification number is treated as a separate person for purposes of the floor stocks tax. For example, a chain of automotive parts stores that has one employer identification number is one person for purposes of the floor stocks tax, and a parent corporation and subsidiary corporation that each have a different employer identification number are two persons for purposes of the floor stocks tax.

(d) *Computation of tax; tentative tax amount*—(1) *In general*—(i) *Generally applicable rules*. This paragraph (d) provides rules for determining the tentative tax amount and the amount of the floor stocks tax. Section 52.4681–1(a)(3) provides that the amount of the floor stocks tax on an ODC is determined by reference to a tentative tax amount. The tentative tax amount is the amount of tax that would be imposed on the ODC under section 4681(a)(1) if a sale of the ODC by the manufacturer or importer had occurred on the date the floor stocks tax is imposed. The amount of the floor stocks tax imposed on the ODCs contained in a nonexempt mixture is computed on the basis of the weight of the ODCs in that mixture.

(ii) *Floor stocks tax imposed on post-1989 ODCs on January 1, 1990*. The floor stocks tax imposed on post-1989 ODCs (as defined in § 52.4681–1(c)(9)) on January 1, 1990, is equal to the tentative tax

amount. See paragraph (d)(2) of this section for rules relating to the floor stocks tax imposed on ODCs used in the manufacture of rigid foam insulation. See paragraph (d)(3) of this section for rules relating to the floor stocks tax imposed on Halons.

(iii) *Floor stocks tax imposed on post-1990 ODCs on January 1, 1991.* The floor stocks tax imposed on post-1990 ODCs (as defined in § 52.4681–1(c)(9)) on January 1, 1991, is equal to the tentative tax amount.

(iv) *Other floor stocks taxes*—(A) *In general.* The following rules apply for floor stocks taxes imposed on post-1989 ODCs after January 1, 1990, and on post-1990 ODCs after January 1, 1991:

(*1*) The tentative tax amount is determined, except as provided in paragraph (d)(2), (3), or (4) of this section, by reference to the rate of tax prescribed in section 4681(b)(1)(B) and the ozone-depletion factors prescribed in section 4682(b).

(*2*) The amount of the floor stocks tax on an ODC is equal to the amount by which the tentative tax amount exceeds the amount of taxes previously imposed on the ODC.

(B) *Example.* The application of this paragraph (d)(1)(iv) may be illustrated by the following example:

Example. The floor stocks tax imposed on one pound of CFC–12 held for sale on January 1, 1992, is $0.30 (the amount by which $1.67, the tentative tax, exceeds $1.37, the tax previously imposed on CFC–12).

(2) *ODCs used in the manufacture of rigid foam insulation; 1990, 1991, 1992, and 1993*—(i) *In general.* In the case of an ODC that was sold in a qualifying sale for purposes of § 52.4682–1(d) (relating to use in the manufacture of rigid foam insulation) the tentative tax amount is determined under section 4682(g) for purposes of computing the floor stocks tax imposed on the ODC on January 1, 1990, 1991, 1992 or 1993. For purposes of computing the floor stocks tax imposed on the ODC on January 1, 1990, the tentative tax amount is zero. The floor stocks tax is not imposed on ODCs for use in the manufacture of rigid foam insulation in 1992 and 1993.

(ii) *Post-1989 ODCs sold before January 1, 1990; post-1990 ODCs sold before January 1, 1991.* A post-1989 ODC that was sold by its manufacturer or importer before January 1, 1990, or a post-1990 ODC that was sold by its manufacturer or importer before January 1, 1991, shall be treated, for purposes of paragraphs (d)(2) and (e) of this section, as an ODC that was sold in a qualifying sale for purposes of § 52.4682–1(d) if the ODC wi11 be used in the manufacture of rigid foam insulation (within the meaning of §§ 52.4682–1(d) (3) and (4)).

(3) *Halons; 1990, 1991, 1992, and 1993.* In the case of Halon-1211, Halon-1301, or Halon-2402 (Halons), the tentative tax amount is determined under section 4682(g) for purposes of computing the floor stocks tax imposed on Halons on January 1, 1990, 1991, 1992, or 1993. For purposes of computing the floor stocks tax imposed on Halons on January 1, 1990, the tentative tax amount is zero. The floor stocks tax is not imposed on Halons in 1992 and 1993.

(4) *Methyl chloroform; 1993.* In the case of methyl chloroform, the tentative tax amount is determined under section 4682(g)(5) for purposes of computing the floor stocks tax imposed on January 1, 1993.

(e) *De minimis exception*—(1) *1990 and 1992.* In the case of the floor stocks tax imposed on January 1, 1990 or 1992, a person is liable for the tax only if, on the date the tax is imposed, the person holds at least 400 pounds of post-1989 ODCs that are not described in paragraph (d) (2) or (3) of this section and are otherwise subject to tax.

(2) *1991.* In the case of the floor stocks tax imposed on January 1, 1991, a person is liable for the tax only if, on such date, the person holds at least 400 pounds of ODCs subject to the 1991 floor stocks tax. For this purpose, ODCs subject to the 1991 floor stocks tax are—

(i) Post-1990 ODCs that are subject to tax; and

(ii) Post-1989 ODCs that are described in paragraph (d) (2) or (3) of this section and are otherwise subject to tax.

(3) *1993.* In the case of the floor stocks tax imposed on January 1, 1993, a person is liable for the tax only if, on such date, the person holds at least 400 pounds of ODCs that are not described in paragraph (d) (2) or (3) of this section and are otherwise subject to tax.

(4) *1994.* In the case of the floor stocks tax imposed on January 1, 1994,

a person is liable for the tax only if, on such date, the person holds—

(i) At least 400 pounds of ODCs that are not described in paragraph (d)(2) or (d)(3) of this section and are otherwise subject to tax;

(ii) At least 200 pounds of ODCs that are described in paragraph (d)(2) of this section and are otherwise subject to tax; or

(iii) At least 20 pounds of ODCs that are described in paragraph (d)(3) of this section and are otherwise subject to tax.

(5) *Calendar years after 1994*. In the case of the floor stocks tax imposed on January 1 of 1995 and each following calendar year, a person is liable for the tax only if, on such date, the person holds—

(i) At least 400 pounds of ODCs that are not described in paragraph (d)(3) or (d)(4) of this section and are otherwise subject to tax;

(ii) At least 50 pounds of ODCs that are described in paragraph (d)(3) of this section and are otherwise subject to tax; or

(iii) At least 1000 pounds of ODCs that are described in paragraph (d)(4) of this section and are otherwise subject to tax.

(6) *Examples*. The rules of this paragraph (e) may be illustrated by the following examples:

Example 1. On January 1, 1990, A holds for sale 300 pounds of CFC–12 (a post-1989 ODC not described in paragraph (d)(2) or (d)(3) of this section)) and 500 pounds of R–500 (a mixture). A does not hold at least 400 pounds of ODCs that are taken into account under paragraph (e)(1) of this section and, under paragraph (b)(2)(i) of this section, mixtures are not subject to the floor stocks tax. Thus, A is not liable for the floor stocks tax imposed on January 1, 1990.

Example 2. On January 1, 1990, B holds for sale 250 pounds of CFC–12 and 250 pounds of CFC–113 (post-1989 ODCs not described in paragraph (d) (2) or (3) of this section). B holds 500 pounds of ODCs that are taken into account under paragraph (e)(1) of this section. Thus, B is liable for the floor stocks tax imposed on January 1, 1990, because B holds at least 400 pounds of ODCs for sale.

Example 3. On January 1, 1990, C holds 200 pounds of post-1990 ODCs and 500 pounds of post-1989 ODCs for use in further manufacture. C will use 300 pounds of the post-1989 ODCs in the manufacture of rigid foam insulation (as defined in § 52.4682–1(d) (3) and (4)). The remainder of the ODCs are not described in paragraph (d) (2) or (3) of this section. Under paragraph (e)(1) of this section, post-1990 ODCs and ODCs that will be used in the manufacture of rigid foam insulation are disregarded in determining whether the *de minimis* exception is applicable in 1990. Thus, C holds only 200 pounds of ODCs that are taken into account under paragraph (e)(1) of this section and is not liable for the floor stocks tax imposed on January 1, 1990.

Example 4. (a) The facts are the same as in *Example 3*, except that the ODCs are held on January 1, 1991. Under paragraph (e)(2) of this section, the 200 pounds of post-1990 ODCs and the 300 pounds of post-1989 ODCs that will be used in the manufacture of rigid foam insulation are taken into account in determining whether the *de minimis* exception is applicable in 1991. Under paragraph (b)(2) of this section, the remaining 200 pounds of post-1989 ODCs are not taken into account because the base tax amount applicable to post-1989 ODCs does not increase in 1991. Thus, C holds 500 pounds of ODCs that are taken into account under paragraph (e)(2) of this section and is liable for the floor stocks tax imposed on January 1, 1991.

(b) The amount of the floor stocks tax imposed on the 200 pounds of post-1990 ODCs and the 300 pounds of post-1989 ODCs that will be used in the manufacture of rigid foam insulation is equal to the tentative tax amount because those ODCs were not previously subject to tax.

Example 5. (a) On January 1, 1994, D holds for sale 300 pounds of CFC–113 (an ODC not described in paragraph (d)(2) or (d)(3) of this section) and 25 pounds of Halon-1301 (an ODC described in paragraph (d)(3) of this section). D is liable for the floor stocks tax imposed on January 1, 1994, because 25 pounds of Halon-1301 exceeds the de minimis amount specified in paragraph (e)(4)(iii) of this section. The 300 pounds of CFC–113 is less than the amount specified in paragraph (e)(4)(i) of this section. Nevertheless, tax is imposed on both the 25 pounds of Halon-1301 and the 300 pounds of CFC–113.

(b) The amount of the floor stocks tax is determined separately for the 300 pounds of CFC–113 and the 25 pounds of Halon-1301 and is equal to the difference between the tentative tax amount and the amount of tax previously imposed on those ODCs. For Halon-1301, for example, the tax is determined as follows. The tentative tax amount is $1,087.50 ($4.35 (the base tax amount in 1994) × 10 (the ozone-depletion factor for Halon-1301) × 25 (the number of pounds held)). The tax previously imposed on the Halon-1301 is $6.28 ($3.35 (the base tax amount in 1993) × 10 (the ozone-depletion factor for Halon-1301) × 0.75 percent (the applicable percentage determined under section 4682(g)(2)(A)) × 25 (the number of pounds held)). Thus, the floor stocks tax imposed on the 25 pounds of Halon-1301 in 1994 is

$1,081.22, the difference between $1,087.50 (the tentative tax amount) and $6.28 (the tax previously imposed).

(f) *Inventory*—(1) *In general*. If, on the date on which the floor stocks tax is imposed, a person holds ODCs for sale or for use in further manufacture and the ODCs were not manufactured or imported by such person, the following rules apply:

(i) The person shall prepare an inventory of all such ODCs that the person holds on the date on which the tax is imposed.

(ii) The inventory shall be taken as of the first moment of the date on which the tax is imposed, but work-back or work-forward inventories will be acceptable if supported by adequate commercial records of receipt, use, and disposition of ODCs held for sale or for use in further manufacture.

(iii) The person must maintain records of the inventory and make such records available for inspection and copying by internal revenue agents and officers. Records of the inventory are not to be filed with the Internal Revenue Service.

(2) *Circumstances in which an inventory is not required*. The inventory requirement of paragraph (f)(1) of this section does not apply to any person holding, on a date on which floor stocks tax is imposed, only ODCs that are not subject to tax by reason of a statutory exemption (e.g., use as a feedstock) or regulatory exclusion other than the *de minimis* exception provided by paragraph (e) of this section (e.g., mixtures). In addition, any person that holds ODCs subject to the floor stocks tax and also holds ODCs that are nontaxable under the provisions of paragraph (b)(2) of this section, is not required to inventory the nontaxable ODCs. However, any person that holds any ODCs that either are subject to the floor stocks tax or would be subject to the floor stocks tax but for the *de minimis* exception must inventory those ODCs.

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

Example 1. On January 1, 1990, A holds for sale 300 pounds of CFC–12 (a post-1989 ODC not described in paragraph (d)(2) or (d)(3) of this section) and 500 pounds of R–500 (a mixture). As required by paragraph (f)(1) of this section, A must prepare an inventory of the CFC–12 A holds for sale on that date even though, under paragraph (e)(1) of this section, the 300 pounds of CFC–12 is not taken into account because it is *de minimis*. However, as provided in paragraph (f)(2) of this section, A is not required to inventory the R–500 because, under paragraph (b)(2) of this section, mixtures are not subject to the floor stocks tax.

Example 2. On January 1, 1991, B holds for sale 1,000 pounds of CFC–12 (a post-1989 ODC not described in paragraph (d)(2) or (d)(3) of this section). As provided under paragraph (f)(2) of this section, B is not required to prepare an inventory because CFC–12 is not subject to the floor stocks tax in 1991.

(g) *Time for paying tax*. The floor stocks tax imposed under section 4682(h) shall be paid without assessment or notice. In the case of the floor stocks tax imposed on January 1, 1990, the tax shall be paid by April 1, 1990. In the case of floor stocks taxes imposed after January 1, 1990, the tax shall be paid by June 30 of the year in which the tax is imposed.

[T.D. 8370, 56 FR 56317, Nov. 4, 1991, as amended by T.D. 8622, 60 FR 52852, Oct. 11, 1995]

§ 52.4682–5 Exports.

(a) *Overview*. This section provides rules relating to the tax imposed under section 4681 on ozone-depleting chemicals (ODCs) that are exported. In general, tax is not imposed on ODCs that a manufacturer or importer sells for export, or for resale by the purchaser to a second purchaser for export, if the procedural requirements set forth in paragraph (d) of this section are met. The tax benefit of this exemption is limited, however, to the manufacturer's or importer's exemption amount. Thus, if the tax that would otherwise be imposed under section 4681 on ODCs that a manufacturer or importer sells for export exceeds this exemption amount, a tax equal to the excess is imposed on the ODCs. The exemption amount, which is determined separately for post-1989 ODCs and post–1990 ODCs, is calculated for each calendar year in accordance with the rules of paragraph (c) of this section. This section also provides rules under which a tax imposed under section 4681 on exported ODCs may be credited or refunded, subject to the same limit on

tax benefits, if the procedural requirements set forth in paragraph (f) of this section are met. See § 52.4681–1(c) for definitions relating to the tax on ODCs.

(b) *Exemption or partial exemption from tax*—(1) *In general*. Except as provided in paragraph (b)(2) of this section, no tax is imposed on an ODC if the manufacturer or importer of the ODC sells the ODC in a qualifying sale for export (within the meaning of paragraph (d)(1) of this section).

(2) *Tax imposed if exemption amount exceeded*—(i) *Post–1989 ODCs*. The tax imposed on post–1989 ODCs that a manufacturer or importer sells in qualifying sales for export during a calendar year is equal to the excess (if any) of—

(A) The tax that would be imposed on the ODCs but for section 4682(d)(3) and this section; over

(B) The post–1989 ODC exemption amount for the calendar year determined under paragraph (c)(1) of this section.

(ii) *Post–1990 ODCs*. The tax imposed on post–1990 ODCs that a manufacturer or importer sells in qualifying sales for export during a calendar year is equal to the excess (if any) of—

(A) The tax that would be imposed on the ODCs but for section 4682(d)(3) and this section; over

(B) The post–1990 ODC exemption amount for the calendar year determined under paragraph (c)(2) of this section.

(iii) *Allocation of tax*—(A) *Post–1989 ODCs*. The tax (if any) determined under paragraph (b)(2)(i) of this section may be allocated among the post–1989 ODCs on which it is imposed in any manner, provided that the amount allocated to any post–1989 ODC does not exceed the tax that would be imposed on such ODC but for section 4682(d)(3) and this section.

(B) *Post–1990 ODCs*. The tax (if any) determined under paragraph (b)(2)(ii) of this section may be allocated among the post–1990 ODCs on which it is imposed in any manner, provided that the amount allocated to any post–1990 ODC does not exceed the tax that would be imposed on such ODC but for section 4682(d)(3) and this section.

(c) *Exemption amount*—(1) *Post–1989 ODC exemption amount*. A manufacturer's or importer's post–1989 ODC exemption amount for a calendar year is the sum of the following amounts:

(i) The 1986 export percentage of the aggregate tax that would (but for section 4682(d), section 4682(g), and this section) be imposed under section 4681 on the maximum quantity, determined without regard to additional production allowances, of post–1989 ODCs that the person is permitted to manufacture during the calendar year under rules prescribed by the Environmental Protection Agency (40 CFR part 82).

(ii) The aggregate tax that would (but for section 4682(d), section 4682(g), and this section) be imposed under section 4681 on post–1989 ODCs that the person manufactures during the calendar year under any additional production allowance granted by the Environmental Protection Agency.

(iii) The aggregate tax that would (but for section 4682(d), section 4682(g), and this section) be imposed under section 4681 on post–1989 ODCs imported by the person during the calendar year.

(2) *Post–1990 ODC exemption amount*. A manufacturer's or importer's post–1990 ODC exemption amount for a calendar year is the sum of the following amounts:

(i) The 1989 export percentage of the aggregate tax that would (but for section 4682(d), section 4682(g), and this section) be imposed under section 4681 on the maximum quantity, determined without regard to additional production allowances, of post–1990 ODCs the person is permitted to manufacture during the calendar year under rules prescribed by the Environmental Protection Agency.

(ii) The aggregate tax that would (but for section 4682(d), section 4682(g), and this section) be imposed under section 4681 on post–1990 ODCs that the person manufactures during the calendar year under any additional production allowance granted by the Environmental Protection Agency.

(iii) The aggregate tax that would (but for section 4682(d), section 4682(g), and this section) be imposed under section 4681 on post–1990 ODCs imported by the person during the calendar year.

(3) *Definitions*—(i) *1986 export percentage*. See section 4682(d)(3)(B)(ii) for the meaning of the term *1986 export percentage*.

(ii) *1989 export percentage*. See section 4682(d)(3)(C) for the meaning of the term *1989 export percentage*.

(d) *Procedural requirements relating to tax-free sales for export*—(1) *Qualifying sales*—(i) *In general*. A sale of ODCs is a qualifying sale for export if—

(A) The seller is the manufacturer or importer of the ODCs and the purchaser is a purchaser for export or for resale to a second purchaser for export;

(B) At the time of the sale, the seller and the purchaser are registered with the Internal Revenue Service; and

(C) At the time of the sale, the seller—

(*1*) Has an unexpired certificate in substantially the form set forth in paragraph (d)(3)(ii) of this section from the purchaser; and

(*2*) Relies on the certificate in good faith.

(ii) *Qualifying resale*. A sale of ODCs is a qualifying resale for export if—

(A) The seller acquired the ODCs in a qualifying sale for export and the purchaser is a second purchaser for export;

(B) At the time of the sale, the seller and the purchaser are registered with the Internal Revenue Service; and

(C) At the time of the sale, the seller—

(*1*) Has an unexpired certificate in substantially the form set forth in paragraph (d)(3)(ii)(A) of this section from the purchaser of the ODCs; and

(*2*) Relies on the certificate in good faith.

(iii) *Special rule relating to sales made before July 1, 1993*. If a sale for export made before July 1, 1993, satisfies all the requirements of paragraph (d)(1)(i) or (ii) of this section other than those relating to registration, the sale will be treated as a qualifying sale (or resale) for export. Thus, a sale made before July 1, 1993, may be a qualifying sale (or resale) even if the parties to the sale are not registered and the required certificate does not contain statements regarding registration.

(iv) *Registration*. Application for registration is made on Form 637 (or any other form designated for the same use by the Commissioner) according to the instructions applicable to the form. A person is registered only if the district director has issued that person a letter of registration and it has not been revoked or suspended. The effective date of the registration must be no earlier than the date on which the district director signs the letter of registration. Each business unit that has, or is required to have, a separate employer identification number is treated as a separate person.

(2) *Good faith reliance*. The requirements of paragraph (d)(1) of this section are not satisfied with respect to a sale of ODCs and the sale is not a qualifying sale (or resale) if, at the time of the sale—

(i) The seller has reason to believe that the ODCs are not purchased for export; or

(ii) The Internal Revenue Service has notified the seller that the purchaser's registration has been revoked or suspended.

(3) *Certificate*—(i) *In general*. The certificate required under paragraph (d)(1) of this section consists of a statement executed and signed under penalties of perjury by a person with authority to bind the purchaser, in substantially the same form as model certificates provided in paragraph (d)(3)(ii) of this section, and containing all information necessary to complete such model certificate. A new certificate must be given if any information in the current certificate changes. The certificate may be included as part of any business records normally used to document a sale. The certificate expires on the earliest of the following dates—

(A) The date one year after the effective date of the certificate;

(B) The date the purchaser provides a new certificate to the seller; or

(C) The date the seller is notified by the Internal Revenue Service or the purchaser that the purchaser's registration has been revoked or suspended.

(ii) *Model certificates*—(A) *ODCs sold for export by the purchaser*. If the purchaser will export the ODCs, the certificate must be in substantially the following form:

CERTIFICATE OF PURCHASER OF CHEMICALS FOR EXPORT BY THE PURCHASER

(To support tax-free sales under section 4682(d)(3) of the Internal Revenue Code.)

Effective Date _____

Expiration Date _____
(not more than one year after effective date)

The undersigned purchaser (Purchaser) certifies the following under penalties of perjury:

Purchaser is registered with the Internal Revenue Service as a purchaser of ozone-depleting chemicals for export under registration number _____. Purchaser's registration has not been suspended or revoked by the Internal Revenue Service.

The following percentage of ozone-depleting chemicals purchased from:

_____
(Name of seller)

_____
(Address of seller)

_____
(Taxpayer identifying number of seller)

are purchased for export by Purchaser.

Product	Percentage
CFC–11	_____
CFC–12	_____
CFC–113	_____
CFC–114	_____
CFC–115	_____
Halon-1211	_____
Halon-1301	_____
Halon-2402	_____
Carbon tetrachloride	_____
Methyl chloroform	_____
Other (specify) _____	_____

This certificate applies to (check and complete as applicable):

_____ All shipments to Purchaser at the following location(s):

_____

_____

_____

_____ All shipments to Purchaser under the following Purchaser account number(s):

_____

_____

_____

_____ All shipments to Purchaser under the following purchase order(s):

_____

_____

_____

_____ One or more shipments to Purchaser identified as follows:

_____

_____

_____

Purchaser understands that Purchaser will be liable for tax imposed under section 4681 if Purchaser does not export the ODCs to which this certificate applies.

Purchaser understands that any use of the ODCs to which this certificate applies other than for export may result in the revocation of Purchaser's registration.

Purchaser will retain the business records needed to document the export of the ozone-depleting chemicals to which this certificate applies and will make such records available for inspection by Government officers.

Purchaser has not been notified by the Internal Revenue Service that its registration has been revoked or suspended.

Purchaser understands that the fraudulent use of this certificate may subject Purchaser and all parties making such fraudulent use of this certificate to a fine or imprisonment, or both, together with the costs of prosecution.

_____
Name of Purchaser

_____
Address of Purchaser

_____

_____
Taxpayer Identifying Number of Purchaser

_____
Title of person signing

_____
Printed or typed name of person signing

_____
Signature

(B) *ODCs sold by the purchaser for resale for export by the second purchaser*. If the purchaser will resell the ODCs to a second purchaser for export by the second purchaser, the certificate must be in substantially the following form:

CERTIFICATE OF PURCHASER OF CHEMICALS FOR RESALE FOR EXPORT BY THE SECOND PURCHASER

(To support tax-free sales under section 4682(d)(3) of the Internal Revenue Code.)

Effective Date _____
Expiration Date _____
(not more than one year after effective date)

The undersigned purchaser (Purchaser) certifies the following under penalties of perjury:

Purchaser is registered with the Internal Revenue Service as a purchaser of ozone-depleting chemicals for export under registration number _____. Purchaser's registration has not been suspended or revoked by the Internal Revenue Service.

The following percentage of ozone-depleting chemicals purchased from:

_____
(Name of seller)

_____
(Address of seller)

_____
(Taxpayer identifying number of seller)

will be resold by Purchaser to persons (Second Purchasers) that certify to Purchaser

that they are (1) registered with the Internal Revenue Service as purchasers of ozone-depleting chemicals for export and (2) purchasing the ozone-depleting chemicals for export.

Product	Percentage
CFC–11	
CFC–12	
CFC–113	
CFC–114	
CFC–115	
Halon-1211	
Halon-1301	
Halon-2402	
Carbon tetrachloride	
Methyl chloroform	
Other (specify)	
_____	

This certificate applies to (check and complete as applicable):

_____ All shipments to Purchaser at the following location(s):

_____ All shipments to Purchaser under the following Purchaser account number(s):

_____ All shipments to Purchaser under the following purchase order(s):

_____ One or more shipments to Purchaser identified as follows:

Purchaser understands that Purchaser will be liable for tax imposed under section 4681 if Purchaser does not resell the ODCs to which this certificate applies to a Second Purchaser for export or export those ODCs.

Purchaser understands that any use of the ODCs to which this certificate applies other than for resale to Second Purchasers for export may result in the revocation of Purchaser's registration.

Purchaser will retain the business records needed to document the sales to Second Purchasers for export covered by this certificate and will make such records available for inspection by Government officers. Purchaser also will retain and make available for inspection by Government officers the certificates of its Second Purchasers.

Purchaser has not been notified by the Internal Revenue Service that its registration has been revoked or suspended. In addition, the Internal Revenue Service has not notified Purchaser of the revocation or suspension of the registration of any Second Purchaser who will purchase ozone-depleting chemicals to which this certificate applies.

Purchaser understands that the fraudulent use of this certificate may subject Purchaser and all parties making such fraudulent use of this certificate to a fine or imprisonment, or both, together with the costs of prosecution.

Name of Purchaser

Address of Purchaser

Taxpayer Identifying Number of Purchaser

Title of person signing

Printed or typed name of person signing

Signature

(4) *Documentation of export*—(i) *After December 31, 1992.* After December 31, 1992, to document the exportation of any ODCs, a person must have the evidence required by the Environmental Protection Agency as proof that the ODCs were exported.

(ii) *Before January 1, 1993.* Before January 1, 1993, to document the exportation of any ODCs, a person must have evidence substantially similar to that required by the Environmental Protection Agency as proof that the ODCs were exported.

(e) *Purchaser liable for tax*—(1) *Purchaser in qualifying sale.* The purchaser of ODCs in a qualifying sale for export is treated as the manufacturer of the ODC and is liable for any tax imposed under section 4681 (determined without regard to exemptions for qualifying sales under this section or § 52.4682–1) when it sells or uses the ODCs if that purchaser does not-

(i) Export the ODCs and document the exportation of the ODCs in accordance with paragraph (d)(4) of this section; or

(ii) Sell the ODCs in a qualifying resale for export.

(2) *Purchaser in qualifying resale.* The purchaser of ODCs in a qualifying resale for export is treated as the manufacturer of the ODC and is liable for any tax imposed under section 4681 (determined without regard to exemptions for qualifying sales under this section or § 52.4682–1) when it sells or uses the ODCs if that purchaser does not export the ODCs and document the exportation of the ODCs in accordance with paragraph (d)(4) of this section.

(f) *Credit or refund*—(1) *In general*. Except as provided in paragraph (f)(2) of this section, a manufacturer or importer that meets the conditions of paragraph (f)(3) of this section is allowed a credit or refund (without interest) of the tax it paid to the government under section 4681 on ODCs that are exported. Persons other than manufacturers and importers of ODCs cannot file claims for credit or refund of tax imposed under section 4681 on ODCs that are exported.

(2) *Limitation*. The amount of credits or refunds of tax under this paragraph (f) is limited—

(i) In the case of tax paid on post-1989 ODCs sold during a calendar year, to the amount (if any) by which the post-1989 exemption amount for the year exceeds the tax benefit provided to such post-1989 ODCs under paragraph (b) of this section; and

(ii) In the case of tax paid on post-1990 ODCs sold during a calendar year, to the amount (if any) by which the post-1990 exemption amount for the year exceeds the tax benefit provided to such post-1990 ODCs under paragraph (b) of this section.

(3) *Conditions to allowance of credit or refund*. The conditions of this paragraph (f)(3) are met if the manufacturer or importer—

(i) Documents the exportation of the ODCs in accordance with paragraph (d)(4) of this section; and

(ii) Establishes that it has—

(A) Repaid or agreed to repay the amount of the tax to the person that exported the ODC; or

(B) Obtained the written consent of the exporter to the allowance of the credit or the making of the refund.

(4) *Procedural rules*. See section 6402 and the regulations under that section for procedural rules relating to filing a claim for credit or refund of tax.

(g) *Examples*. The following examples illustrate the provisions of this section. In each example, the sales are qualifying sales for export (within the meaning of paragraph (d)(1) of this section), all registration, certification, and documentation requirements of this section are met, and the ODCs sold for export are exported:

Example 1. (i) *Facts*. D, a corporation, manufactures CFC–11, a post-1989 ODC, and does not manufacture or import any other ODCs. In 1993, D manufactures 100,000 pounds of CFC–11, the maximum quantity D is allowed to manufacture in 1993 under EPA regulations. D has no additional production allowance from EPA for 1993. In 1993, the tax on CFC–11 is $3.35 per pound. D's 1986 export percentage for post-1989 ODCs is 50%. In 1993, D sells 80,000 pounds of CFC–11 in qualifying sales for export. The remainder of D's production is not exported.

(ii) *Components of limit on tax benefit*. Under paragraph (c)(1) of this section, D's exemption amount for 1993 is equal to the sum of—

(A) D's 1986 export percentage multiplied by the aggregate tax that would (but for section 4682(d), section 4682(g), and § 52.4682–5) be imposed under section 4681 on the maximum quantity of post-1989 ODCs D is permitted to manufacture during 1993;

(B) The aggregate tax that would (but for section 4682(d), section 4682(g), and § 52.4682–5) be imposed under section 4681 on post-1989 ODCs that D manufactures during 1993 under an additional production allowance; and

(C) The aggregate tax that would (but for section 4682(d), section 4682(g), and § 52.4682–5) be imposed under section 4681 on post-1989 ODCs imported by D during 1993.

(iii) *Limit on tax benefit*. The amounts described in paragraphs (ii)(B) and (C) of this *Example 1* are equal to zero. Thus, D's 1993 exemption amount is $167,500 (50% of $335,000 (the tax that would otherwise be imposed on 100,000 pounds of CFC–11 in 1993)).

(iv) *Application of limit on tax benefit*. Under paragraph (b)(2) of this section, the tax imposed on the CFC–11 D sells for export is equal to the excess of the tax that would have been imposed on those ODCs but for section 4682(d) and § 52.4682–5, over D's 1993 exemption amount. But for § 52.4682–5, $268,000 ($3.35 × 80,000) of tax would have been imposed on the CFC–11 sold for export. Thus, $100,500 ($268,000 − $167,500) of tax is imposed on the CFC–11 sold for export.

Example 2. (i) *Facts*. E, a corporation, manufactures CFC–11, a post-1989 ODC, and does not manufacture or import any other ODCs. In 1993, E manufactures 100,000 pounds of CFC–11, the maximum quantity E is allowed to manufacture in 1993 under EPA regulations. E has no additional production allowance from EPA for 1993. In 1993, the tax on CFC–11 is $3.35 per pound. E's 1986 export percentage for post-1989 ODCs is 50%. In 1993, E sells 45,000 pounds of CFC–11 tax free in qualifying sales for export and pays tax under section 4681 on an additional 35,000 pounds of exported CFC–11. The remainder of E's production is not exported.

(ii) *Limit on tax benefit*. E's 1993 exemption amount is $167,500, (50% of $335,000 (the tax that would otherwise be imposed on 100,000 pounds of CFC–11 in 1993)). The credit or refund allowed to E under paragraph (f) of this section is limited under paragraph (f)(2) of

this section to the amount by which E's 1993 exemption amount exceeds E's 1993 tax benefit under paragraph (b) of this section.

(iii) *Application of limit on tax benefit.* Because E sold 45,000 pounds of CFC–11 tax free in qualifying sales for export in 1993, E's 1993 tax benefit under paragraph (b) of this section is $150,750 ($3.35 × 45,000). Thus, the credit or refund allowed to E under paragraph (f) of this section is limited to $16,750 ($167,500 − $150,750).

Example 3. (i) *Facts.* F, a corporation, manufactures CFC–11, a post-1989 ODC, and does not manufacture any other ODCs. F also imports CFC–11. In 1993, F manufactures 60,000 pounds of CFC–11 (100,000 pounds is the maximum quantity F is allowed to manufacture in 1993 under EPA regulations) and imports 40,000 pounds. F has no additional production allowance from EPA for 1993. In 1993, the tax on CFC–11 is $3.35 per pound. F's 1986 export percentage for post-1989 ODCs is 50%. In 1993, F sells 45,000 pounds of CFC–11 tax free in qualifying sales for export and pays tax under section 4681 on an additional 35,000 pounds of exported CFC–11. The remainder of F's production is not exported.

(ii) *Limit on tax benefit.* F's 1993 exemption amount is $301,500, ($167,500 (50% of $335,000 (the tax that would otherwise be imposed on 100,000 pounds of CFC–11 in 1993) plus $134,000 (the tax that would otherwise be imposed on the 40,000 pounds imported)). The credit or refund allowed to F under paragraph (f) of this section is limited under paragraph (f)(2) of this section to the amount by which F's 1993 exemption amount exceeds F's 1993 tax benefit under paragraph (b) of this section.

(iii) *Application of limit on tax benefit.* Because F sold 45,000 pounds of CFC–11 tax free in qualifying sales for export in 1993, F's 1993 tax benefit under paragraph (b) of this section is $150,750 ($3.35 × 45,000). Thus, the credit or refund allowed to F under paragraph (f) of this section is limited to $150,750 ($301,500 − $150,750). The limitation does not affect F's credit or refund because the tax F paid on exported ODCs is only $117,250 ($3.35 × 35,000).

(h) *Effective date.* This section is effective January 1, 1993.

[T.D. 8622, 60 FR 52853, Oct. 11, 1995]

PART 53—FOUNDATION AND SIMILAR EXCISE TAXES

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Subpart A—Taxes on Investment Income

§ 53.4940–1 Excise tax on net investment income.

(a) *In general.* For taxable years beginning after September 30, 1977, section 4940 imposes an excise tax of 2 percent of the net investment income (as defined in section 4940(c) and paragraph (c) of this section) of a tax-exempt private foundation (as defined in section 509). For taxable years beginning after December 31, 1969, and before October 1, 1977, the tax imposed by section 4940 is 4 percent of the net investment income. This tax will be reported on the form the foundation is required to file under section 6033 for the taxable year and will be paid annually at the time prescribed for filing such annual return (determined without regard to any extension of time for filing). In addition, an excise tax is imposed in the manner prescribed in paragraph (b) of this section on certain non-exempt private foundations (including certain non-exempt charitable trusts). Except as provided in the succeeding sentence, this tax is to be reported by means of a schedule attached to the organization's income tax return. For taxable years ending on or after December 31, 1975, the tax imposed by section 4940(b) and paragraph (b) of this section on a trust described in section 4947(a)(1) which is a private foundation shall be reported on Form 5227. The tax imposed by section 4940(b) and this section is to be paid annually at the time the organization is required to pay its income taxes imposed under subtitle A. Except as otherwise provided herein, no exclusions or deductions from gross investment income or credits against tax are allowable under this section.

(b) *Taxable foundations.* (1) The excise tax imposed under section 4940 on private foundations which are not exempt from taxation under section 501(a) is equal to:

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

(A) The tax on net investment income imposed under section 4940(a), computed as if such private foundation were exempt from taxation under section 501(a) and described in section 501(c)(3) for the taxable year, plus

(B) The amount of the tax which would have been imposed under section 511 for such taxable year if such private foundation had been exempt from taxation under section 501(a), exceeds.

(ii) The tax imposed under subtitle A on such private foundation for the taxable year.

(2) The provisions of this paragraph may be illustrated by the following examples:

Example 1. Assume that the tax liability under subtitle A for private foundation X, which is not exempt from taxation under section 501(a) for 1970, is $10,000. Had X been exempt under section 501(a) for 1970, the tax imposed under section 4940(a) would have been $4,000 and the tax imposed under section 511 would have been $7,000. The excess of the sum of the taxes which would have been imposed under sections 4940(a) and 511 ($11,000) over the tax that was imposed under subtitle A ($10,000) is $1,000, the amount of the tax imposed on such organization under section 4940(b).

Example 2. Assume the facts stated in Example (1), except that the tax liability under subtitle A is $15,000 rather than $10,000. Because the sum of the taxes which would have been imposed under sections 4940(a) and 511 ($11,000) does not exceed the tax that was imposed under subtitle A ($15,000), there is no tax imposed under section 4940(b) with respect to such foundation.

(c) *Net investment income defined*—(1) *In general.* For purposes of section 4940(a), *net investment income* of a private foundation is the amount by which:

(i) The sum of the gross investment income (as defined in section 4940(c)(2)

and paragraph (d) of this section) and the capital gain net income (net capital gain for taxable years beginning before January 1, 1977) (within the meaning of section 4940(c)(4) and paragraph (f) of this section) exceeds

(ii) The deductions allowed by section 4940(c)(3) and paragraph (e) of this section.

Except to the extent inconsistent with the provisions of this section, net investment income shall be determined under the principles of Subtitle A.

(2) *Tax-exempt income.* For purposes of computing net investment income under section 4940, the provisions of section 103 (relating to interest on certain governmental obligations) and section 265 (relating to expenses and interest relating to tax-exempt income) and the regulations thereunder shall apply.

(d) *Gross investment income*—(1) *In general.* For purposes of paragraph (c) of this section, ''gross investment income'' means the gross amounts of income from interest, dividends, rents, and royalties (including overriding royalties) received by a private foundation from all sources, but does not include such income to the extent included in computing the tax imposed by section 511. Under this definition, interest, dividends, rents, and royalties derived from assets devoted to charitable activities are includible in gross investment income. Therefore, for example, interest received on a student loan would be includible in the gross investment income of a private foundation making such loan. For purposes of paragraph (c) of this section, gross investment income also includes the items of investment income described in § 1.512(b)–1(a).

(2) *Certain estate and trust disbursements.* In the case of a distribution from an estate or a trust described in section 4947(a) (1) or (2), such distribution shall not retain its character in the hands of the distributee for purposes of computing the tax under section 4940; except that, in the case of a distribution from a trust described in section 4947(a)(2), the income of such trust attributable to transfers in trust after May 26, 1969, shall retain its character in the hands of a distributee private foundation for purposes of section 4940 (unless such income is taken into account because of the application of section 671).

(3) *Treatment of certain distributions in redemption of stock.* For purposes of applying section 302(b)(1), any distribution made to a private foundation by a disqualified person (as defined in section 4946(a)), in redemption of stock held by such private foundation in a business enterprise shall be treated as not essentially equivalent to a dividend if all of the following conditions are satisfied: (i) Such redemption is of stock which was owned by a private foundation on May 26, 1969 (or which is acquired by a private foundation under the terms of a trust which was irrevocable on May 26, 1969, or under the terms of a will executed on or before such date, which is in effect on such date and at all times thereafter, or would have passed under such a will but before that time actually passes under a trust which would have met the test of this subdivision but for the fact that the trust was revocable (but was not in fact revoked)); (ii) such foundation is required to dispose of such property in order not to be liable for tax under section 4943 (relating to taxes on excess business holdings); and (iii) such foundation receives in return an amount which equals or exceeds the fair market value of such property at the time of such disposition or at the time a contract for such disposition was previously executed in a transaction which would not constitute a prohibited transaction (within the meaning of section 503(b) or the corresponding provisions of prior law). In the case of a disposition before January 1, 1975, section 4943 shall be applied without taking section 4943(c) (4) into account. A distribution which otherwise qualifies under section 302 as a distribution in part or full payment in exchange for stock shall not be treated as essentially equivalent to a dividend because it does not meet the requirements of this subparagraph.

(e) *Deductions*—(1) *In general.* (i) For purposes of computing net investment income, there shall be allowed as a deduction from gross investment income all the ordinary and necessary expenses paid or incurred for the production or collection of gross investment income

or for the management, conservation, or maintenance of property held for the production of such income, determined with the modifications set forth in subparagraph (2) of this paragraph. Such expenses include that portion of a private foundation's operating expenses which is paid or incurred for the production or collection of gross investment income. Taxes paid or incurred under this section are not paid or incurred for the production or collection of gross investment income. A private foundation's operating expenses include compensation of officers, other salaries and wages of employees, outside professional fees, interest, and rent and taxes upon property used in the foundation's operations. Where a private foundation's officers or employees engage in activities on behalf of the foundation for both investment purposes and for exempt purposes, compensation and salaries paid to such officers or employees must be allocated between the investment activities and the exempt activities. To the extent a private foundation's expenses are taken into account in computing the tax imposed by section 511, they shall not be deductible for purposes of computing the tax imposed by section 4940.

(ii) Where only a portion of property produces, or is held for the production of, income subject to the section 4940 excise tax, and the remainder of the property is used for exempt purposes, the deductions allowed by section 4940(c)(3) shall be apportioned between the exempt and non-exempt uses.

(iii) No amount is allowable as a deduction under this section to the extent it is paid or incurred for purposes other than those described in subdivision (i) of this subparagraph. Thus, for example, the deductions prescribed by the following sections are not allowable: (1) The charitable deduction prescribed under section 170 and 642(c); (2) the net operating loss deduction prescribed under section 172; and (3) the special deductions prescribed under Part VIII, Subchapter B, Chapter 1.

(2) *Deduction modifications.* The following modifications shall be made in determining deductions otherwise allowable under this paragraph:

(i) The depreciation deduction shall be allowed, but only on the basis of the straight line method provided in section 167(b)(1).

(ii) The depletion deduction shall be allowed, but such deduction shall be determined without regard to section 613, relating to percentage depletion.

(iii) The basis to be used for purposes of the deduction allowed for depreciation or depletion shall be the basis determined under the rules of Part II of Subchapter O of Chapter 1, subject to the provisions of section 4940(c)(3)(B), and without regard to section 4940(c)(4)(B), relating to the basis for determining gain, or section 362(c). Thus, a private foundation must reduce the cost or other substituted or transferred basis by an amount equal to the straight line depreciation or cost depletion, without regard to whether the foundation deducted such depreciation or depletion during the period prior to its first taxable year beginning after December 31, 1969. However, where a private foundation has previously taken depreciation or depletion deductions in excess of the amount which would have been taken had the straight line or cost method been employed, such excess depreciation or depletion also shall be taken into account to reduce basis. If the facts necessary to determine the basis of property in the hands of the donor or the last preceding owner by whom it was not acquired by gift are unknown to a donee private foundation, then the original basis to such foundation of such property shall be determined under the rules of § 1.1015–1(a)(3).

(iv) The deduction for expenses paid or incurred in any taxable year for the production of gross investment income earned as an incident to a charitable function shall be no greater than the income earned from such function which is includible as gross investment income for such year. For example, where rental income is incidentally realized in 1971 from historic buildings held open to the public, deductions for amounts paid or incurred in 1971 for the production of such income shall be limited to the amount of rental income includible as gross investment income for 1971.

(f) *Capital gain and losses*—(1) *General rule.* In determining capital gain net income (net capital gain for taxable

years beginning before January 1, 1977) for purposes of the tax imposed by section 4940, there shall be taken into account only capital gains and losses from the sale or other disposition of property held by a private foundation for investment purposes (other than program-related investments, as defined in section 4944(c)), and property used for the production of income included in computing the tax imposed by section 511 except to the extent gain or loss from the sale or other disposition of such property is taken into account for purposes of such tax. For taxable years beginning after December 31, 1972, property shall be treated as held for investment purposes even though such property is disposed of by the foundation immediately upon its receipt, if it is property of a type which generally produces interest, dividends, rents, royalties, or capital gains through appreciation (for example, rental real estate, stock, bonds, mineral interests, mortgages, and securities). Under this subparagraph, gains and losses from the sale or other disposition of property used for the exempt purposes of the private foundation are excluded. For example, gain or loss on the sale of the buildings used for the exempt activities of a private foundation would not be subject to the section 4940 tax. Where the foundation uses property for its exempt purposes, but also incidentally derives income from such property which is subject to the tax imposed by section 4940(a), any gain or loss resulting from the sale or other disposition of such property is not subject to the tax imposed by section 4940(a). For example, if a tax-exempt private foundation maintains buildings of a historical nature and keeps them open for public inspection, but requires a number of its employees to live in these buildings and charges the employees rent, the rent would be subject to the tax imposed by section 4940(a), but any gain or loss resulting from the sale of such property would not be subject to such tax. However, where the foundation uses property for both exempt purposes and (other than incidentally) for investment purposes (for example, a building in which the foundation's charitable and investment activities are carried on), that portion of any gain or loss from the sale or other disposition of such property which is allocable to the investment use of such property must be taken into account in computing capital gain net income (net capital gain for taxable years beginning before January 1, 1977) for such taxable year. For purposes of this paragraph, a distribution of property for purposes described in section 170(c) (1) or (2)(B) which is a qualifying distribution under section 4942 shall not be treated as a sale or other disposition of property.

(2) *Basis*. (i) The basis for purposes of determining gain from the sale or other disposition of property shall be the greater of:

(A) Fair market value on December 31, 1969, plus or minus all adjustments after December 31, 1969, and before the date of disposition under the rules of Part II of Subchapter O of Chapter 1, provided that the property was held by the private foundation on December 31, 1969, and continuously thereafter to the date of disposition, or

(B) Basis as determined under the rules of Part II of Subchapter O of Chapter 1,

subject to the provisions of section 4940(c)(3)(B) (and without regard to section 362(c)).

(ii) For purposes of determining loss from the sale or other disposition of property, basis as determined in subdivision (i)(B) of this subparagraph shall apply.

(3) *Losses*. Where the sale or other disposition of property referred to in section 4940(c)(4)(A) results in a capital loss, such loss may be subtracted from capital gains from the sale or other disposition of other such property during the same taxable year, but only to the extent of such gains. Should losses from the sale or other disposition of such property exceed gains from the sale or other disposition of such property during the same taxable year, such excess may not be deducted from gross investment income under section 4940(c)(3) in any taxable year, nor may such excess by used to reduce gains in either prior or future taxable years, regardless of whether the foundation is a corporation or a trust.

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

Example 1. A private foundation holds certain depreciable real property on December 31, 1969, having a basis of $102,000. The fair market value of such property on that date was $100,000. For its taxable year 1970 the foundation was allowed depreciation for such property of $5,100 on the straight line method, the allowable amount computed on the $102,000 basis. The property was sold on January 1, 1971, for $100,000. Because fair market value on December 31, 1969, less straight line depreciation of $5,100 ($94,900) is less than basis as determined by Part II of Subchapter O of Chapter 1, $96,900 ($102,000 less $5,100), a gain of $3,100 is recognized (*i.e.*, sales price of $100,000 less the greater of the two possible bases).

Example 2. Assume the same facts in example 1, except that the sale price was $95,000. Because the sale price was $1,900 less than the basis for loss ($96,900 as determined by the application of subparagraph (2)(ii) of this paragraph), there is a capital loss of $1,900 which may be deducted against capital gains for 1971 (if any) in determining net capital gain (capital gain net income for taxable years beginning after December 31, 1976).

Example 3. A private foundation holds certain depreciable real property on December 31, 1969, having a basis of $102,000. The fair market value of such property on that date was $110,000. For its taxable year 1970 the foundation was allowed depreciation for such property of $5,100 on the straight line method, the allowable amount computed on the $102,000 basis. The property was sold on January 1, 1971, for $100,000. Fair market value on December 31, 1969, less straight line depreciation of $5,100 ($104,900) exceeds basis as determined by Part II of Subchapter O of Chapter 1, $96,900 ($102,000 less $5,100), and will be used for purposes of determining gain. Because basis for purposes of determining gain exceeds sale price, there is no gain. There is no loss because basis for purposes of determining loss ($96,900) is less than sale price.

[T.D. 7250, 38 FR 868, Jan. 5, 1973; 38 FR 7549, Mar. 23, 1973, as amended by T.D. 7407, 41 FR 9321, Mar. 4, 1976; T.D. 7606, 44 FR 18971, Mar. 30, 1979; T.D. 7728, 45 FR 72651, Nov. 3, 1980; T.D. 8423, 57 FR 33444, July 29, 1992]

Subpart B—Taxes on Self-Dealing

SOURCE: T.D. 7270, 38 FR 9493, Apr. 17, 1973, unless otherwise noted.

§ 53.4941(a)–1 Imposition of initial taxes.

(a) *Tax on self-dealer*—(1) *In general.* Section 4941(a)(1) of the code imposes an excise tax on each act of self-dealing between a disqualified person (as defined in section 4946(a)) and a private foundation. Except as provided in subparagraph (2) of this paragraph, this tax shall be imposed on a disqualified person even though he had no knowledge at the time of the act that such act constituted self-dealing. Notwithstanding the preceding two sentences, however, a transaction between a disqualified person and a private foundation will not constitute an act of self-dealing if:

(i) The transaction is a purchase or sale of securities by a private foundation through a stockbroker where normal trading procedures on a stock exchange or recognized over-the-counter market are followed;

(ii) Neither the buyer nor the seller of the securities nor the agent of either knows the identity of the other party involved; and

(iii) The sale is made in the ordinary course of business, and does not involve a block of securities larger than the average daily trading volume of that stock over the previous 4 weeks.

However, the preceding sentence shall not apply to a transaction involving a dealer who is a disqualified person acting as a principal or to a transaction which is an act of self-dealing pursuant to section 4941(d)(1)(B) and § 53.4941(d)–2(c)(1). The tax imposed by section 4941(a)(1) is at the rate of 5 percent of the amount involved (as defined in section 4941(e)(2) and § 53.4941(e)–1(b)) with respect to the act of self-dealing for each year or partial year in the taxable period (as defined in section 4941(e)(1)) and shall be paid by any disqualified person (other than a foundation manager acting only in the capacity of a foundation manager) who participates in the act of self-dealing. However, if a foundation manager is also acting as a self-dealer, he may be liable for both the tax imposed by section 4941(a)(1) and the tax imposed by section 4941(a)(2).

(2) *Government officials.* In the case of a government official (as defined in sec. 4946(a)), the tax shall be imposed upon such government official who participates in an act of self-dealing, only if he knows that such act is an act of

self-dealing. See paragraph (b)(3) of this section for a definition of *knowing*.

(3) *Participation*. For purposes of this paragraph, a disqualified person shall be treated as participating in an act of self-dealing in any case in which he engages or takes part in the transaction by himself or with others, or directs any person to do so.

(b) *Tax on foundation manager*—(1) *In general*. Section 4941(a)(2) of the code imposes an excise tax on the participation of any foundation manager in an act of self-dealing between a disqualified person and a private foundation. This tax is imposed only in cases in which the following circumstances are present:

(i) A tax is imposed by section 4941(a)(1),

(ii) Such participating foundation manager knows that the act is an act of self-dealing, and

(iii) The participation by the foundation manager is willful and is not due to reasonable cause.

The tax imposed by section 4941(a)(2) is at the rate of 2½ percent of the amount involved with respect to the act of self-dealing for each year or partial year in the taxable period and shall be paid by any foundation manager described in subdivisions (ii) and (iii) of this subparagraph.

(2) *Participation*. The term ''participation'' shall include silence or inaction on the part of a foundation manager where he is under a duty to speak or act, as well as any affirmative action by such manager. However, a foundation manager will not be considered to have participated in an act of self-dealing where he has opposed such act in a manner consistent with the fulfillment of his responsibilities to the private foundation.

(3) *Knowing*. For purposes of section 4941, a person shall be considered to have participated in a transaction ''knowing'' that it is an act of self-dealing only if:

(i) He has actual knowledge of sufficient facts so that, based solely upon such facts, such transaction would be an act of self-dealing,

(ii) He is aware that such an act under these circumstances may violate the provisions of Federal tax law governing self-dealing, and

(iii) He negligently fails to make reasonable attempts to ascertain whether the transaction is an act of self-dealing, or he is in fact aware that it is such an act.

For purposes of this part and Chapter 42, the term ''knowing'' does not mean ''having reason to know''. However, evidence tending to show that a person has reason to know of a particular fact or particular rule is relevant in determining whether he had actual knowledge of such fact or rule. Thus, for example, evidence tending to show that a person has reason to know of sufficient facts so that, based solely upon such facts, a transaction would be an act of self-dealing is relevant in determining whether he has actual knowledge of such facts.

(4) *Willful*. Participation by a foundation manager shall be deemed willful if it is voluntary, conscious, and intentional. No motive to avoid the restrictions of the law or the incurrence of any tax is necessary to make the participation willful. However, participation by a foundation manager is not willful if he does not know that the transaction in which he is participating is an act of self-dealing.

(5) *Due to reasonable cause*. A foundation manager's participation is due to reasonable cause if he has exercised his responsibility on behalf of the foundation with ordinary business care and prudence.

(6) *Advice of counsel*. If a person, after full disclosure of the factual situation to legal counsel (including house counsel), relies on the advice of such counsel expressed in a reasoned written legal opinion that an act is not an act of self-dealing under section 4941, although such act is subsequently held to be an act of self-dealing, the person's participation in such act will ordinarily not be considered ''knowing'' or ''willful'' and will ordinarily be considered ''due to reasonable cause'' within the meaning of section 4941(a)(2). For purposes of this subparagraph, a written legal opinion will be considered ''reasoned'' even if it reaches a conclusion which is subsequently determined to be incorrect so long as such opinion addresses itself to the facts and applicable law. However, a written legal

opinion will not be considered ''reasoned'' if it does nothing more than recite the facts and express a conclusion. However, the absence of advice of counsel with respect to an act shall not, by itself, give rise to any inference that a person participated in such act knowingly, willfully, or without reasonable cause.

(c) *Burden of proof*. For provisions relating to the burden of proof in cases involving the issue whether a foundation manager or a government official has knowingly participated in an act of self-dealing, see section 7454(b).

[T.D. 7270, 38 FR 9493, Apr. 17, 1973, as amended by T.D. 7299, 38 FR 35304, Dec. 27, 1973]

§ 53.4941(b)–1 Imposition of additional taxes.

(a) *Tax on self-dealer*. Section 4941(b)(1) of the Code imposes an excise tax in any case in which an initial tax is imposed by section 4941(a)(1) on an act of self-dealing by a disqualified person with a private foundation and the act is not corrected within the taxable period (as defined in § 53.4941(e)–1(a)). The tax imposed by section 4941(b)(1) is at the rate of 200 percent of the amount involved and shall be paid by any disqualified person (other than a foundation manager action only in the capacity of a foundation manager) who participated in the act of self-dealing.

(b) *Tax on foundation manager*. Section 4941(b)(2) of the Code imposes an excise tax to be paid by a foundation manager in any case in which a tax is imposed by section 4941(b)(1) and the foundation manager refused to agree to part or all of the correction of the self-dealing act. The tax imposed by section 4941(b)(2) is at the rate of 50 percent of the amount involved and shall be paid by any foundation manager who refused to agree to part or all of the correction of the self-dealing act. For the limitations on liability of a foundation manager, see § 53.4941(c)–1(b).

[T.D. 7270, 38 FR 9493, Apr. 17, 1973, as amended by T.D. 8084, 51 FR 16301, May 2, 1986]

§ 53.4941(c)–1 Special rules.

(a) *Joint and several liability*. (1) In any case where more than one person is liable for the tax imposed by any paragraph of section 4941 (a) or (b), all such persons shall be jointly and severally liable for the taxes imposed under such paragraph with respect to such act of self-dealing.

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

Example. A and B, who are managers of private foundation X, lend one of the foundation's paintings to G, a disqualified person, for display in G's office, in a transaction which gives rise to liability for tax under section 4941(a)(2) (relating to tax on foundation managers). An initial tax is imposed on both A and B with respect to the act of lending the foundation's painting to G. A and B are jointly and severally liable for the tax.

(b) *Limits on liability for management*. (1) The maximum aggregate amount of tax collectible under section 4941(a)(2) from all foundation managers with respect to any one act of self-dealing shall be $10,000, and the maximum aggregate amount of tax collectible under section 4941(b)(2) from all foundation managers with respect to any one act of self-dealing shall be $10,000.

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

Example. A, a disqualified person with respect to private foundation Y, sells certain real estate having a fair market value of $500,000 to Y for $500,000 in cash. B, C, and D, all the managers of foundation Y, authorized the purchase on Y's behalf knowing that such purchase was an act of self-dealing. The actions of B, C, and D in approving the purchase were willful and not due to reasonable cause. Initial taxes are imposed upon the foundation managers under subsections (a)(2) and (c)(2) of section 4941. The tax to be paid by the foundation managers is $10,000 (the lesser of $10,000 or 2½ percent of the amount involved). The managers are jointly and severally liable for this $10,000, and this sum may be collected by the Internal Revenue Service from any one of them.

§ 53.4941(d)–1 Definition of self-dealing.

(a) *In general*. For purposes of section 4941, the term *self-dealing* means any direct or indirect transaction described in § 53.4941(d)–2. For purposes of this section, it is immaterial whether the transaction results in a benefit or a detriment to the private foundation. The term ''self-dealing'' does not, however, include a transaction between a private foundation and a disqualified

person where the disqualified person status arises only as a result of such transaction. For example, the bargain sale of property to a private foundation is not a direct act of self-dealing if the seller becomes a disqualified person only by reason of his becoming a substantial contributor as a result of the bargain element of the sale. For the effect of sections 4942, 4943, 4944, and 4945 upon an act of self-dealing which also results in the imposition of tax under one or more of such sections, see the regulations under those sections.

(b) *Indirect self-dealing*—(1) *Certain business transactions*. The term ''indirect self-dealing'' shall not include any transaction described in §53.4941(d)–2 between a disqualified person and an organization controlled by a private foundation (within the meaning of paragraph (6)(5) of this section) if:

(i) The transaction results from a business relationship which was established before such transaction constituted an act of self-dealing (without regard to this paragraph),

(ii) The transaction was at least as favorable to the organization controlled by the foundation as an arm's-length transaction with an unrelated person, and

(iii) Either:

(*a*) The organization controlled by the foundation could have engaged in the transaction with someone other than a disqualified person only at a severe economic hardship to such organization, or

(*b*) Because of the unique nature of the product or services provided by the organization controlled by the foundation, the disqualified person could not have engaged in the transaction with anyone else, or could have done so only by incurring severe economic hardship. See example (2) of subparagraph (8) of this paragraph.

(2) *Grants to intermediaries*. The term ''indirect self-dealing'' shall not include a transaction engaged in with a government official by an intermediary organization which is a recipient of a grant from a private foundation and which is not controlled by such foundation (within the meaning of paragraph (6) (5) of this section) if the private foundation does not earmark the use of the grant for any named government official and there does not exist an agreement, oral or written, whereby the grantor foundation may cause the selection of the government official by the intermediary organization. A grant by a private foundation is earmarked if such grant is made pursuant to an agreement, either oral or written, that the grant will be used by any named individual. Thus, a grant by a private foundation shall not constitute an indirect act of self-dealing even though such foundation had reason to believe that certain government officials would derive benefits from such grant so long as the intermediary organization exercises control, in fact, over the selection process and actually makes the selection completely independently of the private foundation. See example (3) of subparagraph (8) of this paragraph.

(3) *Transactions during the administration of an estate or revocable trust*. The term ''indirect self-dealing'' shall not include a transaction with respect to a private foundation's interest or expectancy in property (whether or not encumbered) held by an estate (or revocable trust, including a trust which has become irrevocable on a grantor's death), regardless of when title to the property vests under local law, if:

(i) The administrator or executor of an estate or trustee of a revocable trust either:

(*a*) Possesses a power of sale with respect to the property,

(*b*) Has the power to reallocate the property to another beneficiary, or

(*c*) Is required to sell the property under the terms of any option subject to which the property was acquired by the estate (or revocable trust);

(ii) Such transaction is approved by the probate court having jurisdiction over the estate (or by another court having jurisdiction over the estate (or trust) or over the private foundation);

(iii) Such transaction occurs before the estate is considered terminated for Federal income tax purposes pursuant to paragraph (a) of §1.641(b)–3 of this chapter (or in the case of a revocable trust, before it is considered subject to sec. 4947);

(iv) The estate (or trust) receives an amount which equals or exceeds the fair market value of the foundation's

interest or expectancy in such property at the time of the transaction, taking into account the terms of any option subject to which the property was acquired by the estate (or trust); and

(v) With respect to transactions occurring after April 16, 1973, the transaction either:

(*a*) Results in the foundation receiving an interest or expectancy at least as liquid as the one it gave up,

(*b*) Results in the foundation receiving an asset related to the active carrying out of its exempt purposes, or

(*c*) Is required under the terms of any option which is binding on the estate (or trust).

(4) *Transactions with certain organizations.* A transaction between a private foundation and an organization which is not controlled by the foundation (within the meaning of subparagraph (5) of this paragraph), and which is not described in section 4946(a)(1) (E), (F), or (G) because persons described in section 4946(a)(1) (A), (B), (C), or (D) own no more than 35 percent of the total combined voting power or profits or beneficial interest of such organization, shall not be treated as an indirect act of self-dealing between the foundation and such disqualified persons solely because of the ownership interest of such persons in such organization.

(5) *Control.* For purposes of this paragraph, an organization is controlled by a private foundation if the foundation or one or more of its foundation managers (acting only in such capacity) may, only by aggregating their votes or positions of authority, require the organization to engage in a transaction which if engaged in with the private foundation would constitute self-dealing. Similarly, for purposes of this paragraph, an organization is controlled by a private foundation in the case of such a transaction between the organization and a disqualified person, if such disqualified person, together with one or more persons who are disqualified persons by reason of such a person's relationship (within the meaning of section 4946(a)(1) (C) through (G)) to such disqualified person, may, only by aggregating their votes or positions of authority with that of the foundation, require the organization to engage in such a transaction. The ''controlled'' organization need not be a private foundation; for example, it may be any type of exempt or nonexempt organization including a school, hospital, operating foundation, or social welfare organization. For purposes of this paragraph, an organization will be considered to be controlled by a private foundation or by a private foundation and disqualified persons referred to in the second sentence of this subparagraph if such persons are able, in fact, to control the organization (even if their aggregate voting power is less than 50 percent of the total voting power of the organization's governing body) or if one or more of such persons has the right to exercise veto power over the actions of such organization relevant to any potential acts of self-dealing. A private foundation shall not be regarded as having control over an organization merely because it exercises expenditure responsibility (as defined in section 4945 (d)(4) and (h)) with respect to contributions to such organization. See example (6) of subparagraph (8) of this paragraph.

(6) *Certain transactions involving limited amounts.* The term ''indirect self-dealing'' shall not include any transaction between a disqualified person and an organization controlled by a private foundation (within the meaning of subparagraph (5) of this paragraph) or between two disqualified persons where the foundation's assets may be affected by the transaction if:

(i) The transaction arises in the normal and customary course of a retail business engaged in with the general public,

(ii) In the case of a transaction between a disqualified person and an organization controlled by a private foundation, the transaction is at least as favorable to the organization controlled by the foundation as an arm's-length transaction with an unrelated person, and

(iii) The total of the amounts involved in such transactions with respect to any one such disqualified person in any one taxable year does not exceed $5,000.

See example (7) of subparagraph (8) of this paragraph.

(7) *Applicability of statutory exceptions to indirect self-dealing*. The term ''indirect self-dealing'' shall not include a transaction involving one or more disqualified persons to which a private foundation is not a party, in any case in which the private foundation, by reason of section 4941(d)(2), could itself engage in such a transaction. Thus, for example, even if a private foundation has control (within the meaning of subparagraph (5) of this paragraph) of a corporation, the corporation may pay to a disqualified person, except a government official, reasonable compensation for personal services.

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

Example 1. Private foundation P owns the controlling interest of the voting stock of corporation X, and as a result of such interest, elects a majority of the board of directors of X. Two of the foundation managers, A and B, who are also directors of corporation X, form corporation Y for the purpose of building and managing a country club. A and B receive a total of 40 percent of Y's stock, making Y a disqualified person with respect to P under section 4946(a)(1)(E). In order to finance the construction and operation of the country club, Y requested and received a loan in the amount of $4 million from X. The making of the loan by X to Y shall constitute an indirect act of self-dealing between P and Y.

Example 2. Private foundation W owns the controlling interest of the voting stock of corporation X, a manufacturer of certain electronic computers. Corporation Y, a disqualified person with respect to W, owns the patent for, and manufactures, one of the essential component parts used in the computers. X has been making regular purchases of the patented component from Y since 1965, subject to the same terms as all other purchasers of such component parts. X could not buy similar components from another source. Consequently, X would suffer severe economic hardship if it could not continue to purchase these components from Y, since it would then be forced to develop a computer which could be constructed with other components. Under these circumstances, the continued purchase by X from Y of these components shall not be an indirect act of self-dealing between W and Y.

Example 3. Private foundation Y made a grant to M University, an organization described in section 170(b)(1)(A)(ii), for the purpose of conducting a seminar to study methods for improving the administration of the judicial system. M is not controlled by Y within the meaning of subparagraph (5) of this paragraph. In conducting the seminar, M made payments to certain government officials. By the nature of the grant, Y had reason to believe that government officials would be compensated for participation in the seminar. M, however, had completely independent control over the selection of such participants. Thus, such grant by Y shall not constitute an indirect act of self-dealing with respect to the government officials.

Example 4. A, a substantial contributor to P, a private foundation, bequeathed one-half of his estate to his spouse and one-half of his estate to P. Included in A's estate is a one-third interest in AB, a partnership. The other two-thirds interest in AB is owned by B, a disqualified person with respect to P. The one-third interest in AB was subject to an option agreement when it was acquired by the estate. The executor of A's estate sells the one-third interest in AB to B pursuant to such option agreement at the price fixed in such option agreement in a sale which meets the requirements of subparagraph (3) of this paragraph. Under these circumstances, the sale does not constitute an indirect act of self-dealing between B and P.

Example 5. A bequeathed $100,000 to his wife and a piece of unimproved real estate of equivalent value to private foundation Z, of which A was the creator and a foundation manager. Under the laws of State Y, to which the estate is subject, title to the real estate vests in the foundation upon A's death. However, the executor has the power under State law to reallocate the property to another beneficiary. During a reasonable period for administration of the estate, the executor exercises this power and distributes the $100,000 cash to the foundation and the real estate to A's wife. The probate court having jurisdiction over the estate approves the executor's action. Under these circumstances, the executor's action does not constitute an indirect act of self-dealing between the foundation and A's wife.

Example 6. Private foundation P owns 20 percent of the voting stock of corporation W. A, a substantial contributor with respect to P, owns 16 percent of the voting stock of corporation W. B, A's son, owns 15 percent of the voting stock of corporation W. The terms of the voting stock are such that P, A, and B could vote their stock in a block to elect a majority of the board of directors of W. W is treated as controlled by P (within the meaning of subparagraph (5) of this paragraph) for purposes of this example A and B also own 50 percent of the stock of corporation Y, making Y a disqualified person with respect to P under section 4946(a)(1)(E). W makes a loan to Y of $1 million. The making of this loan by W to Y shall constitute an indirect act of self-dealing between P and Y.

Example 7. A, a disqualified person with respect to private foundation P, enters into a

contract with corporation M, which is also a disqualified person with respect to P. P owns 20 percent of M's stock, and controls M within the meaning of subparagraph (5) of this paragraph. M is in the retail department store business. Purchases by A of goods sold by M in the normal and customary course of business at retail or higher prices are not indirect acts of self-dealing so long as the total of the amounts involved in all of such purchases by A in any one year does not exceed $5,000.

[T.D. 7270, 38 FR 9493, Apr. 17, 1973, as amended at 38 FR 12604, May 14, 1973]

§ 53.4941(d)–2 Specific acts of self-dealing.

Except as provided in § 53.4941(d)–3 or § 53.4941(d)–4:

(a) *Sale or exchange of property*—(1) *In general*. The sale or exchange of property between a private foundation and a disqualified person shall constitute an act of self-dealing. For example, the sale of incidental supplies by a disqualified person to a private foundation shall be an act of self-dealing regardless of the amount paid to the disqualified person for the incidental supplies. Similarly, the sale of stock or other securities by a disqualified person to a private foundation in a ''bargain sale'' shall be an act of self-dealing regardless of the amount paid for such stock or other securities. An installment sale may be subject to the provisions of both section 4941(d)(1)(A) and section 4941(d)(1)(B).

(2) *Mortgaged property*. For purposes of subparagraph (1) of this paragraph, the transfer of real or personal property by a disqualified person to a private foundation shall be treated as a sale or exchange if the foundation assumes a mortgage or similar lien which was placed on the property prior to the transfer, or takes subject to a mortgage or similar lien which a disqualified person placed on the property within the 10-year period ending on the date of transfer. For purposes of this subparagraph, the term ''similar lien'' shall include, but is not limited to, deeds of trust and vendors' liens, but shall not include any other lien if such lien is insignificant in relation to the fair market value of the property transferred.

(b) *Leases*—(1) *In general*. Except as provided in subparagraphs (2) and (3) of this paragraph, the leasing of property between a disqualified person and a private foundation shall constitute an act of self-dealing.

(2) *Certain leases without charge*. The leasing of property by a disqualified person to a private foundation shall not be an act of self-dealing if the lease is without charge. For purposes of this subparagraph, a lease shall be considered to be without charge even though the private foundation pays for janitorial services, utilities, or other maintenance costs it incurs for the use of the property, so long as the payment is not made directly or indirectly to a disqualified person.

(3) *Certain leases of office space*. For taxable years beginning after December 31, 1979, the leasing of office space by a disqualified person to a private foundation shall not be an act of self-dealing if:

(i) The leased space is in a building in which there are other tenants who are not disqualified persons,

(ii) The lease is pursuant to a binding lease which was in effect on October 9, 1969, or pursuant to renewals of such a lease,

(iii) The execution of the lease was not a prohibited transaction (within the meaning of section 503(b) or the corresponding provisions of prior law) at the time of such execution, and

(iv) The terms of the lease (or any renewal) reflect an arm's length transaction.

A lease or renewal of such lease is described in this subparagraph (3) only if it satisfies the requirements of § 53.4941(d)–4(c) (1) and (2), applied without regard to the December 31, 1979 deadline described therein.

(c) *Loans*—(1) *In general*. Except as provided in subparagraphs (2), (3), and (4) of this paragraph, the lending of money or other extension of credit between a private foundation and a disqualified person shall constitute an act of self-dealing. Thus, for example, an act of self-dealing occurs where a third party purchases property and assumes a mortgage, the mortgagee of which is a private foundation, and subsequently the third party transfers the property to a disqualified person who either assumes liability under the mortgage or

takes the property subject to the mortgage. Similarly, except in the case of the receipt and holding of a note pursuant to a transaction described in §53.4941(d)–1(b)(3), an act of self-dealing occurs where a note, the obligor of which is a disqualified person, is transferred by a third party to a private foundation which becomes the creditor under the note.

(2) *Loans without interest.* Subparagraph (1) of this paragraph shall not apply to the lending of money or other extension of credit by a disqualified person to a private foundation if the loan or other extension of credit is without interest or other charge.

(3) *Certain evidences of future gifts.* The making of a promise, pledge, or similar arrangement to a private foundation by a disqualified person, whether evidenced by an oral or written agreement, a promissory note, or other instrument of indebtedness, to the extent motivated by charitable intent and unsupported by consideration, is not an extension of credit (within the meaning of this paragraph) before the date of maturity.

(4) *General banking functions.* Under section 4941(d)(2)(E) the performance by a bank or trust company which is a disqualified person of trust functions and certain general banking services for a private foundation is not an act of self-dealing, where the banking services are reasonable and necessary to carrying out the exempt purposes of the private foundation, if the compensation paid to the bank or trust company, taking into account the fair interest rate for the use of the funds by the bank or trust company, for such services is not excessive. The general banking services allowed by this subparagraph are:

(i) Checking accounts, as long as the bank does not charge interest on any overwithdrawals,

(ii) Savings accounts, as long as the foundation may withdraw its funds on no more than 30-days notice without subjecting itself to a loss of interest on its money for the time during which the money was on deposit, and

(iii) Safekeeping activities.

See example (3) §53.4941(d)–3(c)(2).

(d) *Furnishing goods, services, or facilities*—(1) *In general.* Except as provided in subparagraph (2) or (3) of this paragraph (or §53.4941(d)–3(b)), the furnishing of goods, services, or facilities between a private foundation and a disqualified person shall constitute an act of self-dealing. This subparagraph shall apply, for example, to the furnishing of goods, services, or facilities such as office space, automobiles, auditoriums, secretarial help, meals, libraries, publications, laboratories, or parking lots. Thus, for example, if a foundation furnishes personal living quarters to a disqualified person (other than a foundation manager or employee) without charge, such furnishing shall be an act of self-dealing.

(2) *Furnishing of goods, services, or facilities to foundation managers and employees.* The furnishing of goods, services, or facilities such as those described in subparagraph (1) of this paragraph to a foundation manager in recognition of his services as a foundation manager, or to another employee (including an individual who would be an employee but for the fact that he receives no compensation for his services) in recognition of his services in such capacity, is not an act of self-dealing if the value of such furnishing (whether or not includible as compensation in his gross income) is reasonable and necessary to the performance of his tasks in carrying out the exempt purposes of the foundation and, taken in conjunction with any other payment of compensation or payment or reimbursement of expenses to him by the foundation, is not excessive. For example, if a foundation furnishes meals and lodging which are reasonable and necessary (but not excessive) to a foundation manager by reason of his being a foundation manager, then, without regard to whether such meals and lodging are excludable from gross income under section 119 as furnished for the convenience of the employer, such furnishing is not an act of self-dealing. For the effect of section 4945(d)(5) upon an expenditure for unreasonable administrative expenses, see §53.4945–6(b)(2).

(3) *Furnishing of goods, services, or facilities by a disqualified person without charge.* The furnishing of goods, services, or facilities by a disqualified person to a private foundation shall not be

an act of self-dealing if they are furnished without charge. Thus, for example, the furnishing of goods such as pencils, stationery, or other incidental supplies, or the furnishing of facilities such as a building, by a disqualified person to a foundation shall be allowed if such supplies or facilities are furnished without charge. Similarly, the furnishing of services (even though such services are not personal in nature) shall be permitted if such furnishing is without charge. For purposes of this subparagraph, a furnishing of goods shall be considered without charge even though the private foundation pays for transportation, insurance, or maintenance costs it incurs in obtaining or using the property, so long as the payment is not made directly or indirectly to the disqualified person.

(e) *Payment of compensation*. The payment of compensation (or payment or reimbursement of expenses) by a private foundation to a disqualified person shall constitute an act of self-dealing. See, however, § 53.4941(d)–3(c) for the exception for the payment of compensation by a foundation to a disqualified person for personal services which are reasonable and necessary to carry out the exempt purposes of the foundation.

(f) *Transfer or use of the income or assets of a private foundation*—(1) *In general*. The transfer to, or use by or for the benefit of, a disqualified person of the income or assets of a private foundation shall constitute an act of self-dealing. For purposes of the preceding sentence, the purchase or sale of stock or other securities by a private foundation shall be an act of self-dealing if such purchase or sale is made in an attempt to manipulate the price of the stock or other securities to the advantage of a disqualified person. Similarly, the indemnification (of a lender) or guarantee (of repayment) by a private foundation with respect to a loan to a disqualified person shall be treated as a use for the benefit of a disqualified person of the income or assets of the foundation (within the meaning of this subparagraph). In addition, if a private foundation makes a grant or other payment which satisfies the legal obligation of a disqualified person, such grant or payment shall ordinarily constitute an act of self-dealing to which this subparagraph applies. However, if a private foundation makes a grant or payment which satisfies a pledge, enforceable under local law, to an organization described in section 501(c)(3), which pledge is made on or before April 16, 1973, such grant or payment shall not constitute an act of self-dealing to which this subparagraph applies so long as the disqualified person obtains no substantial benefit, other than the satisfaction of his obligation, from such grant or payment.

(2) *Certain incidental benefits*. The fact that a disqualified person receives an incidental or tenuous benefit from the use by a foundation of its income or assets will not, by itself, make such use an act of self-dealing. Thus, the public recognition a person may receive, arising from the charitable activities of a private foundation to which such person is a substantial contributor, does not in itself result in an act of self-dealing since generally the benefit is incidental and tenuous. For example, a grant by a private foundation to a section 509(a) (1), (2), or (3) organization will not be an act of self-dealing merely because such organization is located in the same area as a corporation which is a substantial contributor to the foundation, or merely because one of the section 509(a) (1), (2), or (3) organization's officers, directors, or trustees is also a manager of or a substantial contributor to the foundation. Similarly, a scholarship or a fellowship grant to a person other than a disqualified person, which is paid or incurred by a private foundation in accordance with a program which is consistent with:

(i) The requirements of the foundation's exempt status under section 501(c)(3),

(ii) The requirements for the allowance of deductions under section 170 for contributions made to the foundation, and

(iii) The requirements of section 4945(g)(1),

will not be an act of self-dealing under section 4941(d)(1) merely because a disqualified person indirectly receives an incidental benefit from such grant. Thus, a scholarship or a fellowship

grant made by a private foundation in accordance with a program to award scholarships or fellowship grants to the children of employees of a substantial contributor shall not constitute an act of self-dealing if the requirements of the preceding sentence are satisfied. For an example of the kind of scholarship program with an employment nexus that meets the above requirements, see §53.4945–4(b)(5) (example 1).

(3) *Non-compensatory indemnification of foundation managers against liability for defense in civil proceedings.* (i) Except as provided in §53.4941(d)–3(c), section 4941(d)(1) shall not apply to the indemnification by a private foundation of a foundation manager, with respect to the manager's defense in any civil judicial or civil administrative proceeding arising out of the manager's performance of services (or failure to perform services) on behalf of the foundation, against all expenses (other than taxes, including taxes imposed by chapter 42, penalties, or expenses of correction) including attorneys' fees, judgments and settlement expenditures if—

(A) Such expenses are reasonably incurred by the manager in connection with such proceeding; and

(B) The manager has not acted willfully and without reasonable cause with respect to the act or failure to act which led to such proceeding or to liability for tax under chapter 42.

(ii) Similarly, except as provided in §53.4941(d)–3(c), section 4941(d)(1) shall not apply to premiums for insurance to make or to reimburse a foundation for an indemnification payment allowed pursuant to this paragraph (f)(3). Neither shall an indemnification or payment of insurance allowed pursuant to this paragraph (f)(3) be treated as part of the compensation paid to such manager for purposes of determining whether the compensation is reasonable under chapter 42.

(4) *Compensatory indemnification of foundation managers against liability for defense in civil proceedings.* (i) The indemnification by a private foundation of a foundation manager for compensatory expenses shall be an act of self-dealing under this paragraph unless when such payment is added to other compensation paid to such manager the total compensation is reasonable under chapter 42. A compensatory expense for purposes of this paragraph (f) is—

(A) Any penalty, tax (including a tax imposed by chapter 42), or expense of correction that is owed by the foundation manager;

(B) Any expense not reasonably incurred by the manager in connection with a civil judicial or civil administrative proceeding arising out of the manager's performance of services on behalf of the foundation; or

(C) Any expense resulting from an act or failure to act with respect to which the manager has acted willfully and without reasonable cause.

(ii) Similarly, the payment by a private foundation of the premiums for an insurance policy providing liability insurance to a foundation manager for expenses described in this paragraph (f)(4) shall be an act of self-dealing under this paragraph (f) unless when such premiums are added to other compensation paid to such manager the total compensation is reasonable under chapter 42.

(5) *Insurance allocation.* A private foundation shall not be engaged in an act of self-dealing if the foundation purchases a single insurance policy to provide its managers both the non-compensatory and the compensatory coverage discussed in this paragraph (f), provided that the total insurance premium is allocated and that each manager's portion of the premium attributable to the compensatory coverage is included in that manager's compensation for purposes of determining reasonable compensation under chapter 42.

(6) *Indemnification.* For purposes of this paragraph (f), the term *indemnification* shall include not only reimbursement by the foundation for expenses that the foundation manager has already incurred or anticipates incurring but also direct payment by the foundation of such expenses as the expenses arise.

(7) *Taxable income.* The determination of whether any amount of indemnification or insurance premium discussed in this paragraph (f) is included in the manager's gross income for individual income tax purposes is made on the basis of the provisions of chapter 1 and

without regard to the treatment of such amount for purposes of determining whether the manager's compensation is reasonable under chapter 42.

(8) *De minimis items*. Any property or service that is excluded from income under section 132(a)(4) may be disregarded for purposes of determining whether the recipient's compensation is reasonable under chapter 42.

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

Example 1. M, a private foundation, makes a grant of $50,000 to the governing body of N City for the purpose of alleviating the slum conditions which exist in a particular neighborhood of N. Corporation P, a substantial contributor to M, is located in the same area in which the grant is to be used. Although the general improvement of the area may constitute an incidental and tenuous benefit to P, such benefit by itself will not constitute an act of self-dealing.

Example 2. Private foundation X established a program to award scholarship grants to the children of employees of corporation M, a substantial contributor to X. After disclosure of the method of carrying out such program, X received a determination letter from the Internal Revenue Service stating that X is exempt from taxation under section 501(c)(3), that contributions to X are deductible under section 170, and that X's scholarship program qualifies under section 4945(g)(1). A scholarship grant to a person not a disqualified person with respect to X paid or incurred by X in accordance with such program shall not be an indirect act of self-dealing between X and M.

Example 3. Private foundation Y owns voting stock in corporation Z, the management of which includes certain disqualified persons with respect to Y. Prior to Z's annual stockholder meeting, the management solicits and receives the foundation's proxies. The transfer of such proxies in and of itself shall not be an act of self-dealing.

Example 4. A, a disqualified person with respect to private foundation S, contributes certain real estate to S for the purpose of building a neighborhood recreation center in a particular underprivileged area. As a condition of the gift, S agrees to name the recreation center after A. Since the benefit to A is only incidental and tenuous, the naming of the recreation center, by itself, will not be an act of self-dealing.

(g) *Payment to a government official*. Except as provided in section 4941(d)(2)(G) or § 53.4941(d)–3(e), the agreement by a private foundation to make any payment of money or other property to a government official, as defined in section 4946(c), shall constitute an act of self-dealing. For purposes of this paragraph, an individual who is otherwise described in section 4946(c) shall be treated as a government official while on leave of absence from the government without pay.

[T.D. 7270, 38 FR 9493, Apr. 17, 1973, as amended by T.D. 7938, 49 FR 3848, Jan. 31, 1984; T.D. 8639, 60 FR 65568, Dec. 20, 1995]

§ 53.4941(d)–3 Exceptions to self-dealing.

(a) *General rule*. In general, a transaction described in section 4941(d)(2)(B), (C), (D), (E), (F), (G), or (H) is not an act of self-dealing. Section 4941(d)(2)(B), (C), and (H) provide limited exceptions to certain specific transactions, as described in paragraphs (b)(2), (b)(3), (c)(2), and (d)(3) of § 53.4941(d)–2. Section 4941(d)(2)(D), (E), (F), and (G) and paragraphs (b) through (e) of this section described certain transactions which are not acts of self-dealing.

(b) *Furnishing of goods, services, or facilities to a disqualified person*—(1) *In general*. Under section 4941(d)(2)(D), the furnishing of goods, services, or facilities by a private foundation to a disqualified person shall not be an act of self-dealing if such goods, services, or facilities are made available to the general public on at least as favorable a basis as they are made available to the disqualified person. This subparagraph shall not apply, however, in the case of goods, services, or facilities furnished later than May 16, 1973, unless such goods, services, or facilities are functionally related, within the meaning of section 4942(j)(5), to the exercise or performance by a private foundation of its charitable, educational, or other purpose or function constituting the basis for its exemption under section 501(c)(3).

(2) *General public*. For purposes of this paragraph, the term ''general public'' shall include those persons who, because of the particular nature of the activities of the private foundation, would be reasonably expected to utilize such goods, services, or facilities. This paragraph shall not apply, however, unless there is a substantial number of persons other than disqualified persons

who are actually utilizing such goods, services, or facilities. Thus, a private foundation which furnishes recreational or park facilities to the general public may furnish such facilities to a disqualified person provided they are furnished to him on a basis which is not more favorable than that on which they are furnished to the general public. Similarly, the sale of a book or magazine by a private foundation to disqualified persons shall not be an act of self-dealing if the publication of such book or magazine is functionally related to a charitable or educational activity of the foundation and the book or magazine is made available to the disqualified persons and the general public at the same price. In addition, if the terms of the sale require, for example, payment within 60 days from the date of delivery of the book or magazine, such terms are consistent with normal commercial practices, and payment is made within the 60-day period, the transaction shall not be treated as a loan or other extension of credit under § 53.4941(d)–2(c)(1).

(c) *Payment of compensation for certain personal services*—(1) *In general.* Under section 4941(d)(2)(E), except in the case of a Government official (as defined in section 4946(c)), the payment of compensation (and the payment or reimbursement of expenses, including reasonable advances for expenses anticipated in the immediate future) by a private foundation to a disqualified person for the performance of personal services which are reasonable and necessary to carry out the exempt purpose of the private foundation shall not be an act of self-dealing if such compensation (or payment or reimbursement) is not excessive. For purposes of this subparagraph the term ''personal services'' includes the services of a broker serving as agent for the private foundation, but not the services of a dealer who buys from the private foundation as principal and resells to third parties. For the determination whether compensation is excessive, see § 1.162–7 of this chapter (Income Tax Regulations). This paragraph applies without regard to whether the person who receives the compensation (or payment or reimbursement) is an individual. The portion of any payment which represents payment for property shall not be treated as payment of compensation (or payment or reimbursement of expenses) for the performance of personal services for purposes of this paragraph. For rules with respect to the performance of general banking services, see § 53.4941(d)–2(c)(4). Further, the making of a cash advance to a foundation manager or employee for expenses on behalf of the foundation is not an act of self-dealing, so long as the amount of the advance is reasonable in relation to the duties and expense requirements of the foundation manager. Except where reasonably allowable pursuant to subdivision (iii) of this subparagraph, such advances shall not ordinarily exceed $500. For example, if a foundation makes an advance to a foundation manager to cover anticipated out-of-pocket current expenses for a reasonable period (such as a month) and the manager accounts to the foundation under a periodic reimbursement program for actual expenses incurred, the foundation will not be regarded as having engaged in an act of self-dealing:

(i) When it makes the advance,

(ii) When it replenishes the funds upon receipt of supporting vouchers from the foundation manager, or

(iii) If it temporarily adds to the advance to cover extraordinary expenses anticipated to be incurred in fulfillment of a special assignment (such as long distance travel).

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

Example 1. M, a partnership, is a firm of 10 lawyers engaged in the practice of law. A and B, partners in M, serve as trustees to private foundation W and, therefore, are disqualified persons. In addition, A and B own more than 35 percent of the profits interest in M, thereby making M a disqualified person. M performs various legal services for W from time to time as such services are requested. The payment of compensation by W to M shall not constitute an act of self-dealing if the services performed are reasonable and necessary for the carrying out of W's exempt purposes and the amount paid by W for such services is not excessive.

Example 2. C, a manager of private foundation X, owns an investment counseling business. Acting in his capacity as an investment counselor, C manages X's investment portfolio for which he receives an amount which

is determined to be not excessive. The payment of such compensation to C shall not constitute an act of self-dealing.

Example 3. M, a commercial bank, serves as a trustee for private foundation Y. In addition to M's duties as trustee, M maintains Y's checking and savings accounts and rents a safety deposit box to Y. The use of the funds by M and the payment of compensation by Y to M for such general banking services shall be treated as the payment of compensation for the performance of personal services which are reasonable and necessary to carry out the exempt purposes of Y if such compensation is not excessive.

Example 4. D, a substantial contributor to private foundation Z, owns a factory which manufactures microscopes. D contracts with Z to manufacture 100 microscopes for Z. Any payment to D under the contract shall constitute an act of self-dealing, since such payment does not constitute the payment of compensation for the performance of personal services.

(d) *Certain transactions between a foundation and a corporation*—(1) *In general.* Under section 4941(d)(2)(F), any transaction between a private foundation and a corporation which is a disqualified person will not be an act of self-dealing if such transaction is engaged in pursuant to a liquidation, merger, redemption, recapitalization, or other corporate adjustment, organization, or reorganization, so long as all the securities of the same class as that held (prior to such transaction) by the foundation are subject to the same terms and such terms provide for receipt by the foundation of no less than fair market value. For purposes of this paragraph, all of the securities are not ''subject to the same terms unless, pursuant to such transaction,'' The corporation makes a bona fide offer on a uniform basis to the foundation and every other person who holds such securities. The fact that a private foundation receives property, such as debentures, while all other persons holding securities of the same class receive cash for their interests, will be evidence that such offer was not made on a uniform basis. This paragraph may apply even if no other person holds any securities of the class held by the foundation. In such event, however, the consideration received by holders of other classes of securities, or the interests retained by holders of such other classes, when considered in relation to the consideration received by the foundation, must indicate that the foundation received at least as favorable treatment in relation to its interests as the holders of any other class of securities. In addition, the foundation must receive no less than the fair market value of its interests.

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

Example 1. Private foundation X owns 50 percent of the class A preferred stock of corporation M, which is a disqualified person with respect to X. The terms of such securities provide that the stock may be called for redemption at any time by M at 105 percent of the face amount of the stock. M exercises this right and calls all the class A preferred stock by paying 105 percent of the face amount in cash. At the time of the redemption of the class A preferred stock, it is determined that the fair market value of the preferred stock is equal to its face amount. In such case, the redemption by M of the preferred stock of X is not an act of self-dealing.

Example 2. Private foundation Y, which is on a calendar year basis, acquires 60 percent of the class A preferred stock of corporation N by will on January 10, 1970. N, which is also on a calendar year basis, is a disqualified person with respect to Y. In 1971, N offers to redeem all of the class A preferred stock for a consideration equal to 100 percent of the face amount of such stock by the issuance of debentures. The offer expires January 2, 1972. Both Y and all other holders of the class A preferred stock accept the offer and enter into the transaction on January 2, 1972, at which time it is determined that the fair market value of the debentures is no less than the fair market value of the preferred stock. The transaction on January 2, 1972, shall not be treated as an act of self-dealing for 1972. However, because under § 53.4941 (e)–1 (e)(1)(i) an act of self dealing occurs on the first day of each taxable year or portion of a taxable year that an extension of credit from a foundation to a disqualified person goes uncorrected, if such debentures are held by Y after December 31, 1972, except as provided in § 53.4941(d)–4(c)(4), such extension of credit shall not be excepted from the definition of an act of self dealing by reason of the January 2, 1972, transaction. See § 53.4941(d)–4(c)(4) for rules indicating that under certain circumstances such debentures could be held by Y until December 31, 1979.

(e) *Certain payments to government officials.* Under section 4941(d)(2)(G), in the case of a government official, in addition to the exceptions provided in

section 4941(d)(2) (B), (C), and (D), section 4941(d)(1) shall not apply to:

(1) A prize or award which is not includible in gross income under section 74(b), if the government official receiving such prize or award is selected from the general public;

(2) A scholarship or a fellowship grant which is excludable from gross income under section 117(a) and which is to be utilized for study at an educational institution described in section 151(e)(4);

(3) Any annuity or other payment (forming part of a stock-bonus, pension, or profit sharing plan) by a trust which constitutes a qualified trust under section 401;

(4) Any annuity or other payment under a plan which meets the requirements of section 404(a)(2);

(5) Any contribution or gift (other than a contribution or gift of money) to, or services or facilities made available to, any government official, if the aggregate value of such contributions, gifts, services, and facilities does not exceed $25 during any calendar year;

(6) Any payment made under 5 U.S.C. Chapter 41 (relating to government employees' training programs);

(7) Any payment or reimbursement of traveling expenses (including amounts expended for meals and lodging, regardless of whether the government official is away from home within the meaning of section 162(a)(2), and including reasonable advances for such expenses anticipated in the immediate future) for travel solely from one point in the United States to another in connection with one or more purposes described in section 170(c) (1) or (2)(B), but only if such payment or reimbursement does not exceed the actual cost of the transportation involved plus an amount for all other traveling expenses not in excess of 125 percent of the maximum amount payable under 5 U.S.C. 5702(a) for like travel by employees of the United States;

(8) Any agreement to employ or make a grant to a government official for any period after the termination of his government service if such agreement is entered into within 90 days prior to such termination;

(9) If a government official attends or participates in a conference sponsored by a private foundation, the allocable portion of the cost of such conference and other nonmonetary benefits (for example, benefits of a professional, intellectual, or psychological nature, or benefits resulting from the publication or the distribution to participants of a record of the conference), as well as the payment or reimbursement of expenses (including reasonable advances for expenses anticipated in connection with such a conference in the near future), received by such government official as a result of such attendance or participation shall not be subject to section 4941(d)(1), so long as the conference is in furtherance of the exempt purposes of the foundation; or

(10) In the case of any government official who was on leave of absence without pay on December 31, 1969, pursuant to a commitment entered into on or before such date for the purpose of engaging in certain activities for which such individual was to be paid by one or more private foundations, any payment of compensation (or payment or reimbursement of expenses, including reasonable advances for expenses anticipated in the immediate future) by such private foundations to such individual for any continuous period after December 31, 1969, and prior to January 1, 1971, during which such individual remains on leave of absence to engage in such activities. A commitment is considered entered into on or before December 31, 1969, if on or before such date, the amount and nature of the payments to be made and the name of the individual receiving such payments were entered on the records of the payor, or were otherwise adequately evidenced, or the notice of the payment to be received was communicated to the payee orally or in writing.

[T.D. 7270, 38 FR 9493, Apr. 17, 1973, as amended by T.D. 7938, 49 FR 3848, Jan. 31, 1984]

§ 53.4941(d)–4 Transitional rules.

(a) *Certain transactions involving securities acquired by a foundation before May 27, 1969*—(1) *In general.* Under section 101(l)(2)(A) of the Tax Reform Act of 1969 (83 Stat. 533), any transaction between a private foundation and a corporation which is a disqualified person shall not be an act of self-dealing if such transaction is pursuant to the

terms of securities of such corporation, if such terms were in existence at the time such securities were acquired by the foundation, and if such securities were acquired by the foundation before May 27, 1969.

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

Example. Private foundation X purchased preferred stock of corporation M, a disqualified person with respect to X, on March 15, 1969. The terms of such securities on such date provided that the stock could be called by M at any time if M paid the outstanding shareholders cash equal to 105 percent of the face amount of the stock. If M exercises this right and calls the stock owned by X on February 15, 1970, such call shall not constitute an act of self-dealing even if such price is not equivalent to fair market value on such date and even if not all of the securities of that class are called.

(b) *Disposition of certain business holdings*—(1) *In general*. Under section 101(l)(2)(B) of the Tax Reform Act of 1969 (83 Stat. 533), the sale, exchange, or other disposition of property which is owned by a private foundation on May 26, 1969, to a disqualified person shall not be an act of self-dealing if the foundation is required to dispose of such property in order not to be liable for tax under section 4943 (determined without regard to section 4943(c)(2)(C) and as if every disposition by the foundation were made to disqualified persons) and if such disposition satisfies the requirements of subparagraph (2) of this paragraph. For purposes of applying this paragraph in the case of a disposition completed before January 1, 1975, or after October 4, 1976, and before January 1, 1977, the amount of excess business holdings is determined under section 4943(c) without taking subsection (c)(4) into account.

(2) *Terms of the disposition*. Subparagraph (1) of this paragraph shall not apply unless:

(i) The private foundation receives an amount which equals or exceeds the fair market value of the business holdings at the time of disposition or at the time a contract for such disposition was previously executed; and

(ii) At the time with respect to which subdivision (i) of this subparagraph is applied, the transaction would not have constituted a prohibited transaction within the meaning of section 503(b) or the corresponding provisions of prior law if such provisions had been applied at such time.

(3) *Property received under a trust or will*. For purposes of this paragraph, property shall be considered as owned by a private foundation on May 26, 1969, if such property is acquired by such foundation under the terms of a will executed on or before such date, under the terms of a trust which was irrevocable on such date, or under the terms of a revocable trust executed on or before such date if the property would have passed under a will which would have met the requirements of this subparagraph but for the fact that a grantor dies without having revoked the trust. An amendment or republication of a will which was executed on or before May 26, 1969, does not prevent any interest in a business enterprise which was to pass under the terms of such will (which terms were in effect on May 26, 1969, and at all times thereafter) from being treated as owned by a private foundation on or before May 26, 1969, solely because:

(i) There is a reduction in the interest in the business enterprise which the foundation was to receive under the terms of the will (for example, if the foundation is to receive the residuary estate and one class of stock is disposed of by the decedent during his lifetime or by a subsequent codicil),

(ii) Such amendment or republication is necessary in order to comply with section 508(e) and the regulations thereunder,

(iii) There is a change in the executor of the will, or

(iv) There is any other change which does not otherwise change the rights of the foundation with respect to such interest in the business enterprise.

However, if under such amendment or republication there is an increase of the interest in the business enterprise which the foundation was to receive under the terms of the will in effect on May 26, 1969, such increase shall not be treated as owned by the private foundation on or before May 26, 1969, but under such circumstances the interest which would have been acquired before such increase shall be treated as owned

by the private foundation on or before May 26, 1969.

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

Example 1. On May 26, 1969, private foundation X owns 10 percent of corporation Y's voting stock, which is traded on the New York Stock Exchange. Disqualified persons with respect to X own an additional 40 percent of such voting stock. X is on a calendar year basis. Prior to January 1, 1975, X privately sold its entire 10 percent for cash to B, a disqualified person, at the price quoted on the stock exchange at the close of the day less commissions. Since the 10 percent owned by X would constitute excess business holdings without the application of section 4943(c) (2)(C) or (4), the disposition will not constitute an act of self-dealing.

Example 2. Assume the facts as stated in example (1), except that the only stock of corporation Y which X owns is 1.5 percent of Y's voting stock. Since the 1.5 percent owned by X would constitute excess business holdings without the application of section 4943(c) (2)(C) or (4), the disposition of the stock to B for cash will not constitute an act of self-dealing.

Example 3. Assume the facts as stated in example (1), except that B, instead of paying cash as consideration for the stock, issued a 10-year secured promissory note as consideration for the stock. The issuance of such promissory note will not be treated as an act of self-dealing until taxable years beginning after December 31, 1979, unless such issuance would have been a prohibited transaction under section 503(b), or unless the transaction does not remain throughout its life at least as favorable as an arm's-length contract negotiated currently. See paragraph (c) of this section.

(c) *Existing leases and loans*—(1) *In general.* Under section 101(1)(2)(C) of the Tax Reform Act of 1969 (83 Stat. 533), the leasing of property or the lending of money (or other extension of credit) between a disqualified person and a private foundation pursuant to a binding contract which was in effect on October 9, 1969 (or pursuant to a renewal or modification of such a contract, as described in subparagraph (2) of this paragraph), shall not be an act of self-dealing until taxable years beginning after December 31, 1979, if:

(i) At the time the contract was executed, such contract was not a prohibited transaction (within the meaning of section 503(b) or the corresponding provisions of prior law), and

(ii) The leasing or lending of money (or other extension of credit) remains throughout the term of the lease or extension of credit at least as favorable as a current arm's-length transaction with an unrelated person.

(2) *Renewal or modification of existing contracts.* A renewal or a modification of an existing contract is referred to in subparagraph (1) of this paragraph only if any modifications of the terms of such contract are not substantial and the relative advantages of the modified contract compared with contracts entered into at arm's-length with an unrelated person at the time of the renewal or modification are at least as favorable to the private foundation as the relative advantages of the original contract compared with contracts entered into at arm's-length with an unrelated person at the time of execution of the original contract. Such renewal or modification need not be provided for in the original contract; it may take place before or after the expiration of the original contract and at any time before the first day of the first taxable year of the private foundation beginning after December 31, 1979. Where, in a normal commercial setting, an unrelated party in the position of a private foundation could be expected to insist upon a renegotiation or termination of a binding contract, the private foundation must so act. Thus, for example, if a disqualified person leases office space from a private foundation on a month-to-month basis, and a party in the position of the private foundation could be expected to renegotiate the rent required in such contract because of a rise in the fair market value of such office space, the private foundation must so act in order to avoid participation in an act of self-dealing. Where the private foundation has no right to insist upon renegotiation, an act of self-dealing shall occur if the terms of the contract become less favorable to the foundation than an arm's-length contract negotiated currently, unless:

(i) The variation from current fair market value is de minimis, or

(ii) The contract is renegotiated by the foundation and the disqualified person so that the foundation will receive no less than fair market value.

For purposes of subdivision (i) of this subparagraph de minimis ordinarily shall be no more than one-half of 1 percent in the rate of return in the case of a loan, or 10 percent of the rent in the case of a lease.

(3) *Example*. The provisions of subparagraphs (1) and (2) of this paragraph may be illustrated by the following example.

Example. Under a binding contract entered into on January 1, 1964, X, a private foundation, leases a building for 10 years from Z, a disqualified person. At the time the contract was executed, the lease was not a ''prohibited transaction'' within the meaning of section 503(b), since the rent charged X was only 50 percent of the rent which would have been charged in an arm's-length transaction with an unrelated person. On January 1, 1974, X renewed the lease for 5 additional years. The terms of the renewal agreement provided for a 20 percent increase in the amount of rent charged X. However, at the time of such renewal, the rent which would have been charged in an arm's-length transaction had also increased by 20 percent from that of 1964. The renewal agreement shall not be treated as an act of self-dealing.

(4) *Certain exchanges of stock or securities for bonds, debentures or other indebtedness*. (i) In the case of a transaction described in paragraph (a) or (b) of this section or paragraph (d) of § 53.4941(d)–3, where a bond, debenture, or other indebtedness of a disqualified person is acquired by a private foundation in exchange for stock or securities which it held on October 9, 1969, and at all times thereafter, such indebtedness shall be treated as an extension of credit pursuant to a binding contract in effect on October 9, 1969, to which this paragraph applies. Thus, so long as the extension of credit remains at least as favorable as an arm's-length transaction with an unrelated person and neither the acquisition of the securities which were exchanged for the indebtedness nor the exchange of such securities for the indebtedness was a prohibited transaction within the meaning of section 503(b) (or the corresponding provisions of prior law) at the time of such acquisition, such extension of credit shall not be an act of self-dealing until taxable years beginning after December 31, 1979.

(ii) The provisions of this subparagraph may be illustrated by the following examples:

Example 1. Assume the facts as stated in example (2) of § 53.4941 (d)–3 (d)(2), except that the preferred stock was held by Y on October 9, 1969, and at all times thereafter until the redemption occurred on January 2, 1972. In addition, assume that the acquisition of the preferred stock was not a prohibited transaction within the meaning of section 503(b) at the time of such acquisition and the exchange of the preferred stock for the debentures would not have been a prohibited transaction within the meaning of section 503(b). For 1973 through 1979, the extension of credit arising from the holding of the debentures is not an act of self-dealing so long as the extension of credit remains at least as favorable as an arm's-length transaction with an unrelated person. See, however, example (3) of § 53.4941 (e)–1 (e)(1)(ii).

Example 2. Assume the same facts as stated in example (1) of § 53.4941 (d)–4 (b)(4), except that private foundation X sold its entire 10 percent of corporation Y's voting stock in exchange for Y's secured notes which mature on December 31, 1985. For taxable years beginning before January 1, 1980, the extension of credit arising from the holding of such notes by X is not an act of self-dealing so long as the extension of credit remains at least as favorable as an arm's-length transaction with an unrelated person and neither the acquisition of the securities which were exchanged for the indebtedness nor the exchange of such securities for the indebtedness was a prohibited transaction within the meaning of section 503(b) (or the corresponding provisions of prior law). Under § 53.4941(e)–1, a new extension of credit occurs on the first day of each taxable year in which an indebtedness is outstanding; therefore, if the secured notes are held by X after December 31, 1979, a new extension of credit not excepted from the definition of an act of self-dealing will occur on the first day of the first taxable year beginning after December 31, 1979, and on the first day of each succeeding taxable year in which X holds such secured notes.

(d) *Sharing of goods, services, or facilities before January 1, 1980*. (1) Under section 101(1)(2)(D) of the Tax Reform Act of 1969 (83 Stat. 533), the use (other than leasing) of goods, services, or facilities which are shared by a private foundation and a disqualified person shall not be an act of self-dealing until taxable years beginning after December 31, 1979, if:

(i) The use is pursuant to an arrangement in effect before October 9, 1969, and at all times thereafter;

(ii) The arrangement was not a prohibited transaction (within the meaning of sec. 503(b) or the corresponding provisions of prior law) at the time it was made; and

(iii) The arrangement would not be a prohibited transaction if section 503(b) continued to apply.

For purposes of this paragraph, such arrangement need not be a binding contract.

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

Example. In 1964 X, a private foundation, and B, a disqualified person, arranged for the sharing of computer time in B's son's company for a 10-year period commencing January 1, 1965. B's son has the unilateral right to terminate the arrangement at any time. X uses the computer facilities in connection with an analysis of its grant-making activities, while B's use is related to his business affairs. Both X and B make reasonable fixed payments to the computer company based on the number of hours of computer use and comparable to fees charged in arm's-length transactions with unrelated parties. The company imposes a maximum limit per month on the sum of the number of hours for which X and B use the computer facilities. Under these circumstances, the sharing of computer time is not an act of self-dealing.

(e) *Use of certain property acquired before October 9, 1969*. (1) Under section 101(1)(2)(E) of the Tax Reform Act of 1969 (83 Stat. 533), the use of property in which a private foundation and a disqualified person have a joint or common interest will not be an act of self-dealing if the interests of both in such property were acquired before October 9, 1969.

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

Example. Prior to October 9, 1969, C, a disqualified person, gave beachfront property to private foundation X for use as a recreational facility for underprivileged, inner-city children during the summer months. However, C retained the right to use such property for his life. The use of such property by C or X is not an act of self-dealing.

(f) *Disposition of leased property*—(1) *In general*. Under section 101(1)(2)(F) of the Tax Reform Act of 1969, as amended by the Tax Reform Act of 1976 (90 Stat. 1713), the sale, exchange or other disposition (other than by lease) to a disqualified person of property being leased to the disqualified person by a private foundation is not an act of self-dealing if:

(i) The private foundation is leasing substantially all of the property to the disqualified person under a lease to which paragraph (c) of this section applies;

(ii) The disposition occurs after October 4, 1976, and before January 1, 1978; and

(iii) The disposition satisfies the requirements of paragraph (f)(2) of this section.

(2) *Terms of disposition*. Paragraph (f)(1) of this section applies only if:

(i) The private foundation receives an amount that equals or exceeds the fair market value of the property either at the time of the disposition or at the time (after June 30, 1976) the contract for such disposition was executed;

(ii) In computing the fair market value of the property, no diminution of that value results from the fact that the property is subject to any lease to disqualified persons; and

(iii) At the time with respect to which paragraph (f)(2)(i) of this section is applied, the transaction would not have constituted a prohibited transaction within the meaning of section 503(b) or the corresponding provisions of prior law if those provisions had been applied at the time of the transaction.

[T.D. 7270, 38 FR 9493, Apr. 17, 1973, as amended by T.D. 7678, 45 FR 12416, Feb. 26, 1980]

§53.4941(e)–1 Definitions.

(a) *Taxable period*—(1) *In general*. For purposes of any act of self-dealing, the term ''taxable period'' means the period beginning with the date on which the act of self-dealing occurs and ending on the earliest of:

(i) The date of mailing of a notice of deficiency under section 6212 with respect to the tax imposed by section 4941(a)(1),

(ii) The date on which correction of the act of self-dealing is completed, or

(iii) The date on which the tax imposed by section 4941(a)(1) is assessed.

(2) *Date of occurrence*. An act of self-dealing occurs on the date on which all the terms and conditions of the transaction and the liabilities of the parties

have been fixed. Thus, for example, if a private foundation gives a disqualified person a binding option on June 15, 1971, to purchase property owned by the foundation at any time before June 15, 1972, the act of self-dealing has occurred on June 15, 1971. Similarly, in the case of a conditional sales contract, the act of self-dealing shall be considered as occurring on the date the property is transferred subject only to the condition that the buyer make payment for receipt of such property.

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

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

Example 1. On July 16, 1970, F, a manager of private foundation X acting on behalf of the foundation, knowing his act to be one of self-dealing, willfully and without reasonable cause engaged in an act of self-dealing by selling certain real estate to A, a disqualified person. On March 25, 1973, the Internal Revenue Service mailed a notice of deficiency to A with respect to the tax imposed on the sale under section 4941(a)(1). The taxable period with respect to the act of self-dealing for both A and F is July 16, 1970, through March 25, 1973.

Example 2. Assume the facts as stated in example (1), except that the act of self-dealing is corrected by A on March 17, 1971. The taxable period with respect to the act of self-dealing for both A and F is July 16, 1970, through March 17, 1971.

Example 3. Assume the facts as stated in example (1), except that on August 20, 1972, A files a waiver of the restrictions on assessment and collection of the tax imposed on the sale under section 4941(a)(1) which is accepted. The taxable period with respect to the act of self-dealing for both A and F is July 16, 1970, through August 20, 1972.

(b) *Amount involved*—(1) *In general*. Except as provided in subparagraph (2) of this paragraph, for purposes of any act of self-dealing, the term ''amount involved'' means the greater of the amount of money and the fair market value of the other property given or the amount of money and the fair market value of the other property received.

(2) *Exceptions*. (i) In the case of the payment of compensation for personal services to persons other than Government officials, the amount involved shall be only the excess compensation paid by the private foundation.

(ii) Where the use of money or other property is involved, the amount involved shall be the greater of the amount paid for such use or the fair market value of such use for the period for which the money or other property is used. Thus, for example, in the case of a lease of a building by a private foundation to a disqualified person, the amount involved is the greater of the amount of rent received by the private foundation from the disqualified person or the fair rental value of the building for the period such building is used by the disqualified person.

(iii) In cases in which a transaction would not have been an act of self-dealing had the private foundation received fair market value, the amount involved is the excess of the fair market value of the property transferred by the private foundation over the amount which the private foundation receives, but only if the parties have made a good faith effort to determine fair market value. For purposes of this subdivision a good faith effort to determine fair market value shall ordinarily have been made where:

(*a*) The person making the valuation is not a disqualified person with respect to the foundation and is both competent to make the valuation and not in a position, whether by stock ownership or otherwise, to derive an economic benefit from the value utilized, and

(*b*) The method utilized in making the valuation is a generally accepted method for valuing comparable property, stock, or securities for purposes of arm's-length business transactions where valuation is a significant factor.

See section 4941(d)(2)(F) and §§ 53.4941(d)–1(b)(3), 53.4941(d)–3 (d)(1) and 53.4941(d)–4(b). Thus, for example, if a corporation which is a disqualified person with respect to a private foundation recapitalizes in a transaction which would be described in section 4941(d)(2)(F) but for the fact that the

private foundation receives new stock worth only $95,000 in exchange for the stock which it previously held in the corporation and which has a fair market value of $100,000 at the time of the recapitalization, the amount involved would be $5,000 ($100,000—$95,000) if there had been a good faith attempt to value the stock. Similarly, if an estate enters into a transaction with a disqualified person with respect to a foundation and such transaction would be described in § 53.4941(d)–1(b)(3) but for the fact that the estate receives less than fair market value for the property exchanged, the amount involved is the excess of the fair market value of the property the estate transfers to the disqualified person over the money and the fair market value of the property received by the estate.

(3) *Time for determining fair market value.* The fair market value of the property or the use thereof, as the case may be, shall be determined as of the date on which the act of self-dealing occurred in the case of the initial taxes imposed by section 4941(a) and shall be the highest fair market value during the taxable period in the case of the additional taxes imposed by section 4941(b).

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

Example 1. A, a disqualified person with respect to private foundation M, uses an airplane owned by M on June 15 and June 16, 1970, for a 2-day trip to New York City on personal business and pays M $500 for the use of such airplane. The fair rental value for the use of the airplane for those 2 days is $3,000. For purposes of section 4941(a), the amount involved with respect to the act of self-dealing is $3,000.

Example 2. On April 10, 1970, B, a manager of private foundation P, borrows $100,000 from P at 6 percent interest per annum. Both principal and interest are to be paid 1 year from the date of the loan. The fair market value of the use of the money on April 10, 1970, is 10 percent per annum. Six months later, B and P terminate the loan, and B repays the $100,000 principal plus $3,000 ($100,000 × 6 percent for one-half year) interest. For purposes of section 4941(a), the amount involved with respect to the act of self-dealing is $5,000 ($100,000 × 10 percent for one-half year) for each year or partial year in the taxable period.

Example 3. C, a substantial contributor to private foundation S, leases office space in a building owned by S for $3,600 for 1 year beginning on January 1, 1971. The fair rental value of the building for a 1-year lease on January 1, 1971, is $5,600. On December 31, 1971, the lease is terminated. For purposes of section 4941(a), the amount involved with respect to the act of self-dealing is $5,600 for each year or partial year in the taxable period.

Example 4. D, a disqualified person with respect to private foundation T, purchases 100 shares of stock from T for $5,000 on June 15, 1982. The fair market value of the 100 shares of stock on that date is $4,800. D sells the 100 shares of stock on December 20, 1983, for $6,000. On December 27, 1983, a notice of deficiency with respect to the taxes imposed under subsections (a) and (b) of section 4941 is mailed to D and the taxable period ends. D fails to correct during the taxable period. Between June 15, 1982, and the end of the taxable period, the stock was quoted on the New York Stock Exchange at a high of $67 per share. The amount involved with respect to the tax imposed under subsection (a) is $5,000, and the amount involved with respect to the tax imposed under subsection (b) for failure to correct is $6,700 (100 shares at $67 per share), the highest fair market value during the taxable period.

Example 5. Corporation M, a disqualified person with respect to private foundation V, redeems all of its Class B common stock, some of which is held by V. The redemption of V's stock would be described in section 4941(d)(2)(F) but for the fact that V receives only $95,000 in exchange for stock which has a fair market value of $100,000 at the time of the transaction. The $95,000 value of V's stock, which is not publicly traded, was determined by investment bankers in accordance with accepted methods of valuation that would be utilized if the M stock held by V were to be offered for sale to the public. Therefore, the amount involved with respect to the transaction will ordinarily be limited to $5,000 ($100,000—$95,000).

(c) *Correction*—(1) *In general.* Correction shall be accomplished by undoing the transaction which constituted the act of self-dealing to the extent possible, but in no case shall the resulting financial position of the private foundation be worse than that which it would be if the disqualified person were dealing under the highest fiduciary standards. For example, where a disqualified person sells property to a private foundation for cash, correction may be accomplished by recasting the transaction in the form of a gift by returning the cash to the foundation. Subparagraphs (2) through (6) of this paragraph illustrate the minimum

standards of correction in the case of certain specific acts of self-dealing. Principles similar to the principles contained in such subparagraphs shall be applied with respect to other acts of self-dealing. Any correction pursuant to this paragraph and section 4941 shall not be an act of self-dealing.

(2) *Sales by foundation.* (i) In the case of a sale of property by a private foundation to a disqualified person for cash, undoing the transaction includes, but is not limited to, requiring rescission of the sale where possible. However, in order to avoid placing the foundation in a position worse than that in which it would be if rescission were not required, the amount returned to the disqualified person pursuant to the rescission shall not exceed the lesser of the cash received by the private foundation or the fair market value of the property received by the disqualified person. For purposes of the preceding sentence, fair market value shall be the lesser of the fair market value at the time of the act of self-dealing or the fair market value at the time of rescission. In addition to rescission, the disqualified person is required to pay over to the private foundation any net profits he realized after the original sale with respect to the property he received from the sale. Thus, for example, the disqualified person must pay over to the foundation any income derived by him from the property he received from the original sale to the extent such income during the correction period exceeds the income derived by the foundation during the correction period from the cash which the disqualified person originally paid to the foundation.

(ii) If, prior to the end of the correction period, the disqualified person resells the property in an arm's-length transaction to a bona fide purchaser who is not the foundation or another disqualified person, no rescission is required. In such case, the disqualified person must pay over to the foundation the excess (if any) of the greater of the fair market value of such property on the date on which correction of the act of self-dealing occurs or the amount realized by the disqualified person from such arm's length resale over the amount which would have been returned to the disqualified person pursuant to subdivision (i) of this subparagraph if rescission had been required. In addition, the disqualified person is required to pay over to the foundation any net profits he realized, as described in subdivision (i) of this subparagraph.

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

Example 1. On July 1, 1970, private foundation M sold a painting to A, a disqualified person, for $5,000, in a transaction not within any of the exceptions to self-dealing. The fair market value of the painting on such date was $6,000. On March 25, 1971, the painting is still owned by A and has a fair market value of $7,200. A did not derive any income as a result of purchasing the painting. In order to correct the act of self-dealing under this subparagraph on March 25, 1971, the sale must be rescinded by the return of the painting to M. However, pursuant to such rescission, M must not pay A more than $5,000, the original consideration received by M.

Example 2. Assume the facts as stated in Example (1), except that A sold the painting on December 15, 1970, in an arm's-length transaction to C, a bona fide purchaser who is not a disqualified person, for $6,100. In addition, assume that the fair market value of the painting on March 25, 1971, is $7,600. In order to correct the act of self-dealing under this subparagraph on March 25, 1971, A must pay M $2,600 ($7,600, the fair market value at the time of correction, less $5,000, the amount which would have been returned to A if rescission had been required). Since the painting was sold to C in an arm's-length transaction prior to correction, no rescission is required.

(3) *Sales to foundation.* (i) In the case of a sale of property to a private foundation by a disqualified person for cash, undoing the transaction includes, but is not limited to, requiring rescission of the sale where possible. However, in order to avoid placing the foundation in a position worse than that in which it would be if rescission were not required, the amount received from the disqualified person pursuant to the rescission shall be the greatest of the cash paid to the disqualified person, the fair market value of the property at the time of the original sale, or the fair market value of the property at the time of rescission. In addition to rescission, the disqualified person is required to pay over to the private foundation any net profits he realized after the original sale with respect to the

consideration he received from the sale. Thus, for example, the disqualified person must pay over to the foundation any income derived by him from the cash he received from the original sale to the extent such income during the correction period exceeds the income derived by the foundation during the correction period from the property which the disqualified person originally transferred to the foundation.

(ii) If, prior to the end of the correction period, the foundation resells the property in an arm's-length transaction to a bona fide purchaser who is not a disqualified person, no rescission is required. In such case, the disqualified person must pay over to the foundation the excess (if any) of the amount which would have been received from the disqualified person pursuant to subdivision (i) of this subparagraph, if rescission had been required over the amount realized by the foundation upon resale of the property. In addition, the disqualified person is required to pay over to the foundation any net profits he realized, as described in subdivision (i) of this subparagraph.

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

Example 1. On February 10, 1972, D, a disqualified person with respect to private foundation P, sells 100 shares of X stock to P for $2,500 in a transaction which does not fall within any of the exceptions to selfdealing. The fair market value of the 100 shares of X stock on February 10, 1972, is $3,200. On June 1, 1973, the 100 shares of X stock have a fair market value of $2,900. From February 10, 1972, through June 1, 1973, P has received dividends of $90 from the stock, and D has received interest of $300 from the $2,500 which D received as consideration for the stock. In order to correct the act of self-dealing under this subparagraph on June 1, 1973, the sale must be rescinded by the return of the stock to D. However, pursuant to such rescission, D must pay P $3,200, the fair market value of the stock on the date of sale. In addition, D must pay P $210, the amount of income derived by D during the correction period from the $2,500 received from P ($300) minus the income derived by P during the correction period from the stock sold to P ($90).

Example 2. Assume the facts as stated in Example (1), except that on September 1, 1972, P sells the 100 shares of X stock to E, a bona fide purchaser who is not a disqualified person, in an arm's-length transaction for $2,750. Assume further that P has not received any dividends from the stock prior to the sale to E, but that P receives interest of $260 from the $2,750 received as consideration for the stock for the period from September 1, 1972, to June 1, 1973. In order to correct the act of self-dealing under this subparagraph on June 1, 1973, D must pay P $450 ($3,200, the amount which would have been received from D if rescission had been required, less $2,750, the amount realized by P from the sale to E). In addition, D must pay P $40, the amount of income derived by D during the correction period from the $2,500 received from P ($300) minus the income derived by P during the correction period from the stock sold to P ($260 from the $2,750 received as consideration for the stock). Since the stock was sold to E in an arm's-length transaction prior to correction, no rescission is required.

(4) *Use of property by a disqualified person*. (i) In the case of the use by a disqualified person of property owned by a private foundation, undoing the transaction includes, but is not limited to, terminating the use of such property. In addition to termination, the disqualified person must pay the foundation:

(*a*) The excess (if any) of the fair market value of the use of the property over the amount paid by the disqualified person for such use until such termination, and

(*b*) The excess (if any) of the amount which would have been paid by the disqualified person for the use of the property on or after the date of such termination, for the period such disqualified person would have used the property (without regard to any further extensions or renewals of such period) if such termination had not occurred, over the fair market value of such use for such period.

In applying (*a*) of this subdivision the fair market value of the use of property shall be the higher of the rate (that is, fair rental value per period in the case of use of property other than money or fair interest rate in the case of use of money) at the time of the act of self-dealing (within the meaning of paragraph (e)(1) of this section) or such rate at the time of correction of such act of self-dealing. In applying (*b*) of this subdivision the fair market value of the use of property shall be the rate at the time of correction.

(ii) The provisions of this subparagraph may be illustrated by the following examples:

Example 1. On January 1, 1972, private foundation S rented the third story of its office building to A, a disqualified person, for 1 year at an annual rent of $10,000, in a transaction not within any of the exceptions to self-dealing. Both S and A are on the calendar year basis. The fair rental value of such office space for a 1-year period on January 1, 1972, is $12,000. On June 30, 1972, the fair rental value of such office space for a 1-year period is $13,000. In order to correct the act of self-dealing under this subparagraph on June 30, 1972, A must terminate his use of the property. In addition, A must pay S $1,500, the excess of $6,500 (the fair rental value for 6 months as of June 30, 1972) over $5,000 (the amount paid to S from Jan. 1, 1972, to June 30, 1972).

Example 2. On January 1, 1972, private foundation R rented the fourth story of its office building to B, a disqualified person, for 1 year at an annual rent of $10,000, in a transaction not included in any of the exceptions to self-dealing. Both R and B are on the calendar year basis. On January 1, 1973, B continues to rent the office space as a periodic tenant paying his rent monthly at an annual rate of $10,000. The fair rental value of such office space for a 1-year period on January 1, 1972, is $12,000, and as of January 1, 1973, is $1,250 per month. As of December 31, 1973, the fair rental value of such office space is $14,000 for a 1-year period and $1,200 on a monthly basis. In order to correct his acts of self-dealing (within the meaning of paragraph (e)(1) of this section) under this subparagraph on December 31, 1973, B must terminate his use of the property. In addition, B must pay R $9,000, $4,000 for his use of the property for 1972 (the excess of $14,000, the fair rental value for 1 year as of Dec. 31, 1973, over $10,000, the amount B paid R for his use of the property for 1972) and $5,000 for his use of the property for 1973 (the excess of $15,000, the fair rental value for 12 months as of Jan. 1, 1973, over $10,000, the amount B paid R for his use of the property for 1973).

Example 3. B, a substantial contributor to private foundation T, leases office space in a building owned by T for $5,000 for 1 year beginning on November 10, 1972, in a transaction not included in any of the exceptions to self-dealing. The fair rental value of the building for a 1-year period on November 10, 1972, is $4,000. On May 10, 1973, the fair rental value of the building for the remaining period of the lease is $2,200. In order to correct the acts of self-dealing under this subparagraph on May 10, 1973, B and T must terminate the lease. In addition, B must pay T $300 (the excess of $2,500, the amount which would have been paid by B for the remaining period of the lease if it had not been terminated, over $2,200, the fair rental value at the time of correction for the remaining period of the lease).

(5) *Use of property by a private foundation.* (i) In the case of the use by a private foundation of property owned by a disqualified person, undoing the transaction includes, but is not limited to, terminating the use of such property. In addition to termination, the disqualified person must pay the foundation:

(*a*) The excess (if any) of the amount paid to the disqualified person for such use until such termination over the fair market value of the use of the property, and

(*b*) The excess (if any) of the fair market value of the use of the property, for the period the foundation would have used the property (without regard to any further extensions or renewals of such period) if such termination had not occurred, over the amount which would have been paid to the disqualified person on or after the date of such termination for such use for such period.

In applying (*a*) of this subdivision the fair market value of the use of property shall be the lesser of the rate (that is, fair rental value per period in the case of use of property other than money or fair interest rate in the case of use of money) at the time of the act of self-dealing (within the meaning of paragraph (e)(1) of this section) or such rate at the time of correction of such act of self-dealing. In applying (*b*) of this subdivision the fair market value of the use of property shall be the rate at the time of correction.

(ii) The provisions of this subparagraph may be illustrated by the following examples:

Example 1. On July 1, 1972, private foundation X leases office space in a building owned by C, a disqualified person, for 1 year at an annual rent of $6,000. Both X and C are on the calendar year basis. The fair rental value of such office space for a 1-year period as of July 1, 1972, is $4,200. As of January 1, 1973, the fair rental value of such office space for a 1-year period is $5,400, and as of June 30, 1973, the fair rental value of such office space for a 1-year period is $4,800. In order to correct his acts of self-dealing (within the meaning of paragraph (e)(1) of this section) under this subparagraph on June 30, 1973, C must terminate X's use of the property. In addition, C must pay X $1,500, $900 (the excess of $3,000, the amount paid to C from July 1, 1972, through December 31, 1972, over

$2,100, the fair rental value for 6 months as of July 1, 1972) plus $600 (the excess of $3,000, the amount paid to C from January 1, 1973, through June 30, 1973, over $2,400, the fair rental value for 6 months as of June 30, 1973).

Example 2. On April 1, 1973, D, a disqualified person with respect to private foundation Y, loans $100,000 to Y at 6 percent interest per annum. Both principal and interest are to be paid on April 1, 1978. The fair market value of the use of the money on April 1, 1973, is 9 percent per annum. On April 1, 1974, D and Y terminate the loan. On such date, the fair market value of the use of $100,000 is 10 percent per annum. In order to correct the act of self-dealing on April 1, 1974, in addition to the termination of the loan from D to Y, D must pay Y $16,000, the excess of $40,000 ($100,000 × 10 percent, the fair market value of the use determined at the time of correction, from April 1, 1974, to April 1, 1978) over $24,000 (the amount of interest Y would have paid to D from April 1, 1974, to April 1, 1978, if the loan from D to Y had not been terminated).

(6) *Payment of compensation to a disqualified person.* In the case of the payment of compensation by a private foundation to a disqualified person for the performance of personal services which are reasonable and necessary to carry out the exempt purpose of such foundation, undoing the transaction requires that the disqualified person pay to the foundation any amount which is excessive. However, termination of the employment or independent contractor relationship is not required.

(7) *Special rule for correction of valuation errors.* (i) In the case of a transaction described in paragraph (b)(2)(iii) of this section, a ''correction'' of the act of self-dealing shall ordinarily be deemed to occur if the foundation is paid an amount of money equal to the amount involved (as defined in paragraph (b)(2)(iii) of this section) plus such additional amounts as are necessary to compensate it for the loss of the use of the money or other property during the period commencing on the date of the act of self-dealing and ending on the date the transaction is corrected pursuant to this subparagraph.

(ii) The provisions of this subparagraph may be illustrated by the following example:

Example. Assume the same facts as in example (5) of paragraph (b)(4) of this section. Such transaction shall be considered as corrected by a payment of $5,000 by M to V, together with an additional payment to V of an amount equal to the interest which V could have obtained on $5,000 for the period commencing on the date of the redemption and ending on the date the act is corrected.

(d) *Cross reference.* For rules relating to taxable events that are corrected within the correction period, defined in section 4963 (e), see section 4961 (a), and the regulations thereunder.

(e) *Act of self-dealing*—(1) *Number of acts; use of money or property*—(i) *In general.* If a transaction between a private foundation and a disqualified person is determined to be self-dealing (as defined in section 4941(d)), for purposes of section 4941 there is generally one act of self-dealing. For the date on which such act is treated as occurring, see paragraph (a)(2) of this section. If, however, such transaction relates to the leasing of property, the lending of money or other extension of credit, other use of money or property, or payment of compensation, the transaction will generally be treated (for purposes of section 4941 but not section 507 or section 6684) as giving rise to an act of self-dealing on the day the transaction occurs plus an act of self-dealing on the first day of each taxable year or portion of a taxable year which is within the taxable period and which begins after the taxable year in which the transaction occurs.

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

Example 1. On August 31, 1970, X, a private foundation, sells a building to A, a disqualified person with respect to X. A is on the calendar year basis. Under these circumstances, the transaction between A and X is one act of self-dealing which is treated for purposes of section 4941 as occurring on August 31, 1970.

Example 2. Assume the facts as stated in example (1), except that, instead of selling the building to A, X leases the building to A for a term of 4 years beginning July 31, 1970, at an annual rental of $12,000. The fair rental value of the building is also $12,000 per annum as of July 31, 1970, and throughout the next 4 years. This transaction is corrected on September 30, 1973, in accordance with paragraph (c)(4) of this section. Under these circumstances, the transaction between A and X constitutes four separate acts of self-dealing, which are treated for purposes of section 4941 as occurring on July 31, 1970, January 1, 1971, January 1, 1972, and January 1, 1973. Consequently, there are four

taxable periods. The first taxable period is from July 31, 1970, to September 30, 1973; the second is from January 1, 1971, to September 30, 1973; the third is from January 1, 1972, to September 30, 1973; and the fourth is from January 1, 1973, to September 30, 1973. For purposes of the initial taxes in section 4941(a), the amount involved is $5,000 for the first taxable period, $12,000 for the second, $12,000 for the third, and $9,000 for the fourth. The initial taxes to be paid by A are thus $1,000 ($5,000 × 5% × 4 taxable years or partial taxable years in the taxable period) for the first act; $1,800 ($12,000 × 5% × 3) for the second act; $1,200 ($12,000 × 5% × 2) for the third act; and $450 ($9,000 × 5% × 1) for the fourth act.

Example 3. Assume the facts as stated in example (1) of § 53.4941(d)–4(c)(4)(ii). If the debentures are held by Y after December 31, 1979, the extension of credit will not be excepted from the definition of an act of self-dealing, because an act of self-dealing will be treated (for purposes of section 4941) as occurring on January 1, 1980.

(2) *Number of acts; joint participation by disqualified persons*—(i) *In general.* If joint participation in a transaction by two or more disqualified persons constitutes self-dealing (such as a joint sale of property to a private foundation or joint use of its money or property), such transaction shall generally be treated as a separate act of self-dealing with respect to each disqualified person for purposes of section 4941. For purposes of section 507 and, in the case of a foundation manager, section 6684, however, such transaction shall be treated as only one act of self-dealing. For purposes of this subparagraph, an individual and one or more members of his family (within the meaning of section 4946(d)) shall be treated as one person, regardless of whether a member of the family is a disqualified person not only by reason of section 4946(a)(1)(D) but also by reason of another subparagraph of section 4946(a)(1). However, the liability imposed on a disqualified person and one or more members of his family for joint participation in an act of self-dealing shall be joint and several in accordance with section 4941(c)(1) and § 53.4941(c)–1(a).

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

Example 1. Private foundation X permits A, a substantial contributor to X, and her spouse, H, to use an automobile owned by X and normally used in its foundation activities to travel from State Z to State Y for a vacation on December 1, 1971. The automobile is then returned to X until December 21, 1971, when X again permits them to use the automobile to return to their home in State Z. Under these circumstances, there is one act of self-dealing on December 1, 1971, and a second act of self-dealing on December 21, 1971.

Example 2. Assume the facts as stated in example (1), except that B joined A and H on their vacation and traveled with them both to and from State Y. B is a disqualified person with respect to X, but he is not related by blood or marriage to A or H. Assume also that X is not paid for the use of its automobile, but that the fair rental value during the taxable period is $300 (or $100 per person) for a one-way trip between State Y and State Z. Under these circumstances, there are four acts of self-dealing, two with respect to A and H and two with respect to B. The amount involved with respect to A and H is $200 for each act, and the amount involved with respect to B is $100 for each act.

(f) *Fair market value.* For purposes of §§ 53.4941(a)–1 through 53.4941 (f)–1, fair market value shall be determined pursuant to the provisions of § 53.4942(a)–2 (c)(4).

[T.D. 7270, 38 FR 9493, Apr. 17, 1973, as amended by T.D. 8084, 51 FR 16301, May 2, 1986]

§ 53.4941(f)–1 Effective dates.

(a) *In general.* Except as provided in paragraph (b) of this section, §§ 53.4941(a)–1 through 53.4941(e)–1 shall apply to all acts of self-dealing engaged in after December 31, 1969.

(b) *Transitional rules*—(1) *Commitments made prior to January 1, 1970, between private foundations and government officials.* Section 4941 shall not apply to a payment for one or more purposes described in section 170(c) (1) or (2)(B) made on or after January 1, 1970, by a private foundation to a government official, if such payment is made pursuant to a commitment entered into prior to such date, but only if such commitment was made in accordance with the foundation's usual practices and is reasonable in amount in light of the purposes of the payment. For purposes of this subparagraph, a commitment will be considered entered into prior to January 1, 1970, if prior to such date, the amount and nature of the payments to be made and the name of the payee were entered on the records

of the payor, or were otherwise adequately evidenced, or the notice of the payment to be received was communicated to the payee in writing.

(2) *Special transitional rule*. In the case of an act of self-dealing engaged in prior to July 5, 1971, section 4941(a) (1) shall not apply if:

(i) The participation (as defined in § 53.4941(a)–1(a)(3)) by the disqualified person in such act is not willful and is due to reasonable cause (as defined in § 53.4941(a)–1(b) (4) and (5)),

(ii) The transaction would not be a prohibited transaction if section 503(b) applied, and

(iii) The act is corrected (within the meaning of § 53.4941(e)–1(c)) within a period ending [insert 90 days after date on which final regulations under section 4941 are filed by the Federal Register], extended (prior to the expiration of the original period) by any period which the Commissioner determines is reasonable and necessary (within the meaning of § 53.4941(e)–1(d)) to bring about correction of the act of self-dealing.

Subpart C—Taxes on Failure To Distribute Income

SOURCE: T.D. 7249, 38 FR 768, Jan. 4, 1973, unless otherwise noted.

§ 53.4942(a)–1 Taxes for failure to distribute income.

(a) *Imposition of tax*—(1) *Initial tax*. Except as provided in paragraph (b) of this section, section 4942(a) imposes an excise tax of 15 percent on the undistributed income (as defined in paragraph (a) of § 53.4942(a)–2) of a private foundation for any taxable year which has not been distributed before the first day of the second (or any succeeding) taxable year following such taxable year (if such first day falls within the taxable period as defined in paragraph (c)(1) of this section). For purposes of section 4942 and this section, the term *distributed* means distributed as qualifying distributions under section 4942(g). See paragraph (d)(2) of § 53.4942(a)–3 with respect to correction of deficient distributions for prior taxable years.

(2) *Additional tax*. In any case in which an initial excise tax is imposed by section 4942(a) on the undistributed income of a private foundation for any taxable year, section 4942(b) imposes an additional excise tax on any portion of such income remaining undistributed at the close of the correction period (as defined in paragraph (c)(1) of this section). The tax imposed by section 4942(b) is equal to 100 percent of the amount remaining undistributed at the close of the taxable period.

(3) *Payment of tax*. Payment of the excise taxes imposed by section 4942 (a) or (b) is in addition to, and not in lieu of, making the distribution of such undistributed income as required by section 4942. See section 507(a)(2) and the regulations thereunder.

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

Example 1 M, a private foundation which uses the calendar year as its taxable year, has at the end of 1981, $50,000 of undistributed income (as defined in paragraph (a) of § 53.4942 (a)–2) for 1981. As of January 1, 1983, $40,000 is still undistributed. On August 15, 1983, a notice of deficiency with respect to the excise taxes imposed by section 4942 (a) and (b) is mailed to *M* under section 6212 (a) and the taxable period ends. Thus, under these facts, an initial excise tax of $6,000 (15 percent of $40,000) is imposed upon *M*. An additional excise tax of $40,000 (100 percent of $40,000) is imposed by section 4942(b). Under section 4961(a), however, if the undistributed income is reduced to zero during the correction period, this latter tax will not be assessed, and if assessed, it will be abated, and if collected, it will be credited or refunded as an overpayment.

Example 2. Assume the facts as stated in example (1), except that the notice of deficiency is mailed to *M* on September 7, 1984, and as of January 1, 1984, only $10,000 of the $50,000 of undistributed income with respect to 1981 is undistributed. Therefore, initial excise taxes of $6,000 (15 percent of $40,000, M's undistributed income from 1981, as of January 1, 1983) and $1,500 (15 percent of $10,000, *M's* undistributed income from 1981 as of January 1, 1984) are imposed by section 4942(a). If the $10,000 remains undistributed as of September 7, 1984, the end of the taxable period, an additional excise tax of $10,000 (100 percent of $10,000, *M's* undistributed income from 1981, as of September 7, 1984) is imposed by section 4942(b).

(b) *Exceptions*—(1) *In general*. The initial excise tax imposed by section 4942(a) shall not apply to the undistributed income of a private foundation:

(i) For any taxable year for which it is an operating foundation (as defined in section 4942(j)(3) and the regulations thereunder), or

(ii) To the extent that the foundation failed to distribute any amount solely because of incorrect valuation of assets under paragraph (c)(4) of § 53.4942(a)–2, if:

(*a*) The failure to value the assets properly was not willful and was due to reasonable cause,

(*b*) Such amount is distributed as qualifying distributions (within the meaning of paragraph (a) of § 53.4942 (a)–3) by the foundation during the allowable distribution period (as defined in paragraph (c)(2) of this section),

(*c*) The foundation notifies the Commissioner that such amount has been distributed (within the meaning of subdivision (ii)(*b*) of this subparagraph) to correct such failure, and

(*d*) Such distribution is treated under paragraph (d)(2) of § 53.4942(a)–3 as made out of the undistributed income for the taxable year for which a tax would (except for this subdivision) have been imposed by section 4942(a).

(2) *Improper valuation*. For purposes of subparagraph (1)(ii) of this paragraph, failure to value an asset properly shall be regarded as ''not willful'' and ''due to reasonable cause'' whenever, under all the facts and circumstances, the foundation can show that it has made all reasonable efforts in good faith to value such an asset in accordance with the provisions of paragraph (c)(4) of § 53.4942(a)–2. If a foundation, after full disclosure of the factual situation, obtains a bona fide appraisal of the fair market value of an asset by a person qualified to make such an appraisal (whether or not such a person is a disqualified person with respect to the foundation), and such foundation relies upon such appraisal, then failure to value the asset properly shall ordinarily be regarded as ''not willful'' and ''due to reasonable cause''. Notwithstanding the preceding sentence, the failure to obtain such a bona fide appraisal shall not, by itself, give rise to any inference that a foundation's failure to value an asset properly was willful or not due to reasonable cause.

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

Example. In 1976 M, a private foundation which was established in 1975 and which uses the calendar year as the taxable year, incorrectly values its assets under paragraph (c)(4) of § 53.4942(a)–2 in a manner which is not willful and is due to reasonable cause. As a result of the incorrect valuation of assets, $20,000 which should be distributed with respect to 1976 is not distributed, and as of January 1, 1978, such amount is still undistributed. On March 29, 1978, a notice of deficiency with respect to the excise taxes imposed by section 4942 (a) and (b) is mailed to M under section 6212(a). On May 5, 1978 (within the allowable distribution period), M makes a qualifying distribution of $20,000 which is treated under paragraph (d)(2) of § 53.4942(a)–3 as made out of M's undistributed income for 1976. M notifies the Commissioner of its action. Under the stated facts, an initial excise tax of $3,000 (15 percent of $20,000) would (except for the exception contained in subparagraph (1)(ii) of this paragraph) have been imposed by section 4942(a), but since all of the requirements of such subparagraph are satisfied no tax is imposed by section 4942(a).

(c) *Certain periods*. For purposes of this section—

(1) *Taxable period*. (i) The term ''taxable period'' means, with respect to the undistributed income of a private foundation for any taxable year, the period beginning with the first day of the taxable year and ending on the earlier of:

(A) The date of mailing of a notice of deficiency under section 6212(a) with respect to the initial excise tax imposed under section 4942(a), or

(B) The date on which the initial excise tax imposed under section 4942(a) is assessed.

For example, assume M, a private foundation which uses the calendar year as the taxable year, has $15,000 of undistributed income for 1981. A notice of deficiency is mailed to M under section 6212(a) on June 1, 1983. With respect to the undistributed income of M for 1981, the taxable period began on January 1, 1981, and ended on June 1, 1983.

(ii) Where a notice of deficiency referred to in subdivision (i) of this subparagraph is not mailed because there is a waiver of the restrictions on assessment and collection of a deficiency, or because the deficiency is paid, the date of filing of the waiver or the date

of such payment, respectively, shall be treated as the end of the taxable period.

(2) *Allowable distribution period.* (i) The term ''allowable distribution period'' means the period beginning with the first day of the first taxable year following the taxable year in which the incorrect valuation of foundation assets (described in paragraph (b)(1)(ii) of this section) occurred and ending 90 days after the date of mailing of a notice of deficiency under section 6212(a) with respect to the initial excise tax imposed by section 4942(a). This period shall be extended by any period in which a deficiency cannot be assessed under section 6213(a), and any other period which the Commissioner determines is reasonable and necessary to permit a distribution of undistributed income under section 4942.

(ii) Where a notice of deficiency referred to in subdivision (i) of this subparagraph is not mailed because there is a waiver of the restrictions on assessment and collection of a deficiency, or because the deficiency is paid, the date of filing of the waiver or the date of such payment, respectively, shall be treated as the end of the allowable distribution period.

(3) *Cross reference.* For rules relating to taxable events that are corrected within the correction period, defined in section 4963(e), see section 4961 (a) and the regulations thereunder.

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

Example 1. In 1975 M, a private foundation which uses the calendar year as the taxable year, made an error in valuing its assets which was not willful and was due to reasonable cause. The error caused M not to distribute $25,000 that should have been distributed with respect to 1975. On March 1, 1978, a notice of deficiency with respect to the excise taxes imposed by section 4942 (a) and (b) was mailed to M under section 6212(a). With respect to the undistributed income for 1975, the *taxable period* is the period from January 1, 1975, through March 1, 1978, and the *allowable distribution period* is the period from January 1, 1976, through May 30, 1978 (90 days after the mailing of the notice of deficiency).

Example 2. Assume the facts as stated in example (1), except that the Commissioner determines that it is reasonable and necessary to extend the period for distribution through June 15, 1978. Thus, the *allowable distribution period* is from January 1, 1976, through June 15, 1978.

(d) *Effective date.* Except as otherwise specifically provided, section 4942 and the regulations thereunder shall only apply with respect to taxable years beginning after December 31, 1969.

[T.D. 7256, 38 FR 3317, Feb. 7, 1973, as amended by T.D. 8084, 51 FR 16302, May 2, 1986]

§ 53.4942(a)–2 Computation of undistributed income.

(a) *Undistributed income.* For purposes of section 4942, the term ''undistributed income'' means, with respect to any private foundation for any taxable year as of any time, the amount by which:

(1) The distributable amount (as defined in paragraph (b) of this section) for such taxable year, exceeds

(2) The qualifying distributions (as defined in § 53.4942(a)–3) made before such time out of such distributable amount.

(b) Distributable amount—(1) In general. For purposes of paragraph (a) of this section, the term ''distributable amount'' means:

(i) For taxable years beginning before January 1, 1982, an amount equal to the greater of the minimum investment return (as defined in paragraph (c) of this section) or the adjusted net income (as defined in paragraph (d) of this section); and

(ii) For taxable years beginning after December 31, 1981, an amount equal to the minimum investment return (as defined in paragraph (c) of this section), reduced by the sum of the taxes imposed on such private foundation for such taxable year under subtitle A of the Code and section 4940, and increased by the amounts received from trusts described in subparagraph (2) of this paragraph.

(2) *Certain trust amounts*—(i) *In general.* The distributable amount shall be increased by the income portion (as defined in subdivision (ii) of this subparagraph) of distributions from trusts described in section 4947(a)(2) with respect to amounts placed in trust after May 26, 1969. If such distributions are made with respect to amounts placed in trust both on or before and after May 26, 1969, such distributions shall be

allocated between such amounts to determine the extent to which such distributions shall be included in the foundation's distributable amount. For rules relating to the segregation of amounts placed in trust on or before May 26, 1969, from amounts placed in trust after such date and to the allocation of income derived from such amounts, see paragraph (c) (5) of § 53.4947–1.

(ii) *Income portion of distributions to private foundations.* For purposes of subdivision (i) of this subparagraph, the income portion of a distribution from a section 4947(a)(2) trust to a private foundation in a particular taxable year of such foundation shall be the greater of:

(*a*) The amount of such distribution which is treated as income (within the meaning of section 643(b)) of the trust, or

(*b*) The guaranteed annuity, or fixed percentage of the fair market value of the trust property (determined annually), which the private foundation is entitled to receive for such year, regardless of whether such amount is actually received in such year or in any prior or subsequent year.

(iii) *Limitation.* Notwithstanding subdivisions (i) and (ii) of this subparagraph, a private foundation shall not be required to distribute a greater amount for any taxable year than would have been required (without regard to this subparagraph) for such year had the corpus of the section 4947(a) (2) trust to which the distribution described in subdivision (ii) of this subparagraph is attributable been taken into account by such foundation as an asset described in paragraph (c) (1) (i) of this section.

(c) *Minimum investment return*—(1) *In general.* For purposes of paragraph (b) of this section, the ''minimum investment return'' for any private foundation for any taxable year is the amount determined by multiplying:

(i) The excess of the aggregate fair market value of all assets of the foundation, other than those described in subparagraph (2) or (3) of this paragraph, over the amount of the acquisition indebtedness with respect to such assets (determined under section 514(c)(1), but without regard to the taxable year in which the indebtedness was incurred), by

(ii) The applicable percentage (as defined in subparagraph (5) of this paragraph) for such year.

For purposes of subdivision (i) of this subparagraph, the aggregate fair market value of all assets of the foundation shall include the average of the fair market values on a monthly basis of securities for which market quotations are readily available (within the meaning of subparagraph (4)(i)(*a*) of this paragraph), the average of the foundation's cash balances on a monthly basis (less the cash balances excluded from the computation of the minimum investment return by operation of subparagraph (3)(iv) of this paragraph), and the fair market value of all other assets (except those assets described in subparagraph (2) or (3) of this paragraph) for the period of time during the taxable year for which such assets are held by the foundation. Any determination of the fair market value of an asset required pursuant to the provisions of this subparagraph shall be made in accordance with the rules of subparagraph (4) of this paragraph.

(2) *Certain assets excluded.* For purposes of this paragraph, the assets taken into account in determining minimum investment return shall not include the following:

(i) Any future interest (such as a vested or contingent remainder, whether legal or equitable) of a foundation in the income or corpus of any real or personal property, other than a future interest created by the private foundation after December 31, 1969, until all intervening interests in, and rights to the actual possession or enjoyment of, such property have expired, or, although not actually reduced to the foundation's possession, until such future interest has been constructively received by the foundation, as where it has been credited to the foundation's account, set apart for the foundation, or otherwise made available so that the foundation may acquire it at any time or could have acquired it if notice of intention to acquire had been given;

(ii) The assets of an estate until such time as such assets are distributed to the foundation or, due to a prolonged period of administration, such estate is

considered terminated for Federal income tax purposes by operation of paragraph (a) of §1.641(b)–3 of this chapter (Income Tax Regulations);

(iii) Any present interest of a foundation in any trust created and funded by another person (see, however, paragraph (b) (2) of this section with respect to amounts received from certain trusts described in section 4947(a) (2));

(iv) Any pledge to the foundation of money or property (whether or not the pledge may be legally enforced); and

(v) Any assets used (or held for use) directly in carrying out the foundation's exempt purpose.

(3) *Assets used (or held for use) in carrying out the exempt purpose*—(i) *In general.* For purposes of subparagraph (2)(v) of this paragraph, an asset is ''used (or held for use) directly in carrying out the foundation's exempt purpose'' only if the asset is actually used by the foundation in the carrying out of the charitable, educational, or other similar purpose which gives rise to the exempt status of the foundation, or if the foundation owns the asset and establishes to the satisfaction of the Commissioner that its immediate use for such exempt purpose is not practical (based on the facts and circumstances of the particular case) and that definite plans exist to commence such use within a reasonable period of time. Consequently, assets which are held for the production of income or for investment (for example, stocks, bonds, interest-bearing notes, endowment funds, or, generally, leased real estate) are not being used (or held for use) directly in carrying out the foundation's exempt purpose, even though the income from such assets is used to carry out such exempt purpose. Whether an asset is held for the production of income or for investment rather than used (or held for use) directly by the foundation to carry out its exempt purpose is a question of fact. For example, an office building used for the purpose of providing offices for employees engaged in the management of endowment funds of the foundation is not being used (or held for use) directly by the foundation to carry out its charitable, educational, or other similar exempt purpose. However, where property is used both for charitable, educational, or other similar exempt purposes and for other purposes, if such exempt use represents 95 percent or more of the total use, such property shall be considered to be used exclusively for a charitable, educational, or other similar exempt purpose. If such exempt use of such property represents less than 95 percent of the total use, reasonable allocation between such exempt and nonexempt use must be made for purposes of this paragraph. Property acquired by the foundation to be used in carrying out its charitable, educational, or other similar exempt purpose may be considered as used (or held for use) directly to carry out such exempt purpose even though the property, in whole or in part, is leased for a limited period of time during which arrangements are made for its conversion to the use for which it was acquired, provided such income-producing use of the property does not exceed a reasonable period of time. Generally, 1 year shall be deemed to be a reasonable period of time for purposes of the immediately preceding sentence. For treatment of the income derived from such income-producing use, see paragraph (d)(2)(viii) of this section. Where the income-producing use continues beyond a reasonable period of time, the property shall not be deemed to be used by the foundation to carry out its charitable, educational, or other similar exempt purpose, but, instead, as of the time the income-producing use becomes unreasonable, such property shall be treated as disposed of within the meaning of paragraph (d)(2)(iii)(*b*) of this section to the extent that the acquisition of the property was taken into account as a qualifying distribution (within the meaning of paragraph (a)(2) of §53.4942(a–3) for any taxable year. If, subsequently, the property is used by the foundation directly in carrying out its charitable, educational, or other similar exempt purpose, a qualifying distribution in the amount of its then fair market value, determined in accordance with the rules contained in subparagraph (4) of this paragraph, shall be deemed to have been made as of the time such exempt use begins.

(ii) *Illustrations.* Examples of assets which are ''used (or held for use) directly in carrying out the foundation's exempt purpose'' include, but are not limited to, the following:

(*a*) Administrative assets, such as office equipment and supplies which are used by employees or consultants of the foundation, to the extent such assets are devoted to and used directly in the administration of the foundation's charitable, educational or other similar exempt activities;

(*b*) Real estate or the portion of a building used by the foundation directly in its charitable, educational, or other similar exempt activities;

(*c*) Physical facilities used in such activities, such as paintings or other works of art owned by the foundation which are on public display, fixtures and equipment in classrooms, research facilities and related equipment which under the facts and circumstances serve a useful purpose in the conduct of such activities;

(*d*) Any interest in a functionally related business (as defined in subdivision (iii) of this subparagraph) or in a program-related investment (as defined in section 4944(c));

(*e*) The reasonable cash balances (as described in subdivision (iv) of this subparagraph) necessary to cover current administrative expenses and other normal and current disbursements directly connected with the foundation's charitable, educational, or other similar exempt activities; and

(*f*) Any property leased by a foundation in carrying out its charitable, educational, or other similar exempt purpose at no cost (or at a nominal rent) to the lessee or for a program-related purpose (within the meaning of section 4944(c)), such as the leasing of renovated apartments to low-income tenants at a low rental as part of the lessor foundation's program for rehabilitating a blighted portion of a community. For treatment of the income derived from such use, see paragraph (d)(2)(viii) of this section.

(iii) *Functionally related business—(a) In general.* The term ''functionally related business'' means:

(*1*) A trade or business which is not an unrelated trade or business (as defined in section 513), or

(*2*) An activity which is carried on within a larger aggregate of similar activities or within a larger complex of other endeavors which is related (aside from the need of the organization for income or funds or the use it makes of the profits derived) to the charitable, educational, or other similar exempt purpose of the organization.

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

Example 1. X, a private foundation, maintains a community of historic value which is open to the general public. For the convenience of the public, X, through a wholly owned, separately incorporated, taxable entity, maintains a restaurant and hotel in such community. Such facilities are within the larger aggregate of activities which makes available for public enjoyment the various buildings of historic interest and which is related to X's exempt purpose. Thus, the operation of the restaurant and hotel under such circumstances constitutes a functionally related business.

Example 2. Y, a private foundation, as part of its medical research program under section 501(c)(3), publishes a medical journal in carrying out its exempt purpose. Space in the journal is sold for commercial advertising. Notwithstanding the fact that the advertising activity may be subject to the tax imposed by section 511, such activity is within a larger complex of endeavors which makes available to the scientific community and the general public developments with respect to medical research and is therefore a functionally related business.

(iv) *Cash held for charitable, etc. activities.* For purposes of subdivision (ii)(*e*) of this subparagraph, the reasonable cash balances which a private foundation needs to have on hand to cover expenses and disbursements described in such subdivision will generally be deemed to be an amount, computed on an annual basis, equal to one and one-half percent of the fair market value of all assets described in subparagraph (1)(i) of this paragraph, without regard to subdivision (ii)(*e*) of this subparagraph. However, if the Commissioner is satisfied that under the facts and circumstances an amount in addition to such one and one-half percent is necessary for payment of such expenses and disbursements, then such additional amount may also be excluded from the amount of assets described in subparagraph (1)(i) of this paragraph.

All remaining cash balances, including amounts necessary to pay any tax imposed by section 511 or any section of chapter 42 of the Code except section 4940, are to be included in the assets described in subparagraph (1)(i) of this paragraph.

(4) *Valuation of assets*—(i) *Certain securities.* (*a*) For purposes of subparagraph (1)(i) of this paragraph, a private foundation may use any reasonable method to determine the fair market value on a monthly basis of securities for which market quotations are readily available, as long as such method is consistently used. For purposes of this subparagraph, market quotations are readily available if a security is:

(*1*) Listed on the New York Stock Exchange, the American Stock Exchange, or any city or regional exchange in which quotations appear on a daily basis, including foreign securities listed on a recognized foreign national or regional exchange;

(*2*) Regularly traded in the national or regional over-the-counter market, for which published quotations are available; or

(*3*) Locally traded, for which quotations can readily be obtained from established brokerage firms.

(*b*) For purposes of this subdivision, commonly accepted methods of valuation must be used in making an appraisal. Valuations made in accordance with the principles stated in the regulations under section 2031 constitute acceptable methods of valuation. This paragraph (c)(4)(i)(*b*) applies only for taxable years beginning before January 1, 1976. See section 4942(e)(2)(B) and paragraph (c)(4)(i)(*c*) of this section for special valuation rules that apply for subsequent taxable years.

(*c*) For purposes of this subdivision (i) and with respect to taxable years beginning after December 31, 1975, if the private foundation can show that the value of securities determined on the basis of market quotations as provided by subdivision (i)(*a*) does not reflect the fair market value thereof because:

(*1*) The securities constitute a block of securities so large in relation to the volume of actual sales on the existing market that it could not be liquidated in a reasonable time without depressing the market.

(*2*) The securities are securities in a closely held corporation and sales are few or of a sporadic nature, and, or

(*3*) The sale of the securities would result in a forced or distress sale because the securities could not be offered to the public for sale without first being registered under the Securities Act of 1933 or because of other factors,

then the price at which the securities could be sold as such outside the usual market, as through an underwriter, may be a more accurate indication of value than market quotations. On the other hand, if the securities to be valued represents a controlling interest, either actual or effective, in a going business, the price at which other lots change hands may have little relation to the true value of the securities. No decrease in the fair market value of any given class of securities determined on the basis of market quotations as provided by subdivision (i)(*a*) shall be allowed except as authorized by this subdivision, and no such decrease shall in the aggregate exceed 10 percent of the fair market value of such class of securities so determined on the basis of market quotations and without regard to this subdivision.

(*d*) In the case of securities described in subdivision (i)(*a*) of this subparagraph, which are held in trust for, or on behalf of, a foundation by a bank or other financial institution which values such securities periodically by use of a computer, a foundation may determine the correct value of such securities by use of such computer pricing system, provided the Commissioner has accepted such computer pricing system as a valid method for valuing securities for Federal estate tax purposes.

(*e*) This subdivision may be illustrated by the following examples:

Example 1. U, a private foundation, owns 1,000 shares of the stock of M Corporation. M stock is regularly traded on the New York Stock Exchange. U consistently follows a practice of valuing its 1,000 shares of M stock on the last trading day of each month based upon the quoted closing price for M stock. U's method of valuing its M Corporation stock is permissible under the rules contained in subdivision (i)(*a*) of this subparagraph.

Example 2. Assume the facts as stated in example (1), except that U consistently follows a practice of valuing its 1,000 shares of M stock by taking the mean of the closing prices for M stock on the first and last trading days of each month and the trading day nearest the 15th day of each month. U's method of valuing its M stock is permissible under the rules contained in subdivision (i)(*a*) of this subparagraph.

Example 3. Assume the facts as stated in example (1), except that U consistently follows a practice of valuing its M stock by taking the mean of the highest and lowest quoted prices for the stock on the last trading day of each month. U's method of valuing its M stock is permissible under the rules contained in subdivision (1)(*a*) of this subparagraph.

Example 4. V, a private foundation, owns 1,000 shares of the stock of N Corporation. N stock is regularly traded in the national over-the-counter market and published quotations of the bid and asked prices for the stock are available. V consistently follows a practice of valuing its 1,000 shares of N stock on the first trading day of each month by taking the mean of the bid and asked prices on that day. V's method of valuing its N Corporation stock is permissible under the rules contained in subdivision (i)(*a*) of this subparagraph.

Example 5. W, a private foundation, owns 1,000 shares of the stock of O Corporation. O stock is locally traded and quotations can readily be obtained from established brokerage firms. W consistently follows a practice of valuing its O stock on the 15th day of each month by obtaining a bona fide quotation of bid and asked prices for the stock from an established brokerage firm and taking the mean of such prices on that day. If a quotation is unavailable on the regular valuation date, W values its O stock based upon a bona fide quotation on the first day thereafter on which such a quotation is available. W's method of valuing its O Corporation stock is permissible under the rules contained in subdivision (i)(*a*) of this subparagraph.

(ii) *Cash.* In order to determine the amount of a foundation's cash balances, the foundation shall value its cash on a monthly basis by averaging the amount of cash on hand as of the first day of each month and as of the last day of each month.

(iii) *Common trust funds.* If a private foundation owns a participating interest in a common trust fund (as defined in section 584) established and administered under a plan providing for the periodic valuation of participating interests during the fund's taxable year and the reporting of such valuations to participants, the value of the foundation's interest in the common trust fund based upon the average of the valuations reported to the foundation during its taxable year will ordinarily constitute an acceptable method of valuation.

(iv) *Other assets.* (*a*) Except as otherwise provided in subdivision (iv)(*b*) of this subparagraph, the fair market value of assets other than those described in subdivisions (i) through (iii) of this subparagraph shall be determined annually. Thus, the fair market value of securities other than those described in subdivision (i) of this subparagraph shall be determined in accordance with this subdivision (*a*). If, however, a private foundation owns voting stock of an issuer of unlisted securities and has, or together with disqualified persons or another private foundation has, effective control of the issuer (within the meaning of § 53.4943–3(b)(3)(ii), then to the extent that the issuer's assets consist of shares of listed securities issues, such assets shall be valued monthly on the basis of market quotations or in accordance with section 4942(e)(2)(B), if applicable. Thus, for example, if a private foundation and a disqualified person together own all of the unlisted voting stock of a holding company which in turn holds a portfolio of securities of issues which are listed on the New York Stock Exchange, in determining the net worth of the holding company, the underlying portfolio securities are to be valued monthly by reference to market quotations for their issues unless a decrease in such value is authorized in accordance with section 4942(e)(2)(b). Such determination may be made by employees of the private foundation or by any other person, without regard to whether such person is a disqualified person with respect to the foundation. A valuation made pursuant to the provisions of this subdivision, if accepted by the Commissioner, shall be valid only for the taxable year for which it is made. A new valuation made in accordance with these provisions is required for the succeeding taxable year.

(*b*) If the requirements of this subdivision are met, the fair market value

of any interest in real property, including any improvements thereon, may be determined on a 5-year basis. Such value must be determined by means of a certified, independent appraisal made in writing by a qualified person who is neither a disqualified person with respect to, nor an employee of, the private foundation. The appraisal is certified only if it contains a statement at the end thereof to the effect that, in the opinion of the appraiser, the values placed on the assets appraised were determined in accordance with valuation principles regularly employed in making appraisals of such property using all reasonable valuation methods. The foundation shall retain a copy of the independent appraisal for its records. If a valuation made pursuant to the provisions of this subdivision in fact falls within the range of reasonable values for the appraised property, such valuation may be used by the foundation for the taxable year for which the valuation is made and for each of the succeeding 4 taxable years. Any valuation made pursuant to the provisions of this subdivision may be replaced during the 5-year period by a subsequent 5-year valuation made in accordance with the rules set forth in this subdivision, or with an annual valuation made in accordance with subdivision (iv)(*a*) of this subparagraph, and the most recent such valuation of such assets shall be used in computing the foundation's minimum investment return. In the case of a foundation organized before May 27, 1969, a valuation made in accordance with this subdivision applicable to the foundation's first taxable year beginning after December 31, 1972, and the 4 succeeding taxable years must be made no later than the last day of such first taxable year. In the case of a foundation organized after May 26, 1969, a valuation made in accordance with this subdivision applicable to the foundation's first taxable year beginning after February 5, 1973 and the succeeding 4 taxable years must be made no later than the last day of such first taxable year. Any subsequent valuation made in accordance with this subdivision must be made no later than the last day of the first taxable year for which such new valuation is applicable. A valuation, if properly made in accordance with the rules set forth in this subdivision, will not be disturbed by the Commissioner during the 5-year period for which it applies even if the actual fair market value of such property changes during such period.

(*c*) For purposes of this subdivision, commonly accepted methods of valuation must be used in making an appraisal. Valuations made in accordance with the principles stated in the regulations under section 2031 constitute acceptable methods of valuation. The term *appraisal*, as used in this subdivision, means a determination of fair market value and is not to be construed in a technical sense peculiar to particular property or interests therein, such as, for example, mineral interests in real property.

(v) *Definition of ''securities''*. For purposes of this subparagraph, the term ''securities'' includes, but is not limited to, common and preferred stocks, bonds, and mutual fund shares.

(vi) *Valuation date*. (*a*) In the case of an asset which is required to be valued on an annual basis as provided in subdivision (iv)(*a*) of this subparagraph, such asset may be valued as of any day in the private foundation's taxable year to which such valuation applies, provided the foundation follows a consistent practice of valuing such asset as of such date in all taxable years.

(*b*) A valuation described in subdivision (iv)(*b*) of this subparagraph may be made as of any day in the first taxable year of the private foundation to which such valuation is to be applied.

(vii) *Assets held for less than a taxable year*. For purposes of this paragraph, any asset described in subparagraph (1)(i) of this paragraph which is held by a foundation for only part of a taxable year shall be taken into account for purposes of determining the foundation's minimum investment return for such taxable year by multiplying the fair market value of such asset (as determined pursuant to this subparagraph) by a fraction, the numerator of which is the number of days in such taxable year that the foundation held such asset and the denominator of which is the number of days in such taxable year.

(5) *Applicable percentage*—(i) *In general*. For purposes of paragraph (c)(1)(ii) of this section, except as provided in paragraph (c)(5)(ii) or (iii) of this section, the applicable percentage is:

(*a*) Six percent for a taxable year beginning in 1970 or 1971;

(*b*) Five and a half percent for a taxable year beginning in 1972;

(*c*) Five and one-quarter percent for a taxable year beginning in 1973;

(*d*) Six percent for a taxable year beginning in 1974 or 1975; and

(*e*) Five percent for taxable years beginning after Dec. 31, 1975.

(ii) *Transitional rule*. In the case of organizations organized before May 27, 1969 (including organizations deemed to be so organized by virtue of the provisions of paragraph (e)(2) of this section), section 4942 shall, for all purposes other than the determination of the minimum investment return under section 4942(j)(3)(B)(ii), for taxable years:

(*a*) Beginning before January 1, 1972, apply without regard to section 4942(e).

(*b*) Beginning in 1972, apply with an applicable percentage of 4⅛ percent,

(*c*) Beginning in 1973, apply with an applicable percentage of 4⅜ percent and

(*d*) Beginning in 1974, apply with an applicable percentage of 5½ percent.

(iii) *Short taxable periods*. In any case in which a taxable year referred to in this subparagraph is a period less than 12 months, the applicable percentage to be applied to the amount determined under the provisions of subparagraph (1) of this paragraph shall be equal to the applicable percentage for the calendar year in which the short taxable period began multiplied by a fraction, the numerator of which is the number of days in such short taxable period and the denominator of which is 365.

(d) *Adjusted net income*—(1) *Definition*. For purposes of paragraph (b) of this section, the term ''adjusted net income'' means the excess (if any) of:

(i) The gross income for the taxable year (including gross income from any unrelated trade or business) determined with the income modifications provided by subparagraph (2) of this paragraph, over

(ii) The sum of the deductions (including deductions directly connected with the carrying on of any unrelated trade or business), determined with the deduction modifications provided by subparagraph (4) of this paragraph, which would be allowed to a corporation subject to the tax imposed by section 11 for the taxable year.

In computing the income includible under this paragraph as gross income and the deductions allowable under this paragraph from such income, the principles of subtitle A of the Code shall apply except to the extent such principles conflict with section 4942 and the regulations thereunder (without regard to this sentence). Except as otherwise provided in this paragraph, no exclusions or deductions from gross income or credits against tax are allowable under this paragraph. For purposes of subdivision (i) of this subparagraph, the term ''gross income'' does not include gifts, grants, or contributions received by the private foundation but does include income from a functionally related business (as defined in paragraph (c)(3)(iii) of this section).

(2) *Income modifications*. The income modifications referred to in subparagraph (1)(i) of this paragraph are as follows:

(i) Section 103 (relating to interest on certain governmental obligations) shall not apply. Hence, interest which would have been excluded from gross income by section 103 shall be included in gross income.

(ii) Capital gains and losses from the sale or other disposition of property shall be taken into account only in an amount equal to any net short-term capital gain (as defined in section 1222(5)) for the taxable year. Long-term capital gain or loss is not included in the computation of adjusted net income. Similarly, net section 1231 gains shall be excluded from the computation of adjusted net income. However, net section 1231 losses shall be included in the computation of adjusted net income, if such losses are otherwise described in subparagraph (1)(ii) of this paragraph. Any net short-term capital loss for a given taxable year shall not be taken into account in computing adjusted net income for such year or in computing net short-term capital gain for purposes of determining adjusted

net income for prior or future taxable years regardless of whether the foundation is a corporation or a trust.

(iii) The following amounts shall be included in gross income for the taxable year:

(*a*) Amounts received or accrued as repayments of amounts which were taken into account as a qualifying distribution within the meaning of paragraph (a)(2)(i) of §53.4942(a)–3 for any taxable year;

(*b*) Notwithstanding subdivision (ii) of this subparagraph, gross amounts received or accrued from the sale or other disposition of property to the extent that the acquisition of such property was taken into account as a qualifying distribution (within the meaning of paragraph (a)(2)(ii) of §53.4942(a)–3) for any taxable year; and

(*c*) Any amount set aside under paragraph (b) of §53.4942(a)–3 to the extent it is determined that such amount is not necessary for the purposes for which it was set aside.

(iv) Any distribution received by a private foundation from a disqualified person in redemption of stock held by such private foundation in a business enterprise shall be treated as not essentially equivalent to a dividend under section 302(b)(1) if all of the following conditions are satisfied:

(*a*) Such redemption is of stock which was owned by a private foundation on May 26, 1969 (or which is acquired by a private foundation under the terms of a trust which was irrevocable on May 26, 1969, or under the terms of a will executed on or before such date which are in effect on such date and at all times thereafter);

(*b*) Such foundation is required to dispose of such property in order not to be liable for tax under section 4943 (relating to taxes on excess business holdings) applied, in the case of a disposition before January 1, 1975, without taking section 4943(c)(4) into account; and

(*c*) Such foundation receives in return an amount which equals or exceeds the fair market value of such property at the time of such disposition or at the time a contract for such disposition was previously executed in a transaction which would not constitute a prohibited transaction (within the meaning of section 503(b) or the corresponding provisions of prior law).

(v) If, as of the date of distribution of property for purposes described in section 170(c) (1) or (2)(B), the fair market value of such property exceeds its adjusted basis, such excess shall not be deemed an amount includible in gross income.

(vi) The income received by a private foundation from an estate during the period of administration of such estate shall not be included in such foundation's gross income, unless, due to a prolonged period of administration, such estate is considered terminated for Federal income tax purposes by operation of paragraph (a) of §1.641(b)–3 of this chapter (Income Tax Regulations).

(vii) Distributions received by a private foundation from a trust created and funded by another person shall not be included in the foundation's gross income. However, with respect to distributions from certain trusts described in section 4947(a)(2), see paragraph (b)(2) of this section.

(viii) Gross income shall include all amounts derived from, or in connection with, property held by the foundation, even though the fair market value of such property may not be included in such foundation's assets for purposes of determining minimum investment return by operation of paragraph (c)(3) of this section.

(ix) Gross income shall include amounts treated in a preceding taxable year as a ''qualifying distribution'' by operation of paragraph (c) of §53.4942(a)–3 where such amounts are not redistributed by the close of the donee organization's succeeding taxable year in accordance with the rules prescribed in such paragraph (c). In such cases, such amounts shall be included in the donor foundation's gross income for such foundation's first taxable year beginning after the close of the donee organization's first taxable year following the donee organization's taxable year of receipt.

(x) For taxable years ending after October 4, 1976, section 4942(f)(2)(D) states that section 483 (relating to imputed interest on deferred payments) does not apply to payments made pursuant to a binding contract entered into in a taxable year beginning before January

1, 1970. Amounts that are not treated as imputed interest because of section 4942(f)(2)(D) and this subdivision will represent gain or loss from the sale of property. If the gain or loss is long term capital gain or loss, section 4942(f)(2)(B) excludes the gain or loss from the computation of the foundation's gross income. If, in a taxable year beginning after December 31, 1969, there is a substantial change in the terms of a contract entered into in a taxable year beginning before January 1, 1970, then any payment made pursuant to the changed contract is not considered a payment made pursuant to a contract entered into in a taxable year beginning before January 1, 1970. Whether or not a change in the terms of a contract (for example, a change relating to time of payment, sales price, or obligations under the contract) is a substantial change is determined by applying the rules under section 483 and § 1.483–1(b)(4). As used in this subdivision, a binding contract includes an irrevocable written option.

(3) *Adjusted basis*—(i) *In general.* For purposes of subparagraph (2)(ii) of this paragraph, the adjusted basis for purposes of determining gain from the sale or other disposition of property shall be determined in accordance with the rules set forth in subdivision (ii) of this subparagraph and the adjusted basis for purposes of determining loss from such disposition shall be determined in accordance with the rules set forth in subdivision (iii) of this subparagraph. Further, the provisions of this subparagraph do not apply for any purpose other than for purposes of subparagraph (2)(ii) of this paragraph. For example, the determination of gain pursuant to the provisions of section 341 is determined without regard to this subparagraph.

(ii) *Gain from sale or other disposition.* The adjusted basis for purposes of determining gain from the sale or other disposition of property shall be the greater of:

(*a*) The fair market value of such property on December 31, 1969, plus or minus all adjustments after December 31, 1969, and before the date of sale or other disposition under the rules of Part II, Subchapter O, Chapter 1 of the Code, provided that the property was held by the private foundation on December 31, 1969, and continuously thereafter to such date of sale or other disposition; or

(*b*) The adjusted basis as determined under the rules of Part II, Subchapter O, Chapter 1 of the Code, subject to the provisions of section 4940(c)(3)(B) and the regulations thereunder (and without regard to section 362(c)). With respect to assets acquired prior to December 31, 1969, which were subject to depreciation or depletion, for purposes of determining the adjustments to be made to basis between the date of acquisition and December 31, 1969, and amount equal to straight-line depreciation or cost depletion shall be taken into account. In addition, in determining such adjustments to basis, if any other adjustments would have been made during such period (such as a change in useful life based upon additional data or a change in facts), such adjustments shall also be taken into account.

(iii) *Loss from sale or other disposition.* For purposes of determining loss from the sale or other disposition of property, adjusted basis as determined in subdivision (ii)(*b*) of this subparagraph shall apply.

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

Example 1. A private foundation, which uses the cash receipts and disbursements method of accounting, purchased certain depreciable real property on December 1, 1969. On December 31, 1969, the fair market value of such property was $100,000 and its adjusted basis (determined under the provisions of this subparagraph) was $102,000. The property was sold on January 2, 1970, for $105,000. Because fair market value on December 31, 1969, $100,000, is less than the adjusted basis as determined by Part II, Subchapter O, Chapter 1 of the Code, $102,000, a short-term gain of $3,000 is recognized (*i.e.*, sale price of $105,000 less the greater of the two possible bases) for purposes of subparagraph (2)(ii) of this paragraph.

Example 2. Assume the facts as stated in example (1), except that the sale price was $95,000. Because the sale price was $7,000 less than the adjusted basis for loss ($102,000 as determined by the application of subdivision (iii) of this subparagraph), there is a capital loss of $7,000 which may be deducted against short-term capital gains for 1970 (if any) in determining net short-term capital gain.

Example 3. A private foundation, which uses the cash receipts and disbursements method of accounting, purchased unimproved land on December 1, 1969. On December 31, 1969, the fair market value of such property was $110,000 and its adjusted basis (determined under the provisions of this subparagraph) was $102,000. The property was sold on January 2, 1970, for $105,000. Since the fair market value on December 31, 1969, $110,000, exceeds the adjusted basis as determined by Part II, Subchapter O, Chapter 1 of the Code, $102,000, such fair market value will be used for purposes of determining gain. However, because the adjusted basis for purposes of determining gain exceeds the sale price, there is no gain. Furthermore, because the adjusted basis for purposes of determining loss, $102,000, is less than sale price, there is no loss.

(4) *Deduction modifications*—(i) *In general.* For purposes of computing adjusted net income under subparagraph (1) of this paragraph, no deduction shall be allowed other than all the ordinary and necessary expenses paid or incurred for the production or collection of gross income or for the management, conservation, or maintenance of property held for the production of such income, except as provided in subdivision (ii) of this subparagraph. Such expenses include that portion of a private foundation's operating expenses which is paid or incurred for the production or collection of gross income. Operating expenses include compensation of officers, other salaries and wages of employees, interest, rent, and taxes. Where only a portion of the property produces (or is held for the production of) income subject to the provisions of section 4942, and the remainder of the property is used for charitable, educational, or other similar exempt purposes, the deductions allowed by this subparagraph shall be apportioned between the exempt and nonexempt uses. Similarly, where the deductions with respect to property used for a charitable, educational, or other similar exempt purpose exceed the income derived from such property, such excess shall not be allowed as a deduction, but may be treated as a qualifying distribution described in paragraph (a)(2)(ii) of § 53.4942(a)–3. Furthermore, this subdivision does not allow deductions which are not paid or incurred for the purposes herein prescribed. Thus, for example, the deductions prescribed by the following sections are not allowable: (*a*) The charitable contributions deduction prescribed under sections 170 and 642(c); (*b*) the net operating loss deduction prescribed under section 172; and (*c*) the special deductions prescribed under Part VIII, Subchapter B, Chapter 1 of the Code.

(ii) *Special rules.* For purposes of computing adjusted net income under subparagraph (1) of this paragraph: (*a*) The allowances for depreciation and depletion as determined under section 4940(c)(3)(B) and the regulations thereunder shall be taken into account, and (*b*) section 265 (relating to expenses and interest relating to tax-exempt interest) shall not apply.

(e) *Certain transitional rules*—(1) *In general.* In the case of organizations organized before May 27, 1969, section 4942 shall:

(i) Not apply to an organization to the extent its income is required to be accumulated pursuant to the mandatory terms (as in effect on May 26, 1969, and at all times thereafter) of an instrument executed before May 27, 1969, with respect to the transfer of income producing property to such organization, except that section 4942 shall apply to such organization if the organization would have been denied exemption had section 504(a) not been repealed, or would have had its deductions under section 642(c) limited had section 681(c) not been repealed. In applying the preceding sentence, in addition to the limitations contained in section 504(a) or 681(c) before its repeal, section 504(a)(1) or 681(c)(1) shall be treated as not applying to an organization to the extent its income is required to be accumulated pursuant to the mandatory terms (as in effect on January 1, 1951, and at all times thereafter) of an instrument executed before January 1, 1951, with respect to the transfer of income producing property to such organization before such date, if such transfer was irrevocable on such date; and

(ii) Not apply to an organization which is prohibited by its governing instrument or other instrument from distributing capital or corpus to the extent the requirements of section 4942

are inconsistent with such prohibitions.

(2) *Certain existing organizations.* For purposes of this section, an organization will be deemed to be organized prior to May 26, 1969, if it is either a testamentary trust created under the will of an individual who died prior to such date or an inter visos trust which was in existence and irrevocable prior to such date, even though it is not funded until after May 26, 1969. Similarly, a split-interest trust, as described in section 4947(a)(2) (without regard to section 4947(a)(2)(C)), which became irrevocable prior to May 27, 1969, and which is treated as a private foundation under section 4947(a)(1) subsequent to such date, likewise shall be treated as an organization organized prior to such date. See section 507(b)(2) and the regulations thereunder with respect to the applicability of transitional rules where there has been a merger of two or more private foundations or a reorganization of a private foundation.

(3) *Limitation.* With respect to taxable years beginning after December 31, 1971, subparagraph (1) (i) and (ii) of this paragraph shall apply only for taxable years during which there is pending any judicial proceeding by the private foundation which is necessary to reform, or to excuse such foundation from compliance with, its governing instrument or any other instrument (as in effect on May 26, 1969) in order to comply with the provisions of section 4942, and in the case of subparagraph (1)(i) of this paragraph for all taxable years following the taxable year in which such judicial proceeding is terminated during which the governing instrument or any other instrument does not permit compliance with such provisions. Thus, the exception described in subparagraph (1)(ii) of this paragraph applies after 1971 only for taxable years during which such judicial proceeding is pending. Accordingly, beginning with the first taxable year following the taxable year in which such judicial proceeding is terminated, such foundation will be required to meet the requirements of section 4942 and the regulations thereunder (and be subject to the taxes provided upon failure to do so) except to the extent such foundation is required to accumulate income as described in subparagraph (1)(i) of this paragraph, even if the governing instrument continues to prohibit invasion of capital or corpus. In any case where a foundation's governing instrument or any other instrument requires accumulation of income as described in subparagraph (1)(i) of this paragraph beginning with the first taxable year following the taxable year in which such judicial proceeding is terminated, the distributable amount (as defined in paragraph (b) of this section) for such foundation shall be reduced by the amount of the income required to be accumulated. Therefore, if the foundation's adjusted net income for any taxable year equals or exceeds its minimum investment return for such year, the accumulation provisions will be given full effect. However, if the minimum investment return exceeds the adjusted net income for any taxable year, the foundation will be required to distribute such excess for such year. For purposes of this paragraph, a judicial proceeding will be treated as pending only if the foundation is diligently pursuing its judicial remedies and there is no unreasonable delay in such proceeding for which the private foundation is responsible.

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

Example 1. X, a private foundation organized in 1930, is required by the mandatory terms of its governing instrument to accumulated 25 percent of its adjusted net income and to add such accumulations to corpus. The instrument also prohibits distribution of corpus for any purpose. On July 13, 1971, X instituted an action in the appropriate State court to reform the instrument by deleting the accumulation and corpus provisions described above. If the court's final order reforms the accumulation provisions to allow distributions of income sufficient to avoid the imposition of a tax under section 4942, then section 4942 applies to X, regardless of the court's action with respect to the corpus provisions. However, if the court rules that the accumulation provision may not be reformed, section 4942 applies to X only to the extent provided for in subparagraph (3) of this paragraph, regardless of the court's action with respect to the corpus provision.

Example 2. Private foundation Y was created by the will of A who died in 1940. Y's

governing instrument requires that 40 percent of Y's adjusted net income be added to corpus each year. In an action commenced prior to December 31, 1971, a court of competent jurisdiction rules that this accumulation provisions must be complied with. In Y's succeeding taxable year its adjusted net income is $120,000, and its minimum investment return is $140,000. Thus, Y is required to accumulated $48,000 (40 percent of $120,000) and shall be allowed to do so. Therefore, Y's distributable amount for such taxable year shall be the greater of its adjusted net income ($120,000) or its minimum investment return ($140,000), reduced by the amount of the income required to be accumulated ($48,000) and the taxes imposed by Subtitle A of the Code and section 4940 and increased by any trust distributions described in paragraph (b)(2) of this section. Accordingly, Y's distributable amount for such taxable year is $92,000 ($140,000 reduced by $48,000), before other adjustments. If Y's minimum investment return had been $120,000 instead of $140,000, its distributable amount for such taxable year would have been $72,000 ($120,000 reduced by $48,000), before other adjustments. Similarly, if Y's minimum investment return had been $100,000 instead of $140,000, its distributable amount for such taxable year would also have been $72,000, before other adjustments.

[T.D. 7256, 38 FR 3317, Feb. 5, 1973; 38 FR 4577, Feb. 16, 1973, as amended by T.D. 7486, 42 FR 24265, May 13, 1977; T.D. 7594, 44 FR 7138, Feb. 6, 1979; T.D. 7610, 44 FR 21644, Apr. 11, 1979; T.D. 7715, 45 FR 56803, Aug. 26, 1980; T.D. 7849, 47 FR 50857, Nov. 10, 1982; T.D. 7878, 48 FR 11943, Mar. 22, 1983]

§ 53.4942(a)–3 Qualifying distributions defined.

(a) *In general*—(1) *Distributions generally*. For purposes of section 4942 and the regulations thereunder, the amount of a qualifying distribution of property (as defined in subparagraph (2) of this paragraph) is the fair market value of such property as of the date such qualifying distribution is made. The amount of an organization's qualifying distributions will be determined solely on the cash receipts and disbursements method of accounting described in section 446(c)(1).

(2) *Definition*. The term ''qualifying distribution'' means:

(i) Any amount (including program related investments, as defined in section 4944(c), and reasonable and necessary administrative expenses) paid to accomplish one or more purposes described in section 170(c)(1) or (2)(B), other than any contribution to:

(*a*) A private foundation which is not an operating foundation (as defined in section 4942(j)(3)), except as provided in paragraph (c) of this section;

(*b*) An organization controlled (directly or indirectly) by the contributing private foundation or one or more disqualified persons with respect to such foundation, except as provided in paragraph (c) of this section; or

(*c*) An organization described in section 4942(g)(4)(A)(i) or (ii), if paid by a private foundation that is not an operating foundation;

(ii) Any amount paid to acquire an asset used (or held for use) directly in carrying out one or more purposes described in section 170(c) (1) or (2)(B). See paragraph (c)(3) of § 53.4942(a)–2 for the definition of *used (or held for use)*; or

(iii) Any amount set aside within the meaning of paragraph (b) of this section.

(3) *Control*. For purposes of subparagraph (2)(i)(*b*) of this paragraph, an organization is ''controlled'' by a foundation or one or more disqualified persons with respect to the foundation if any of such persons may, by aggregating their votes or positions of authority, require the donee organization to make an expenditure, or prevent the donee organization from making an expenditure, regardless of the method by which the control is exercised or exercisable. ''Control'' of a donee organization is determined without regard to any conditions imposed upon the donee as part of the distribution or any other restrictions accompanying the distribution as to the manner in which the distribution is to be used, unless such conditions or restrictions are described in paragraph (a)(8) of § 1.507–2 of this chapter (Income Tax Regulations). In general, it is the donee, not the distribution, which must be ''controlled'' by the distributing private foundation for the provisions of subparagraph (2)(i)(*b*) of this paragraph to apply. Thus, the furnishing of support to an organization and the consequent imposition of budgetary procedures upon that organization with respect to such support shall not in itself be treated as

subjecting that organization to the distributing foundation's control within the meaning of this subparagraph. Such ''budgetary procedures'' include expenditure responsibility requirements under section 4945(d)(4). The ''controlled'' organization need not be a private foundation; it may be any type of exempt or nonexempt organization including a school, hospital, operating foundation, or social welfare organization.

(4) *Borrowed funds*—(i) *In general*. For purposes of this paragraph, if a private foundation borrows money in a particular taxable year to make expenditures for a specific charitable educational, or other similar purpose, a qualifying distribution out of such borrowed funds will, except as otherwise provided in subdivision (ii) of this subparagraph, be deemed to have been made only at the time that such borrowed funds are actually distributed for such exempt purpose.

(ii) *Funds borrowed before 1970*. (*a*) If a private foundation has borrowed money in a taxable year beginning before January 1, 1970, or subsequently borrows money pursuant to a written commitment which was binding as of the last day of such taxable year, to make expenditures for a specific charitable, educational, or other similar exempt purpose, if such borrowed funds are in fact expended for such purpose in any taxable year, and if such loan is thereafter repaid, in whole or in part, in a taxable year beginning after December 31, 1969, then, at the election of the foundation as provided in subdivision (ii)(*b*) of this subparagraph, a qualifying distribution will be deemed to have been made at such time or times that such loan principal is so repaid rather than at the earlier time that the borrowed funds were actually distributed for such exempt purpose.

(*b*) The election described in subdivision (ii)(*a*) of this subparagraph is to be made by attaching a statement to the form the private foundation is required to file under section 6033 for the first taxable year beginning after December 31, 1969, in which a repayment of loan principal is made. Such statement shall be made a part of such form and shall be attached to such form in each succeeding taxable year in which any repayment of loan principal is made. The statement shall set forth the name and address of the lender, the amount borrowed, the specific use made of such borrowed funds, and the private foundation's election to treat repayments of loan principal as qualifying distributions.

(iii) *Interest*. Any payment of interest with respect to a loan described in subdivision (i) or (ii) of this subparagraph shall be treated as a deduction under paragraph (d)(1)(ii) of § 53.4942(a)–2 in the taxable year in which it is made.

(5) *Changes in use of an asset*. If an asset not used (or held for use) directly in carrying out one or more purposes described in section 170(c) (1) or (2)(B) is subsequently converted to such a use, the foundation may treat such conversion as a qualifying distribution. The amount of such qualifying distribution shall be the fair market value of the converted asset as of the date of its conversion. For purposes of the preceding sentence, fair market value shall be determined by making a valuation of the converted asset as of the date of its conversion in accordance with the rules set forth in paragraph (c)(4) of § 53.4942(a)-2.

(6) *Certain foreign organizations*—(i) *In general*. A distribution for purposes described in section 170(c)(2)(B) to a foreign organization, which has not received a ruling or determination letter that it is an organization described in section 509(a)(1), (a)(2), or (a)(3) or in section 4942 (j)(3), will be treated as a distribution made to an organization described in section 509(a)(1), (a)(2), or (a)(3) (other than an organization described in section 4942(g)(4)(A)(i) or (ii)) or in section 4942(j)(3) if the distributing foundation has made a good faith determination that the donee organization is an organization described in section 509(a)(1), (a)(2), or (a)(3) (other than an organization described in section 4942(g)(4)(A)(i) or (ii)) or in section 4942(j)(3). A determination ordinarily will be considered a good faith determination if the determination is based on current written advice received from a qualified tax practitioner concluding that the donee is an organization described in section 509(a)(1), (a)(2), or (a)(3) (other than an organization described in section 4942(g)(4)(A)(i)

or (ii)) or in section 4942(j)(3), and if the foundation reasonably relied in good faith on the written advice in accordance with the requirements of § 1.6664–4(c)(1) of this chapter. The written advice must set forth sufficient facts concerning the operations and support of the donee organization for the Internal Revenue Service to determine that the donee organization would be likely to qualify as an organization described in section 509(a)(1), (a)(2), or (a)(3) (other than an organization described in section 4942(g)(4)(A)(i) or (ii)) or in section 4942(j)(3) as of the date of the written advice. For purposes of this section, except as provided in the next sentence, written advice will be considered current if, as of the date of distribution, the relevant law on which the advice is based has not changed since the date of the written advice and the factual information on which the advice is based is from the donee's current or prior taxable year (or annual accounting period if the donee does not have a taxable year for United States federal tax purposes). Written advice that a donee met the public support test under section 170(b)(1)(A)(vi) or section 509(a)(2) for a test period of five years will be treated as current for purposes of distributions to the donee during the two taxable years (or, as applicable, annual accounting periods) of the donee immediately following the end of the five-year test period.

(ii) *Definitions*. For purposes of this paragraph (a)(6)—

(*a*) The term ''foreign organization'' means any organization that is not described in section 170(c)(2)(A).

(*b*) The term ''qualified tax practitioner'' means an attorney, a certified public accountant, or an enrolled agent, within the meaning of 31 CFR 10.2 and 10.3, who is subject to the requirements in 31 CFR part 10.

(7) *Payment of tax*. The payment of any tax imposed under chapter 42 of the Code shall not be treated as a qualifying distribution.

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

Example 1. M, a private foundation which uses the calendar year as the taxable year, makes the following payments in 1970: (i) a payment of $44,000 to five employees for conducting a foundation program of educational grants for research and study; (ii) $20,000 for various items of overhead, 10 percent of which is attributable to the activities of the employees mentioned in payment (i) of this example and the other 90 percent of which is attributable to administrative expenses which were not paid to accomplish any section 170(c) (1) or (2)(B) purpose; and (iii) a $100,000 general purpose grant paid to an educational institution described in section 170(b)(1)(A)(ii) which is not controlled by M or any disqualified persons with respect to M. Payments (i) and (ii) of this example are qualifying distributions to the extent of $46,000 ($44,000 of salaries and 10 percent of the overhead, both of which are reasonable administrative expenses paid to accomplish section 170(c) (1) or (2)(B) purposes). Payment (iii) of this example is also a qualifying distribution, since it is a contribution for section 170(c)(2)(B) purposes to an organization which is not described in subparagraph (2)(i) (*a*) or (*b*) of this paragraph. The other 90 percent of payment (ii) of this example may constitute items of deduction under paragraph (d)(1)(ii) of § 53.4942(a)–2 if such items otherwise qualify under such paragraph.

Example 2. On February 21, 1972, N, a private foundation which uses the calendar year as the taxable year, pays $500,000 for real property on which it plans to build hospital facilities to be used for medical care and education. The real property produces no income and the hospital facilities will not be constructed until 1974 according to the set-aside plan submitted to and approved by the Commissioner pursuant to paragraph (b) of this section. The purchase of the land is a qualifying distribution under subparagraph (2)(ii) of this paragraph. If, however, the property used were to produce rental income for more than a reasonable period of time before construction of the hospital is begun, then as of the time such rental use becomes unreasonable (i) such purchase would no longer constitute a qualifying distribution under subparagraph (2)(ii) of this paragraph, and (ii) the amount of the qualifying distribution would be included in N's gross income. See paragraphs (c)(3)(i) and (d)(2)(iii)(*b*) of § 53.4942(a)–2.

Example 3. In 1971, X, a private foundation engaged in holding paintings and exhibiting them to the public, purchases an additional building to be used to exhibit the paintings. Such expenditure is a qualifying distribution under subparagraph (2)(ii) of this paragraph. In 1975, X sells the building. Under paragraph (d)(2)(iii)(*b*) of § 53.4942(a)–2, all of the proceeds of the sale (less direct costs of the sale) are included in X's adjusted net income for 1975.

Example 4. In January 1969, M, a private foundation which uses the calendar year as the taxable year, borrows $10 million to give to N, a private college, for the construction

of a science center. M borrowed the money from X, a commercial bank. M is to repay X at the rate of $1.1 million per year ($1 million principal and $0.1 million interest) for 10 years, beginning in January, 1973. M distributed $5 million of the borrowed funds to N in February 1969 and the other $5 million in March 1970. M files a statement with the form it is required to file under section 6033 for 1973 which contains the information required by subparagraph (4)(ii)(*b*) of this paragraph. Pursuant to M's election, each repayment of loan principal constitutes a qualifying distribution in the year of repayment. Accordingly, the distribution of $5 million to N in March 1970 will not be treated as a qualifying distribution. Each payment of interest ($0.1 million annually) with respect to M's loan from X is treated as a deduction under paragraph (d)(1)(ii) of § 53.4942(a)–2 in the taxable year in which it is made.

Example 5. Private foundation Y engages in providing care for the aged. Y makes a distribution of cash to H, a hospital described in section 170(b)(1)(A)(iii) which is not controlled by Y or any disqualified person with respect to Y. The distribution is made subject to the conditions that H will invest the money as a separate fund which will bear a name commemorating the creator of Y and will use the income from such fund only for H's exempt hospital purposes which relate to care for the aged. Under these circumstances, the distribution from Y to H is a qualifying distribution pursuant to subparagraph (2)(i) of this paragraph.

(b) *Certain set-asides*—(1) *In general.* An amount set aside for a specific project that is for one or more of the purposes described in section 170(c) (1) or (2)(B) may be treated as a qualifying distribution in the year in which set aside (but not in the year in which actually paid), if the requirements of section 4942(g)(2) and this paragraph (b) are satisfied. The requirements of this paragraph (b) are satisfied if the private foundation establishes to the satisfaction of the Commissioner that the amount set aside will be paid for the specific project within 60 months after it is set aside, and

(i) The set-aside satisfies the suitability test described in subparagraph (2) of this paragraph, or

(ii) With respect to a set-aside made in a taxable year beginning after December 31, 1974, the private foundation satisfies the cash distribution test described in subparagraph (3) of this paragraph.

If the suitability test or cash distribution test is otherwise satisfied, the 60 month period for paying the amount set aside may, for good cause shown, be extended by the Commissioner.

(2) *Suitability test.* The suitability test is satisfied if the private foundation establishes to the satisfaction of the Commissioner that the specific project for which the amount is set aside is one that can be better accomplished by the set-aside than by the immediate payment of funds. Specific projects that can be better accomplished by the use of a set-aside include, but are not limited to, projects in which relatively long-term grants or expenditures must be made in order to assure the continuity of particular charitable projects or program-related investments (as defined in section 4944(c)) or where grants are made as part of a matching-grant program. Such projects include, for example, a plan to erect a building to house the direct charitable, educational, or other similar exempt activity of the private foundation (such as a museum building in which paintings are to be hung), even though the exact location and architectural plans have not been finalized; a plan to purchase an additional group of paintings offered for sale only as a unit that requires an expenditure of more than one year's income; or a plan to fund a specific research program that is of such magnitude as to require an accumulation of funds before beginning the research, even though not all of the details of the program have been finalized.

(3) *Cash distribution test; in general.* The cash distribution test is satisfied if:

(i) The specific project for which the amount is set aside will not be completed before the end of the taxable year in which the set-aside is made,

(ii) The private foundation actually distributes, in cash or its equivalent and for one or more of the purposes described in section 170(c) (1) or (2)(B), the ''start-up period minimum amount'' described in subparagraph (4) of this paragraph during the private foundation's start-up period, and

(iii) The private foundation actually distributes, in cash or its equivalent and for one or more of the purposes described in section 170(c) (1) or (2)(B), the ''full-payment period minimum

amount'' described in subparagraph (5) of this paragraph in each taxable year of the private foundation's full-payment period.

For purposes of the cash distribution test, an amount set aside will be treated as distributed in the year in which actually paid and not in the year in which set aside.

(4) *Minimum distribution required during start-up period*—(i) *Start-up period.* For private foundations created before January 1, 1972, the start-up period is the four taxable years immediately preceding the taxable year beginning in calendar year 1976. For private foundations created after December 31, 1971 (or for organizations that first become private foundations after that date), the start-up period is the four taxable years following the taxable year in which the private foundation was created (or otherwise became a private foundation). For purposes of this subparagraph (4), a private foundation will be considered ''created'' in the taxable year in which the private foundation's distributable amount (as determined under section 4942(d)) first exceeds $500.

(ii) *Start-up period minimum amount.* The amount that a private foundation must actually distribute in cash or its equivalent during the private foundation's start-up period is not less than the sum of:

(*a*) Twenty percent of the private foundation's distributable amount (as determined under section 4942(d)) for the first taxable year of the start-up period,

(*b*) Forty percent of the private foundation's distributable amount for the second taxable year of the start-up period,

(*c*) Sixty percent of the private foundation's distributable amount for the third taxable year of the start-up period, and

(*d*) Eighty percent of the private foundation's distributable amount for the fourth taxable year of the start-up period.

(iii) *Timing of distributions.* The requirement that a private foundation distribute the start-up period minimum amount during the start-up period is a requirement that such amount be distributed before the end of the start-up period, and is not a requirement that any portion of such amount be distributed in any one taxable year of the start-up period.

(iv) *Distribution actually made during start-up period.* In general, only a distribution actually made during the start-up period is taken into account in determining whether a private foundation has distributed the start-up period minimum amount. However, in the case of a private foundation created after December 31, 1971 (or an organization that first became a private foundation after that date), a distribution actually made during the taxable year in which the foundation was created (the year immediately preceding the first taxable year of the private foundation's start-up period) may be treated as a distribution actually made during the start-up period. In addition, a distribution actually made by a private foundation within 5½ months after the end of the start-up period will be treated as a distribution actually made during the start-up period if:

(*a*) The private foundation was unable to determine the distributable amount for the fourth taxable year of the start-up period until after the end of such period, and

(*b*) The private foundation actually made distributions prior to the end of the start-up period based upon a reasonable estimate of the private foundation's distributable amount for the fourth taxable year of the start-up period.

(v) *Examples.* The provisions of this subparagraph (4) may be illustrated by the following examples:

Example 1. F, a private foundation created on January 1, 1975, uses the calendar year as its taxable year. The start-up period for F is January 1, 1976 through December 31, 1979. F has distributable amounts under section 4942(d) for taxable years 1976 through 1979 in the following amounts: 1976, $100,000; 1977, $120,000; 1978, $150,000; 1979, $200,000. F's start-up period minimum amount is the sum of the following amounts: 20% of $100,000 ($20,000); 40% of $120,000 ($48,000); 60% of $150,000 ($90,000); and 80% of $200,000 ($160,000); which equals $318,000. Thus F is required to actually distribute at least $318,000 in cash or its equivalent during the start-up period.

Example 2. F, a private foundation created in 1969, uses the calendar year as its taxable year. F's start-up period is the calendar years 1972 through 1975. F makes two cash distributions in 1972. The first distribution is

made on account of a set-aside made in 1969. Under section 4942(g), that distribution is treated as a qualifying distribution made in 1969. The second distribution is treated under section 4942(h) has made out of F's undistributed income for 1971. In addition, F makes a cash distribution in 1976 that is treated under section 4942(h) as made out of F's undistributed income for 1975. In determining whether F has distributed its start-up period minimum amount within the start-up period, the 1972 distributions are both taken into account because they were actually made during F's start-up period. The 1976 distribution is not taken into account, however, because that distribution was not actually made during F's start-up period.

(5) *Minimum distribution required during full-payment period*—(i) *Full-payment period*. A private foundation's full-payment period includes each taxable year that begins after the end of the private foundation's start-up period.

(ii) *Full-payment period minimum amount*. The amount that a private foundation must actually distribute in cash or its equivalent in a taxable year of the private foundation's full-payment period is not less than 100 percent of the private foundation's distributable amount determined under section 4942(d) (without regard to section 4942(i)) with respect to the taxable year.

(iii) *Carryover of distributions in excess of full-payment period minimum amount*. If, in a taxable year beginning after December 31, 1975, a private foundation distributes an amount in excess of the full-payment period minimum amount for the taxable year, the excess shall be used to reduce the full-payment period minimum amount in the taxable years in the adjustment period. The amount of the excess distribution used to reduce the full-payment period minimum amount in each successive taxable year of the adjustment period shall be equal to the amount of such excess less the sum of the full-payment period minimum amounts for all prior taxable years in the adjustment period to which the excess was previously applied. The taxable years in the adjustment period are the five taxable years immediately following the taxable year in which the excess distribution is made. Any distribution in excess of the full-payment period minimum amount made during a taxable year of the adjustment period shall not be taken into account under this subparagraph (iii) until any earlier excess has been completely applied against full-payment period minimum amounts during its adjustment period.

(iv) *Distributions actually made during a taxable year*. Except as described in subdivision (ii) of subparagraph (6), only a distribution actually made during a taxable year of the full-payment period is taken into account in determining whether a private foundation has distributed the full-payment period minimum amount for such year.

(v) *Examples*. The provisions of this subparagraph (5) may be illustrated by the following examples:

Example 1. F, a private foundation created on January 1, 1973, uses the calendar year as its taxable year. F has a start-up period of January 1, 1974, through December 31, 1977, and a full-payment period that includes every taxable year beginning after December 31, 1977. F's distributable amount (as determined under section 4942(d)) for 1978 is $500,000. Thus, F's full-payment period minimum amount for 1978 is $500,000. During 1978 F distributes $100,000 in cash to Charity X and $400,000 in cash to Charity Y on account of a set-aside made in 1973. F has distributed its full-payment period minimum amount for 1978 because it has made actual cash distributions during that year which total $500,000. However, F has made qualifying distributions (as determined under section 4942(g)) with respect to 1978 of only $100,000. In order to avoid liability for the tax on undistributed income under section 4942(a), F must distribute or set aside an additional $400,000 before January 1, 1980.

Example 2. Assume the facts as stated in Example (1) except that in 1978 F makes cash distributions totaling $600,000. Since the total cash distributions made in 1978 ($600,000) exceed the full-payment period minimum amount for 1978 ($500,000), there exists a $100,000 excess which must be used by F to reduce its full-payment period minimum amounts for the years 1979–1983 (the taxable years in the adjustment period with respect to the 1978 excess). Therefore, if F's distributable amount (as determined under section 4942(d)) for 1979 is $500,000, F's full-payment period minimum amount for 1979 is $400,000 ($500,000–$100,000).

(6) *Failure to distribute minimum amounts*—(i) *In general*. If a private foundation fails to actually distribute the start-up period minimum amount during the start-up period or, except as described in subdivision (ii) of this subparagraph (6), if a private foundation

fails to actually distribute the full-payment period minimum amount during a taxable year of the full-payment period, then any set-aside made by the private foundation during the start-up period (if the failure relates to the start-up period) or during the taxable year (if the failure relates to the full-payment period) that was not approved by the Commissioner under the suitability test described in subparagraph (2) of this paragraph will not be treated as a qualifying distribution. Further, any set-aside made after the year of such a failure to so distribute a minimum amount will be treated as a qualifying distribution only if the Commissioner approves the set-aside under the suitability test. In any case in which a set-aside ceases to be treated as a qualifying distribution as a result of a failure to distribute the full-payment period minimum amount, a private foundation may be assessed a deficiency under section 4942(a) within the period described in section 6501(n)(3).

(ii) *Correction of certain failures to distribute*. If a private foundation's failure to distribute the full-payment period minimum amount during a taxable year of the full-payment period was not willful and was due to reasonable cause, the private foundation may correct the failure to so distribute. Correction will be achieved if the private foundation distributes within the correction period cash or its equivalent in an amount not less than the difference between the full-payment period minimum amount for the taxable year and the amount actually distributed during the taxable year. The correction period is the correction period as defined in section 4962(e), determined with respect to the earliest occurring taxable event (as defined in section 4962(e)(2)(A)) that would result if the failure to distribute a full-payment period minimum amount were not corrected. The additional distribution will be treated for purposes of subparagraph (5) of this paragraph as made during the taxable year with respect to which the failure occurred. If a private foundation fails to distribute the full-payment period minimum amount during a taxable year of the full-payment period because such amount can be determined only after the end of the taxable year, no ''willful failure to distribute'' the full-payment period minimum amount will occur if the private foundation makes an additional distribution within 5½ months after the end of the taxable year.

(7) *Approval and information requirements*—(i) *Suitability test*. If an amount is set aside under the suitability test of section 4942(g)(2)(B)(i) and subparagraph (2) of this paragraph, the private foundation must apply for the Commissioner's approval of the set-aside before the end of the taxable year in which the amount is set aside. The Commissioner will either approve or disapprove the set-aside in writing. An otherwise proper set-aside will not be treated as a qualifying distribution under this paragraph (b) with respect to a taxable year if the Commissioner's approval is not sought before the end of the taxable year in which the amount is actually set aside. To obtain approval by the Commissioner for a set-aside under the suitability test, the private foundation must write to Commissioner of Internal Revenue, Attention: OP:E:EO:T, 1111 Constitution Avenue, NW., Washington, DC 20224, and include:

(*a*) A statement describing the nature and purposes of the specific project and the amount of the set-aside for which approval is requested;

(*b*) A statement describing the amounts and approximate dates of any planned additions to the set-aside after its initial establishment;

(*c*) A statement of the reasons why the project can be better accomplished by a set-aside than by the immediate payment of funds;

(*d*) A detailed description of the project, including estimated costs, sources of any future funds expected to be used for completion of the project, and the location or locations (general or specific) of any physical facilities to be acquired or constructed as part of the project; and

(*e*) A statement by an appropriate foundation manager (as defined in section 4946(b)) that the amounts to be set aside will actually be paid for the specific project within a specified period of time that ends not more than 60 months after the date of the first set-aside, or a statement showing good

cause why the period for paying the amount set aside should be extended (including a showing that the proposed project could not be divided into two or more projects covering periods of no more than 60 months each) and setting forth the extension of time required.

(ii) *Cash distribution test.* If an amount is set aside under the cash distribution test of section 4942(g)(2)(B)(ii) and subparagraphs (3), (4), and (5) of this paragraph, then for taxable years ending after April 2, 1984, the private foundation must submit an attachment with the return required by section 6033 for the taxable year in which the amount is set aside and for certain subsequent taxable years. For the taxable year in which the amount is set aside the attachment must include:

(*a*) A statement describing the nature and purposes of the specific project for which amounts are to be set aside;

(*b*) A statement that the amounts set aside for the specific project will actually be paid for the specific project within a specified period of time that ends not more than 60 months after the date of the set-aside;

(*c*) A statement that the project will not be completed before the end of the taxable year of the private foundation in which the set-aside is made;

(*d*) A statement showing the distributable amounts determined under section 4942(d) for any past taxable years in the private foundation's start-up and full-payment periods; and

(*e*) A statement showing the aggregate amount of actual payments made in cash or its equivalent, for purposes described in section 170(c) (1) or (2)(B), during each taxable year in the private foundation's start-up and full-payment periods. This statement should include a detailed description of any payments that are to be treated, pursuant to the rules of subparagraphs (4)(iv) and (6)(ii) of this paragraph (b), as distributed during a taxable year prior to the taxable year in which such payments were actually made and, in addition, should explain the circumstances that justify the application of those rules.

For the five taxable years following the taxable year in which the amount is set aside (or, if longer, for each taxable year in the extended period for paying the amount set aside), the attachment must include the statements required by (*d*) and (*e*) of this subdivision (ii). The submission of the statement required by (*b*) of this subdivision (ii) will satisfy the requirement of section 4942(g)(2)(B) and subparagraph (1) of this paragraph (b) that the private foundation establish to the satisfaction of the Commissioner that the amount set aside will be paid for the specific project within 60 months after it is set aside.

(8) *Evidence of set-aside.* A set-aside that is approved by the Commissioner or which satisfies the cash distribution test shall be evidenced by the entry of a dollar amount on the books and records of a private foundation as a pledge or obligation to be paid at a future date or dates. Any amount which is set aside shall be taken into account for purposes of determining the private foundation's minimum investment return under § 53.4942(a)–2 (c)(1), and any income attributable to such set-aside shall be taken into account in computing adjusted net income under § 53.4942(a)–2(d).

(9) *Contingent set-aside.* In the event a private foundation is involved in litigation and may not distribute assets or income because of a court order, the private foundation may (except as provided in § 53.4942(a)–2 (e)(1)(i) or (ii)) seek and obtain a set-aside for a purpose described in § 53.4942(a)–3 (a)(2). The amount to be set aside shall be equal to that portion of the private foundation's distributable amount which is attributable to the assets or income that are held pursuant to court order and which, but for the court order precluding the distribution of such assets or income, would have been distributed. In the event that the litigation encompasses more than one taxable year, the private foundation may seek additional contingent set-asides. Such amounts must actually be distributed by the last day of the taxable year following the taxable year in which the litigation is terminated. Amounts not distributed by the close of the appropriate taxable year shall be treated as described in § 53.4942(a)–2 (d)(2)(iii)(*c*) for the succeeding taxable year.

(c) *Certain contributions to section 501(c)(3) organizations*—(1) *In general.*

For purposes of this section, the term ''qualifying distribution'' includes (in the year in which it is paid) a contribution to an exempt organization described in section 501(c)(3) and described in paragraph (a)(2)(i) (*a*) or (*b*) of this section if:

(i) Not later than the close of the first taxable year after the donee organization's taxable year in which such contribution is received, such donee organization makes a distribution equal to the full amount of such contribution and such distribution is a qualifying distribution (within the meaning of paragraph (a) of this section, without regard to this paragraph) which is treated under paragraph (d) of this section as a distribution out of corpus (or would be so treated if such section 501(c)(3) organization were a private foundation which is not an operating foundation); and

(ii) The private foundation making the contribution obtains adequate records or other sufficient evidence from such donee organization (such as a statement by an appropriate officer, director, or trustee of such donee organization) showing (except as otherwise provided in this subparagraph) (*a*) that the qualifying distribution described in subdivision (i) of this subparagraph has been made by such organization, (*b*) the names and addresses of the recipients of such distribution and the amount received by each, and (*c*) that the distribution is treated as a distribution out of corpus under paragraph (d) of this section (or would be so treated if the donee organization were a private foundation which is not an operating foundation). Where a distribution is for an administrative expense which is part of a section 170(c) (1) or (2)(B) expenditure or is part of another section 170(c) (1) or (2)(B) expenditure that cannot reasonably be separately accounted for, the provisions of subdivision (ii) of this subparagraph may be satisfied by the submission by the donee organization of a statement setting forth the general purpose for which such expenditure was made and that the amount was distributed as a qualifying distribution described in subdivision (ii)(*c*) of this subparagraph.

(2) *Distribution requirements.* (i) In order for a donee organization to meet the distribution requirements of subparagraph (1)(i) of this paragraph, it must, not later than the close of the first taxable year after its taxable year in which any contributions are received, distribute (within the meaning of this subparagraph) an amount equal in value to the contributions received in such prior taxable year and have no remaining undistributed income for such prior taxable year. In the event that a donee organization redistributes less than an amount equal to the total contributions from donor organizations which are required to be redistributed by such donee organization by the close of the first taxable year following the taxable year in which such contributions were received, amounts treated as redistributions of such contributions shall be deemed to have been made pro rata out of all such contributions regardless of any earmarking or identification made by such donee organization with respect to the source of such distributions. See paragraph (d)(2)(ix) of §53.4942(a)–2 for the treatment of amounts deemed not to have been so redistributed. For purposes of this paragraph, the term *contributions* means all contributions, whether of cash or property, and the fair market value of contributed property determined as of the date of the contribution must be used in determining whether an amount equal in value to the contributions received has been redistributed.

(ii) For purposes of this paragraph, the characterization of qualifying distributions made during the taxable year (*i.e.*, whether out of the prior year's undistributed income, the current year's undistributed income, or corpus) is to be made as of the close of the taxable year in question, except to the extent that a different characterization is effected by means of the election provided for by paragraph (d)(2) of this section or by subdivision (iv) of this subparagraph. Once it is determined that a qualifying distribution is attributable to corpus, such distribution will first be charged to distributions which are required to be redistributed under this paragraph.

(iii) All amounts contributed to a specific exempt organization described in section 501(c)(3) and in paragraph

(a)(2)(i) (*a*) or (*b*) of this section within any one taxable year of such organization shall be treated (with respect to the contributing private foundation) as one ''contribution''. If subparagraph (1)(i) or (ii) of this paragraph is not completely satisfied with respect to such contribution within the meaning of such subparagraph, only that portion of such contribution which was redistributed (within the meaning of subparagraph (1) (i) and (ii) of this paragraph) shall be treated as a qualifying distribution.

(iv) In order to satisfy distribution requirements under section 170(b)(1)(E)(ii) or this paragraph, a donee organization may elect to treat as a current distribution out of corpus any amount distributed in a prior taxable year which was treated as a distribution out of corpus under paragraph (d)(1)(iii) of this section provided that (*a*) such amount has not been availed of for any other purpose, such as a carryover under paragraph (e) of this section or a redistribution under this paragraph for a prior year, (*b*) such corpus distribution occurred within the preceding 5 years, and (*c*) such amount is not later availed of for any other purpose. Such election must be made by attaching a statement to the return the foundation is required to file under section 6033 with respect to the taxable year for which such election is to apply. Such statement must contain a declaration by an appropriate foundation manager (within the meaning of section 4946(b)(1)) that the foundation is making an election under this paragraph and it must specify that the distribution was treated under paragraph (d)(1)(iii) of this section as a distribution out of corpus in a designated prior taxable year (or years).

(3) *Examples*. The provisions of subparagraphs (1) and (2) of this paragraph may be illustrated by the following examples. It is assumed in these examples that all private foundations described use the calendar as the taxable year.

Example 1. In 1972 M, a private foundation, makes a contribution out of 1971 income to X, another private foundation which is not an operating foundation. The contribution is the only one received by X in 1972. In 1973 X makes a qualifying distribution to an art museum maintained by an operating foundation in an amount equal to the amount of the contribution received from M. X also distributes all of its undistributed income for 1972 and 1973 for other purposes described in section 170(c)(2)(B). Under the provisions of paragraph (d) of this section, such distribution to the museum is treated as a distribution out of corpus. Thus, M's contribution to X is a qualifying distribution out of M's 1971 income provided M obtains adequate records or other sufficient evidence from X showing the nature and amount of the distribution made by X, the identity of the recipient, and the fact that the distribution is treated as made out of corpus. If X's qualifying distributions during 1973 had been equal only to M's contribution to X and X's undistributed income for 1972, X could have made an election under paragraph (d)(2) of this section to treat the amount distributed in excess of its 1972 undistributed income as a distribution out of corpus and in that manner satisfied the requirements of this paragraph.

Example 2. Assume the facts stated in example (1), except that X is a private college described in section 170(b)(1)(A)(ii) which is controlled by disqualified persons with respect to M and that the records which X furnishes to M show that the distribution would have been treated as made out of corpus if X were a private nonoperating foundation. Under these circumstances, result is the same as in example (1).

Example 3. Assume the facts stated in example (1), except that X makes a distribution to the museum equal only to one-half of the contribution from M, that the remainder of such contribution is added to X's funds and used to pay charitable administrative expenses, and that the records obtained by M from X are not sufficient to show the amounts distributed or the identities of the recipients of the distributions. The contribution by M to X will be a qualifying distribution only to the extent that M can obtain (i) other sufficient evidence (such as statements from officers or employees of X or from the museum) showing the facts required by subparagraph (1)(ii) (*a*), (*b*), and (*c*) of this paragraph and (ii) a statement from X setting forth that the remainder of the contribution was used for charitable administrative expenses which constituted qualifying distributions described in paragraph (a)(2)(i) of this section.

Example 4. X and Y are private nonoperating foundations. A is an exempt organization which is not described in section 501(c)(3) but which supervises and conducts a program described in section 170(c)(2)(B). Y, but not X, controls A within the meaning of paragraph (a)(3) of this section. In 1972, X and Y each makes a grant to A of $100, specifically designated for use in the operation of A's section 170(c)(2)(B) program. X has made a qualifying distribution to A because

the distribution is one described in paragraph (a)(2)(i) of this section. However, because A is controlled by Y, Y's grant of $100 to A does not constitute a qualifying distribution within the meaning of such paragraph (a)(2)(i). Furthermore, because A is not an exempt organization described in section 501(c)(3), Y's grant to A does not constitute a qualifying distribution by operation of the provisions of this paragraph.

Example 5. N, a private nonoperating foundation, had distributable amounts of $100 in 1970 and $125 in 1971. In 1970 N received total contributions of $540: $150 from Y, a public charity; $70 from Z, a private foundation; $140 from Q, a private foundation, subject to the requirement that N earmark the amount and distribute it before distributing Z's contribution; and, $180 from R, also a private foundation. However, R specifically instructed N that such contribution did not have to be redistributed because R already had made enough qualifying distributions to avoid all section 4942 taxes. N is not controlled by Y, Z, Q, or R, and N made no qualifying distributions in 1970. By the close of 1971, N had made qualifying distributions of $420, earmarking $140 as having been a distribution of Q's contribution, but had made no election under paragraph (d)(2) of this section to have any amount distributed which was in excess of N's 1970 undistributed income treated as distributed out of corpus. Therefore, the first $225 of qualifying distributions made in 1971 (the sum of $100 and $125, N's distributable amounts for 1970 and 1971, respectively) are treated as amounts described in paragraph (d)(1) (i) and (ii) of this section. Since Y's contribution is a contribution from a public charity and does not have to be ''redistributed'' and since R specifically instructed N that its contribution need not be ''redistributed'', the remaining $195 of qualifying distributions will be treated as distributed pro rata from Z's and Q's contributions, regardless of N's earmarking. Accordingly, of Z's original qualifying distribution of $70 only $65 ($195 multiplied by $70, Z's contribution, over $210, the total ($70 plus $140) of Z's and Q's contributions) will be treated as redistributed by N. Similarly, of Q's original qualifying distribution of $140 only $130 ($195 multiplied by $140 over $210) will be treated as redistributed by N. Thus, Z's gross income for 1972 will be increased by $5 ($70 less the $65 actually redistributed), and Q's gross income for 1972 will be increased by $10 ($140 less the $130 actually redistributed).

(4) *Limitation.* A contribution by a private foundation to a donee organization which the donee uses to make payments to another organization (the secondary donee) shall not be regarded as a contribution by the private foundation to the secondary donee if the distributing foundation does not earmark the use of the contribution for any named secondary donee and does not retain power to cause the selection of the secondary donee by the organization to which such foundation has made the contribution. For purposes of this subparagraph, a contribution described herein shall not be regarded as a contribution by the foundation to the secondary donee even though such foundation has reason to believe that certain organizations would derive benefits from such contribution so long as the original donee organization exercises control, in fact, over the selection process and actually makes the selection completely independently of such foundation.

(5) *Transitional rule.* (i) For purposes of this paragraph, a contribution to a private foundation which is not an operating foundation and which is not controlled (directly or indirectly) by the distributing foundation or one or more disqualified persons with respect to the distributing foundation will be treated as a contribution to an operating foundation if:

(*a*) Such contribution is made pursuant to a written commitment which was binding on May 26, 1969, and at all times thereafter.

(*b*) Such contribution is made for one or more of the purposes described in section 170(c) (1) or (2)(B), and

(*c*) Such contribution is to be paid out to the donee private foundation on or before December 31, 1974.

(ii) For purposes of this subparagraph, a written commitment will be considered to have been binding prior to May 27, 1969, only if the amount and nature of the contribution and the name of the donee foundation were entered in the records of the distributing foundation, or were otherwise adequately evidenced, prior to May 27, 1969, or notice of the contribution was communicated in writing to such donee prior to May 27, 1969.

(d) *Treatment of qualifying distributions*—(1) *In general.* Except as provided in subparagraph (2) of this paragraph, any qualifying distribution made during a taxable year shall be treated as made:

(i) First out of the undistributed income (as defined in paragraph (a) of § 53.4942(a)–2) of the immediately preceding taxable year (if the private foundation was subject to the initial excise tax imposed by section 4942(a) for such preceding taxable year) to the extent thereof;

(ii) Second out of the undistributed income for the taxable year to the extent thereof; and

(iii) Then out of corpus.

(2) *Election*. In the case of any qualifying distribution which (under subparagraph (1) of this paragraph) is not treated as made out of the undistributed income of the immediately preceding taxable year, the foundation may elect to treat any portion of such distribution as made out of the undistributed income of a designated prior taxable year or out of corpus. Such election must be made by filing a statement with the Commissioner during the taxable year in which such qualifying distribution is made or by attaching a statement to the return the foundation is required to file under section 6033 with respect to the taxable year in which such qualifying distribution was made. Such statement must contain a declaration by an appropriate foundation manager (within the meaning of section 4946(b)(1)) that the foundation is making an election under this subparagraph, and it must specify whether the distribution is made out of the undistributed income of a designated prior taxable year (or years) or is made out of corpus. In any case where the election described in this subparagraph is made during the taxable year in which the qualifying distribution is made, such election may be revoked in whole or in part by filing a statement with the Commissioner during such taxable year revoking such election in whole or in part or by attaching a statement to the return the foundation is required to file under section 6033 with respect to the taxable year in which the qualifying distribution was made revoking such election in whole or in part. Such statement must contain a declaration by an appropriate foundation manager (within the meaning of section 4946(b)(1)) that the foundation is revoking an election under this subparagraph in whole or in part, and it must specify the election or part thereof being revoked.

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

Example 1. M, a private foundation which was created in 1968 and which uses the calendar year as the taxable year, has distributable amounts and qualifying distributions for 1970 through 1976 as follows:

	1970	1971	1972	1973
Distributable amount	$100	$100	$100	$100
Qualifying distribution	0	100	250	100
	1974	1975	1976	.....
Distributable amount	$100	$100	$100	.....
Qualifying distribution	100	100	100	.....

In 1971 the qualifying distribution of $100 is treated under subparagraph (1)(i) of this paragraph as made out of the $100 of undistributed income for 1970. The qualifying distribution of $250 in 1972 is treated as made: (i) $100 out of the undistributed income for 1971 under subparagraph (1)(i) of this paragraph; (ii) $100 out of the undistributed income for 1972 under subparagraph (1)(ii) of this paragraph; and (iii) $50 out of corpus in 1972 under subparagraph (1)(iii) of this paragraph. The qualifying distribution of $100 in each of the years 1973 through 1976 is treated as made out of the undistributed income for each of those respective years under subparagraph (1)(ii) of this paragraph. See paragraph (e) of this section for rules relating to the carryover of qualifying distributions out of corpus.

Example 2 M, a private foundation which uses the calendar year as the taxable year, has undistributed income of $300 for 1981, $200 for 1982, and $400 for 1983. On January 14, 1983, *M* makes its first qualifying distribution in 1983 when it sets aside (within the meaning of paragraph (b) of this section) $700 for construction of a hospital. On February 24, 1983 a notice of deficiency with respect to the excise taxes imposed by section 4942 (a) and (b) in regard to *M*'s undistributed income for 1981 is mailed to *M* under section 6212(a). *M* notifies the Commissioner in writing on March 24, 1983, that it is making an election under subparagraph (2) of this paragraph to have its distribution of January 14th applied first against its undistributed income for 1982, next against its undistributed income for 1981, and last against its undistributed income for 1983. Thus, $200 of the $700 qualifying distribution is treated as made out of the undistributed income for 1982; $300, out of undistributed income for 1981; and $200 ($700 less the sum of $200 and $300), out of the undistributed income for 1983. Thus, an initial excise tax of $45 (15 percent of $300) is imposed under section 4942(a).

Since *M* made the election described above, the $300 (treated as distributed out of undistributed income for 1981) corrects (within the meaning of section 4963(d)(2)) the taxable act because the undistributed income for 1981 is reduced to zero. Furthermore, correction is effected within the correction period (as defined in section 4963(e)(1) and § 53.4963–1(e)). Therefore, under the provisions of section 4961(a), the additional tax imposed by section 4942(b) will not be assessed.

(e) *Carryover of excess qualifying distributions*—(1) *In general.* If in any taxable year for which an organization is subject to the initial excise tax imposed by section 4942(a) there is created an excess of qualifying distributions (as determined under subparagraph (2) of this paragraph), such excess may be used to reduce distributable amounts in any taxable year of the adjustment period (as defined subparagraph (3) of this paragraph). For purposes of section 4942, including paragraph (d) of this section, the distributable amount for a taxable year in the adjustment period shall be reduced to the extent of the lesser of (i) the excess of qualifying distributions made in prior taxable years to which such adjustment period applies or (ii) the remaining undistributed income at the close of such taxable year after applying any qualifying distributions made in such taxable year to the distributable amount for such taxable year (determined without regard to this paragraph). If during any taxable year of the adjustment period there is created another excess of qualifying distributions, such excess shall not be taken into account until any earlier excess of qualifying distributions has been completely applied against distributable amounts during its adjustment period.

(2) *Excess qualifying distributions.* An excess of qualifying distributions is created for any taxable year beginning after December 31, 1969, if:

(i) The total qualifying distributions treated (under paragraph (d) of this section) as made out of the undistributed income for such taxable year or as made out of corpus with respect to such taxable year (other than amounts distributed by an organization in satisfaction of section 170(b)(1)(E)(ii) or paragraph (c) of this section, or applied to a prior taxable year by operation of the elections contained in paragraphs (c)(2)(iv) and (d)(2) of this section), exceeds

(ii) The distributable amount for such taxable year (determined without regard to this paragraph).

(3) *Adjustment period.* For purposes of this paragraph, the taxable years in the adjustment period are the 5 taxable years immediately following the taxable year in which the excess of qualifying distributions is created. Thus, an excess (within the meaning of subparagraph (2) of this paragraph) for any 1 taxable year cannot be carried over beyond the succeeding 5 taxable years. However, if during any taxable year in the adjustment period an organization ceases to be subject to the initial excise tax imposed by section 4942(a), any portion of the excess of qualifying distributions, which prior to such taxable year has not been applied against distributable amounts, may not be carried over to such taxable year or subsequent taxable years in the adjustment period, even if during any of such taxable years the organization again becomes subject to the initial excise tax imposed by section 4942(a).

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

Example 1. (i) F, a private foundation which was created in 1967 and which uses the calendar year as the taxable year, has distributable amounts and qualifying distributions for 1970 through 1976 as follows:

Year	1970	1971	1972	1973
Distributable amount	$100	$100	$100	$100
Qualifying distribution	0	$250	$70	$140

Year	1974	1975	1976	
Distributable amount	$100	$100	$100	.....
Qualifying distribution	$60	$75	$105	.....

(ii) The qualifying distributions made in 1971 will be treated under paragraph (d) of this section as $100 made out of the undistributed income for 1970, then as $100 made out of the undistributed income for 1971, and finally as $50 out of corpus in 1971. Since the total qualifying distributions for 1971 ($150) exceed the distributable amount for 1971 ($100), there exists a $50 excess of qualifying distributions which F may use to reduce its distributable amounts for the years 1972 through 1976 (the taxable years in the adjustment period with respect to the 1971 excess). Therefore, the $100 distributable amount for 1972 is reduced by $30 (the lesser of the 1971

excess ($50) and the remaining undistributed income at the close of 1972 ($30), after the qualifying distributions of $70 for 1972 were applied to the original distributable amount for 1972 of $100). Since the distributable amount for 1972 was reduced to $70, there is no remaining undistributed income for 1972. Accordingly, the qualifying distributions made in 1973 will be treated as $100 made out of the undistributed income for 1973 and as $40 out of corpus in 1973. Since this amount ($140) exceeds the distributable amount for 1973 ($100), there exists a $40 excess which F may use to reduce its distributable amounts for the years 1974 through 1978 (the taxable years in the adjustment period with respect to the 1973 excess). However, in accordance with subparagraph (1) of this paragraph such excess may not be used to reduce F's distributable amounts for the years 1974 through 1976 until the excess created in 1971 has been completely applied against distributable amounts during such years. The distributable amount for 1974 is reduced by $40 (the lesser of the unused portion of the 1971 excess ($20) plus the 1973 excess ($40) and the remaining undistributed income at the close of 1974 ($40), after the qualifying distributions of $60 for 1974 were applied to the original distributable amount for 1974 of $100). The distributable amount for 1975 is reduced by $20 (the lesser of the unused portion of the 1973 excess of qualifying distributions ($20) and the remaining undistributed income at the close of 1975 ($25), after the qualifying distributions of $75 for 1975 were applied to the original distributable amount for 1975 of $100). Consequently, qualifying distributions made in 1976 will be treated as made first out of the $5 of remaining undistributed income for 1975 and then as $100 made out of the undistributed income for 1976.

Example 2. Assume the facts as stated in example (1), except that in 1974 F receives a contribution of $300 from G, a private foundation which controls F (within the meaning of paragraph (a)(3) of this section), and F distributes such contribution in 1975 in satisfaction of paragraph (c) of this section. Under these circumstances, there would be no excess of qualifying distributions for 1975 with respect to such distribution, since such distribution is excluded from the computation of an excess of qualifying distributions by operation of subparagraph (2)(i) of this paragraph.

Example 3. Assume the facts as stated in example (1), except that in 1972 F is treated as an operating foundation (as such term is defined in section 4942(j)(3)). In accordance with subparagraph (3) of this paragraph since F is not subject to the initial excise tax imposed by section 4942(a) for 1972, the 1971 excess cannot be carried forward to 1972 or any subsequent year in the adjustment period with respect to the 1971 excess, even if F is subsequently treated as a private nonoperating foundation for any year during the period 1973 through 1976.

(f) *Effective/applicability date and transition relief.* Paragraphs (a)(2)(i) and (a)(6) of this section are effective on and apply with respect to distributions made after September 25, 2015. However, foundations may continue to rely on the provisions of paragraph (a)(6) of this section as contained in 26 CFR part 53, revised April 1, 2015, with respect to distributions made on or before December 24, 2015 pursuant to a good faith determination made in accordance with such provisions. Also, foundations may continue to rely on the provisions of paragraph (a)(6) of this section as contained in 26 CFR part 53, revised April 1, 2015, with respect to distributions pursuant to a written commitment made on or before September 25, 2015 and pursuant to a good faith determination made on or before such date in accordance with such provisions if the committed amount is distributed within five years of such date.

[T.D. 7256, 38 FR 3323, Feb. 5, 1973, as amended by T.D. 7486, 42 FR 24265, May 13, 1977; T.D. 7849, 47 FR 50857, Nov. 10, 1982; T.D. 7938, 49 FR 3848, Jan. 31, 1984; T.D. 8084, 51 FR 16302, May 2, 1986; T.D. 9740, 80 FR 57715, Sept. 25, 2015]

§ 53.4942(b)–1 Operating foundations.

(a) *Operating foundation defined*—(1) *In general.* For purposes of section 4942 and the regulations thereunder, the term ''operating foundation'' means any private foundation which, in addition to satisfying the assets test, the endowment test or the support test set forth in § 53.4942(b)–2 (a), (b) and (c), makes qualifying distributions (within the meaning of § 53.4942(a)–3(a)(2)) directly for the active conduct of activities constituting its charitable, educational, or other similar exempt purpose equal in value to:

(i) For taxable years beginning before January 1, 1982, substantially all of the foundation's adjusted net income (as defined in § 53.4942(a)–2(d)); and

(ii) For taxable years beginning after December 31, 1981, substantially all of the lesser of the foundation's adjusted net income (as defined in § 53.4942(a)–2(d)) or minimum investment return (as defined in § 53.4942(a)–2(c)). If the

foundation's qualifying distributions exceed its minimum investment return (but are less than the foundation's adjusted net income) substantially all of such qualifying distributions must be made directly for the active conduct of activities constituting its charitable, educational or other similar exempt purpose. However, if the foundation's minimum investment return is less than its adjusted net income and the foundation's qualifying distributions equal or exceed such adjusted net income, only that portion of the qualifying distributions equal to substantially all of the foundation's adjusted net income must be made directly for the active conduct of activities constituting its charitable, educational or other similar exempt purpose.

(2) *Certain elderly care facilities described in section 4942(j)(6)*—(i) *In general.* For purposes of the distribution requirements of section 4942 (but no other provision of the Internal Revenue Code) and for taxable years beginning after December 31, 1969, the term ''operating foundation'' includes a private foundation which:

(A) On or before May 26, 1969, and continuously thereafter to the close of the taxable year, operates and maintains, as its principal functional purpose, residential facilities for the long-term care, comfort, maintenance, or education of permanently and totally disabled persons, elderly persons, needy widows, or children, and

(B) Satisfies the endowment test set forth in §53.4942(b)–2 (b).

(ii) *Principal functional purpose.* For purposes of section 4942(j)(6) and this subparagraph (2), an organization's ''principal functional purpose'' is operating and maintaining residential facilities for the long-term care, comfort, maintenance, or education of permanently and totally disabled persons, elderly persons, needy widows, or children, if it is organized for the principal purpose of operating and maintaining such residential facilities and is primarily engaged directly in the operation and maintenance of those facilities. An organization will be treated as being primarily engaged directly in the operation and maintenance of the described residential facilities if at least 50% of the qualifying distributions (as defined in §53.4942(a)–3(a)(2)) normally made by the organization are expended for the operation and maintenance of the facilities.

(b) *Active conduct of activities constituting the exempt purpose*—(1) *In general.* For purposes of this section, except as provided in subparagraph (2) or (3) of this paragraph, qualifying distributions are not made by a foundation ''directly for the active conduct of activities constituting its charitable, educational, or other similar exempt purpose'' unless such qualifying distributions are used by the foundation itself, rather than by or through one or more grantee organizations which receive such qualifying distributions directly or indirectly from such foundation. Thus, grants made to other organizations to assist them in conducting activities which help to accomplish their charitable, educational, or other similar exempt purpose are considered an indirect, rather than direct, means of carrying out activities constituting the charitable, educational, or other similar exempt purpose of the grantor foundation, regardless of the fact that the exempt activities of the grantee organization may assist the grantor foundation in carrying out its own exempt activities. However, amounts paid to acquire or maintain assets which are used directly in the conduct of the foundation's exempt activities, such as the operating assets of a museum, public park, or historic site, are considered direct expenditures for the active conduct of the foundation's exempt activities. Likewise, administrative expenses (such as staff salaries and traveling expenses) and other operating costs necessary to conduct the foundation's exempt activities (regardless of whether they are ''directly for the active conduct'' of such exempt activities) shall be treated as qualifying distributions expended directly for the active conduct of such exempt activities if such expenses and costs are reasonable in amount. Conversely, administrative expenses and operating costs which are not attributable to exempt activities, such as expenses in connection with the production of investment income, are not treated as such qualifying distributions. Expenses attributable to both exempt and nonexempt

activities shall be allocated to each such activity on a reasonable and consistently applied basis. Any amount set aside by a foundation for a specific project, such as the acquisition and restoration, or construction, of additional buildings or facilities which are to be used by the foundation directly for the active conduct of the foundation's exempt activities, shall be deemed to be qualifying distributions expended directly for the active conduct of the foundation's exempt activities if the initial setting aside of the funds constitutes a set-aside within the meaning of paragraph (b) of § 53.4942(a)–3.

(2) *Payments to individual beneficiaries*—(i) *In general.* If a foundation makes or awards grants, scholarships, or other payments to individual beneficiaries (including program related investments within the meaning of section 4944(c) made to individuals or corporate enterprises) to support active programs conducted to carry out the foundation's charitable, educational, or other similar exempt purpose, such grants, scholarships, or other payments will be treated as qualifying distributions made directly for the active conduct of exempt activities for purposes of paragraph (a) of this section only if the foundation, apart from the making or awarding of the grants, scholarships, or other payments, otherwise maintains some significant involvement (as defined in subdivision (ii) of this subparagraph) in the active programs in support of which such grants, scholarships, or other payments were made or awarded. Whether the making or awarding of grants, scholarships, or other payments constitutes qualifying distributions made directly for the active conduct of the foundation's exempt activities is to be determined on the basis of the facts and circumstances of each particular case. The test applied is a qualitative, rather than a strictly quantitative, one. Therefore, if the foundation maintains a significant involvement (as defined in subdivision (ii) of this subparagraph) it will not fail to meet the general rule of subparagraph (1) of this paragraph solely because more of its funds are devoted to the making or awarding of grants, scholarships, or other payments than to the active programs which such grants, scholarships, or other payments support. However, if a foundation does no more than select, screen, and investigate applicants for grants or scholarships, pursuant to which the recipients perform their work or studies alone or exclusively under the direction of some other organization, such grants or scholarships will not be treated as qualifying distributions made directly for the active conduct of the foundation's exempt activities. The administrative expenses of such screening and investigation (as opposed to the grants or scholarships themselves) may be treated as qualifying distributions made directly for the active conduct of the foundation's exempt activities.

(ii) *Definition.* For purposes of this subparagraph, a foundation will be considered as maintaining a ''significant involvement'' in a charitable, educational, or other similar exempt activity in connection with which grants, scholarships, or other payments are made or awarded if:

(A) An exempt purpose of the foundation is the relief of poverty or human distress, and its exempt activities are designed to ameliorate conditions among a poor or distressed class of persons or in an area subject to poverty or national disaster (such as providing food or clothing to indigents or residents of a disaster area), the making or awarding of the grants or other payments to accomplish such exempt purpose is direct and without the assistance of an intervening organization or agency, and the foundation maintains a salaried or voluntary staff of administrators, researchers, or other personnel who supervise and direct the activities described in this subdivision (A) on a continuing basis; or

(B) The foundation has developed some specialized skills, expertise, or involvement in a particular discipline or substantive area (such as scientific or medical research, social work, education, or the social sciences), it maintains a salaried staff of administrators, researchers, or other personnel who supervise or conduct programs or activities which support and advance the foundation's work in its particular area of interest, and, as a part of such

programs or activities, the foundation makes or awards grants, scholarships, or other payments to individuals to encourage and further their involvement in the foundation's particular area of interest and in some segment of the programs or activities carried on by the foundation (such as grants under which the recipients, in addition to independent study, attend classes, seminars, or conferences sponsored or conducted by the foundation, or grants to engage in social work or scientific research projects which are under the general direction and supervision of the foundation).

(3) *Payment of section 4940 tax.* For purposes of section 4942(j)(3) (A) and (B)(ii), payment of the tax imposed upon a foundation under section 4940 shall be considered a qualifying distribution which is made directly for the active conduct of activities constituting the foundation's charitable, educational, or other similar exempt purpose.

(c) *Substantially all.* For purposes of this section, the term ''substantially all'' shall mean 85 percent or more. Thus, if a foundation makes qualifying distributions directly for the active conduct of activities constituting its charitable, educational, or other similar exempt purpose in an amount equal to at least 85 percent of its adjusted net income, it will be considered as satisfying the income test described in this section even if it makes grants to organizations or engages in other activities with the remainder of its adjusted net income and with other funds. In determining whether the amount of qualifying distributions made directly for the active conduct of such exempt activities equals at least 85 percent of a foundation's adjusted net income, a foundation is not required to trace the source of such expenditures to determine whether they were derived from income or from contributions.

(d) *Examples.* The provisions of this section may be illustrated by the following examples. It is assumed that none of the organizations described in these examples is described in section 509(a) (1), (2), or (3).

Example 1. N, an exempt museum described in section 501(c)(3), was founded by the gift of an endowment from a single contributor. N uses 90 percent of its adjusted net income to operate the museum. If N satisfies one of the tests set forth in §53.4942(b)–2 it may be classified as an operating foundation since substantially all of the qualifying distributions made by N are used directly for the active conduct of N's exempt activities within the meaning of paragraph (b)(1) of this section.

Example 2. M, an exempt organization described in section 501(c)(3), was created to improve conditions in a particular urban ghetto. M receives its funds primarily from a limited number of wealthy contributors interested in helping carry out its exempt purpose. M's program consists of making a survey of the problems of the ghetto to determine the areas in which its funds may be applied most effectively. Approximately 10 percent of M's adjusted net income is used to conduct this survey. The balance of its income is used to make grants to other nonprofit organizations doing work in the ghetto in those areas determined to have the greatest likelihood of resulting in improved conditions. Under these circumstances, since only 10 percent of M's adjusted net income may be considered as constituting qualifying distributions made directly for the active conduct of M's exempt activities, M cannot qualify as an operating foundation.

Example 3. Assume the facts as stated in example (2), except that M uses the remaining 90 percent of its adjusted net income for the following purposes: (1) M maintains a salaried staff of social workers and researchers who analyze its surveys and make recommendations as to methods for improving ghetto conditions; (2) M makes grants to independent social scientists who assist in these analyses and recommendations; (3) M publishes periodic reports indicating the results of its surveys and recommendations; (4) M makes grants to social workers and others who act as advisers to nonprofit organizations, as well as small business enterprises, functioning in the community (these advisers acting under the general direction of M attempt to implement M's recommendations through their advice and assistance to the nonprofit organizations and small business enterprises); and (5) M makes grants to other social scientists who study and report on the success of the various enterprises which attempt to implement M's recommendations. Under these circumstances, M satisfies the requirements of paragraph (b) (2) of this section, and the various grants it makes constitute qualifying distributions made directly for the active conduct of its exempt activities. Thus, if M satisfies one of the tests set forth in §53.4942(b)–2 it may be classified as an operating foundation.

Example 4. P, an exempt educational organization described in section 501(c)(3), was created for the purpose of training teachers for institutions of higher education. Each

year P awards a substantial number of fellowships to students for graduate study leading toward their M.A. or Ph. D. degrees. The applicants for these fellowships are carefully screened by P's staff, and only those applicants who indicate a strong interest in teaching in colleges or universities are chosen. P publishes and circulates various pamphlets encouraging a development of interest in college teaching and describing its fellowships. P also conducts annual summer seminars which are attended by its fellowship recipients, its staff, consultants, and other interested parties. The purpose of these seminars is to foster and encourage the development of college teaching. P publishes a report of the seminar proceedings along with related studies written by those who attended. Despite the fact that a substantial portion of P's adjusted net income is devoted to granting fellowships, its commitment to encouraging individuals to become teachers at institutions of higher learning, its maintenance of a staff and programs designed to further this purpose, and the granting of fellowships to encourage involvement both in its own seminars and in its exempt purpose indicate a significant involvement by P beyond the mere granting of fellowships. Thus, the fellowship grants made by P constitute qualifying distributions made directly for the active conduct of P's exempt activities within the meaning of paragraph (b) (2) of this section.

Example 5. Q, an exempt organization described in section 501(c) (3), is composed of professional organizations interested in different branches of one academic discipline. Q trains its own professional staff, conducts its own program of research, selects research topics, screens and investigates grant recipients, makes grants to those selected, and sets up and conducts conferences and seminars for the grantees. Q has particular knowledge and skill in the given discipline, carries on activities to advance its study of that discipline, and makes grants to individuals to enable them to participate in activities which it conducts in carrying out its exempt purpose. Under these circumstances, Q's grants constitute qualifying distributions made directly for the active conduct of Q's exempt activities within the meaning of paragraph (b) (2) of this section.

Example 6. R, an exempt medical research organization described in section 501 (c) (3), was created to study and perform research concerning heart disease. R has its own research center in which it carries on a broad number of research projects in the field of heart disease with its own professional staff. Physicians and scientists who are interested in special projects in this area present the plans for their projects to R. The directors of R study these plans and decide if the project is feasible and will further the work being done by R. If it is, R makes a grant to the individual to enable him to carry out his project, either at R's facilities or elsewhere. Reports of the progress of the project are made periodically to R, and R exercises a certain amount of supervision over the project. The resulting findings of these projects are usually published by R. Under these circumstances, the grants made by R constitute qualifying distributions made directly for the active conduct of R's exempt activities within the meaning of paragraph (b) (2) of this section.

Example 7. S, an exempt organization described in section 501(c) (3), maintains a large library of manuscripts and other historical reference material relating to the history and development of the region in which the collection is located. S makes a limited number of annual grants to enable post-doctoral scholars and doctoral candidates to use its library. Sometimes S obtains the right to publish the scholar's work, although this is not a prerequisite to the receipt of a grant. The primary criterion for selection of grant recipients is the usefulness of the library's resources to the applicant's field of study. Under these circumstances, the grants made by S constitute qualifying distributions made directly for the active conduct of S's exempt activities within the meaning of paragraph (b) (2) of this section.

Example 8. T, an exempt charitable organization described in section 501(c)(3), was created by the members of one family for the purpose of relieving poverty and human suffering. T has a large salaried staff of employees who operate offices in various areas throughout the country. Its employees make gifts of food and clothing to poor persons in the area serviced by each office. On occasion, T also provides temporary relief in the form of food and clothing to persons in areas stricken by natural disasters. If conditions improve in one poverty area, T transfers the resources of the office in that area to another poverty area. Under these circumstances, the gifts of food and clothing made by T constitute qualifying distributions made directly for the active conduct of T's exempt activities within the meaning of paragraph (b) (2) of this section.

Example 9. U, an exempt scientific organization described in section 501(c) (3), was created for the principal purpose of studying the effects of early childhood brain damage. U conducts an active and continuous research program in this area through a salaried staff of scientists and physicians. As part of its research program, U awards scholarships to young people suffering mild brain damage to enable them to attend special schools equipped to handle such problems. The recipients are periodically tested to determine the effect of such schooling upon them. Under these circumstances, the scholarships awarded by U constitute qualifying distributions made directly for the active

conduct of U's exempt activities within the meaning of paragraph (b) (2) of this section.

Example 10. O, an exempt charitable organization described in section 501(c) (3), was created for the purpose of giving scholarships to children of the employees of X Corporation who meet the standards set by O. O not only screens and investigates each applicant to make sure that he complies with the academic and financial requirements set for scholarship recipients, but also administers an examination which each applicant must take—90 percent of O's adjusted net income is used in awarding these scholarships to the chosen applicants. O does not conduct any activities of an educational nature on its own. Under these circumstances, O is not using substantially all of its adjusted net income directly for the active conduct of its exempt activities within the meaning of paragraph (b) of this section. Thus, O is not an operating foundation because it fails to satisfy the income test set forth in paragraph (a) of this section.

[T.D. 7249, 38 FR 768, Jan. 4, 1973, as amended by T.D. 7718, 45 FR 58520, Sept. 4, 1980; 46 FR 11254, Feb. 6, 1981; T.D. 7878, 48 FR 11943, Mar. 22, 1983]

§ 53.4942(b)–2 Alternative tests.

(a) *Assets test*—(1) *In general.* A private foundation will satisfy the assets test under the provisions of this paragraph if substantially more than half of the foundation's assets:

(i) Are devoted directly (A) to the active conduct of activities constituting the foundation's charitable, educational, or other similar exempt purpose, (B) to functionally related businesses (as defined in paragraph (c)(3)(iii) of § 53.4942(a)–2), or (C) to any combination thereof;

(ii) Are stock of a corporation which is controlled by the foundation (within the meaning of section 368(c)) and substantially all the assets of which (within the meaning of paragraph (c) of § 53.4942(b)–1) are so devoted; or

(iii) Are in part assets which are described in subdivision (i) of this subparagraph and in part stock which is described in subdivision (ii) of this subparagraph.

(2) *Qualifying assets*—(i) *In general.* For purposes of subparagraph (1) of this paragraph, an asset is ''devoted directly to the active conduct of activities constituting the foundation's charitable, educational, or other similar exempt purpose'' only if the asset is actually used by the foundation directly for the active conduct of activities constituting its charitable, educational, or other similar exempt purpose. Thus, such assets as real estate, physical facilities or objects (such as museum assets, classroom fixtures and equipment, and research facilities), and intangible assets (such as patents, copyrights, and trademarks) will be considered qualifying assets for purposes of this paragraph to the extent they are used directly for the active conduct of the foundation's exempt activities. However, assets which are held for the production of income, for investment, or for some other similar use (for example, stocks, bonds, interest-bearing notes, endowment funds, or, generally, leased real estate) are not devoted directly to the active conduct of the foundation's exempt activities, even though the income derived from such assets is used to carry out such exempt activities. Whether an asset is held for the production of income, for investment, or for some other similar use rather than being used for the active conduct of the foundation's exempt activities is a question of fact. For example, an office building used for the purpose of providing offices for employees engaged in the management of endowment funds of the foundation is not devoted to the active conduct of the foundation's exempt activities. However, where property is used both for exempt purposes and for other purposes, if such exempt use represents 95 percent or more of the total use, such property shall be considered to be used exclusively for an exempt purpose. Property acquired by a foundation to be used in carrying out the foundation's exempt purpose may be considered as devoted directly to the active conduct of such purpose even though the property, in whole or in part, is leased for a limited period of time during which arrangements are made for its conversion to the use for which it was acquired, provided such income-producing use of the property does not exceed a reasonable period of time. Generally, 1 year shall be deemed to be a reasonable period of time for purposes of the immediately preceding sentence. Similarly, where property is leased by a foundation in carrying out its exempt purpose and where the rental income derived from

such property by the foundation is less than the amount which would be required to be charged in order to recover the cost of purchase and maintenance of such property (taking into account the deductions permitted by paragraph (d)(4) of § 53.4942(a)–2), such property shall be considered devoted directly to the active conduct of the foundation's exempt activities.

(ii) *Limitations.* (A) Assets which are held for the purpose of extending credit or making funds available to members of a charitable class (including any interest in a program related-investment, except as provided in paragraph (b)(2) of § 53.4942(b)–1) are not considered assets devoted directly to the active conduct of activities constituting the foundation's charitable, educational, or other similar exempt purpose. For example, assets which are set aside in special reserve accounts to guarantee student loans made by lending institutions will not be considered assets devoted directly to the active conduct of the foundation's exempt activities.

(B) Any amount set aside by a foundation within the meaning of paragraph (b) (1) of § 53.4942(b)–1 shall not be treated as an asset devoted directly to the active conduct of the foundation's exempt activities.

(3) *Assets held for less than a taxable year.* For purposes of this paragraph, any asset which is held by a foundation for part of a taxable year shall be taken into account for such taxable year by multiplying the fair market value of such asset (as determined pursuant to subparagraph (4) of this paragraph) by a fraction, the numerator of which is the number of days in such taxable year that the foundation held such asset and the denominator of which is the number of days in such taxable year.

(4) *Valuation.* For purposes of this paragraph, all assets shall be valued at their fair market value. Fair market value shall be determined in accordance with the rules set forth in paragraph (c)(4) of § 53.4942(a)–2, except in the case of assets which are devoted directly to the active conduct of the foundation's exempt activities and for which neither a ready market nor standard valuation methods exist (such as historical objects or buildings, certain works of art, and botanical gardens). In such cases, the historical cost (unadjusted for depreciation) shall be considered equal to fair market value unless the foundation demonstrates that fair market value is other than cost. In any case in which the foundation so demonstrates that the fair market value of an asset is other than historical cost, such substituted valuation may be used for the taxable year for which such new valuation is demonstrated and for each of the succeeding 4 taxable years if the valuation methods and procedures prescribed by paragraph (c)(4)(iv)(B) of § 53.4942 (a)–2 are followed.

(5) *Substantially more than half.* For purposes of this paragraph, the term *substantially more than half* shall mean 65 percent or more.

(6) *Examples.* The provisions of this paragraph may be illustrated by the following examples. It is assumed that none of the organizations described in these examples is described in section 509(a) (1), (2), or (3).

Example 1. W, an exempt organization described in section 501(c)(3), is devoted to the maintenance and operation of a historic area for the benefit of the general public. W has acquired and erected facilities for lodging and other visitor accommodations in such area, which W operates through a wholly owned, separately incorporated, taxable entity. These facilities comprise substantially all of the subsidiary's assets. The operation of such accommodations constitutes a functionally related business within the meaning of paragraph (c)(3)(iii) of § 53.4942(a)–2. Under these circumstances, the stock of the subsidiary will be considered as part of W's assets which may be taken into account by W in determining whether it satisfies the assets test described in this paragraph.

Example 2. M, an exempt conservation organization described in section 501(c)(3), is devoted to acquiring, preserving, and otherwise making available for public use geographically diversified areas of natural beauty. M has acquired and erected facilities for lodging and other visitor accommodations in national park areas. The operation of such accommodations constitutes a functionally related business within the meaning of paragraph (c)(3)(iii) of § 53.4942(a)–2. Therefore, M's assets which are directly devoted to such visitor accommodations may be taken into account by M in determining whether it satisfies the assets test described in this paragraph.

Example 3. P, an exempt organization described in section 501(c)(3), is devoted to acquiring and restoring historic houses. To insure that the restored houses will be kept in the restored condition, and to make the houses more readily available for public display, P rents the houses rather than sells them once they have been restored. The rental income derived by P is substantially less than the amount which would be required to be charged in order to recover the cost of purchase, restoration, and maintenance of such houses. Therefore, such houses may be taken into account by P in determining whether it satisfies the assets test described in this paragraph.

Example 4. Z, an exempt organization described in section 501(c)(3), is devoted to improving the public's understanding of Renaissance art. Z's principal assets are a number of paintings of this period which it circulates on an active and continuing basis to museums and schools for public display. These paintings constitute 80 percent of Z's assets. Under these circumstances, although Z does not have a building in which it displays these paintings, such paintings are devoted directly to the active conduct of activities constituting Z's exempt purpose. Therefore, Z has satisfied the assets test described in this paragraph.

(b) *Endowment test*—(1) *In general.* A foundation will satisfy the endowment test under the provisions of this paragraph if it normally makes qualifying distributions (within the meaning of paragraph (a)(2) of § 53.4942(a)–3) directly for the active conduct of activities constituting its charitable, educational, or other similar exempt purpose in an amount not less than two-thirds of its minimum investment return (as defined in paragraph (c) of § 53.4942(a)–2). In determining whether the amount of such qualifying distributions is not less than an amount equal to two-thirds of the foundation's minimum investment return, the foundation is not required to trace the source of such expenditures to determine whether they were derived from investment income or from contributions.

(2) *Definitions.* For purposes of this paragraph, the phrase *directly for the active conduct of activities constituting the foundation's charitable, educational, or other similar exempt purpose* shall have the same meaning as in paragraph (b) of § 53.4942(b)–1.

(3) *Example.* This paragraph may be illustrated by the following example:

Example X, an exempt organization described in section 501(c)(3) and not described in section 509(a) (1), (2), or (3), was created on July 15, 1970. X uses the cash receipts and disbursements method of accounting. For 1971, the fair market value of X's assets not described in paragraph (c) (2) or (3) of § 53.4942(a)–2 is $400,000. X makes qualifying distributions for 1971 directly for the active conduct of its exempt activities of $17,000. For 1971 two-thirds of X's minimum investment return is $16,000 (6 percent × $400,000 = $24,000; ⅔ × $24,000 = $16,000). Under these circumstances, X has satisfied the endowment test described in this paragraph for 1971. However, if X's qualifying distributions for 1971 directly for the active conduct of its exempt activities were only $15,000, X would not satisfy the endowment test for 1971, unless the fair market value of its assets not described in paragraph (c) (2) or (3) of § 53.4942(a)–2 were no greater than $375,000 (6 percent × $375,000 = $22,500; ⅔ × $22,500 = $15,000).

(c) *Support test*—(1) *In general.* A foundation will satisfy the support test under the provisions of this paragraph if:

(i) Substantially all of its support (other than gross investment income as defined in section 509(e)) is normally received from the general public and from five or more exempt organizations which are not described in section 4946(a)(1)(H) with respect to each other or the recipient foundation;

(ii) Not more than 25 percent of its support (other than gross investment income) is normally received from any one such exempt organization; and

(iii) Not more than half of its support is normally received from gross investment income.

(2) *Definitions and special rules.* For purposes of this paragraph:

(i) *Support.* The term *support* shall have the same meaning as in section 509(d).

(ii) *Substantially all.* The term *substantially all* shall have the same meaning as in paragraph (c) of § 53.4942(b)–1.

(iii) *Support from exempt organizations.* The support received from any one exempt organization may be counted towards satisfaction of the support test described in this paragraph only if the foundation receives support from no fewer than five exempt organizations. For example, a foundation which normally receives 20 percent of its support (other than gross investment income)

from each of five exempt organizations may qualify under this paragraph even though it receives no support from the general public. However, if a foundation normally received 10 percent of its support from each of three exempt organizations and the balance of its support from sources other than exempt organizations, such support could not be taken into account in determining whether the foundation had satisfied the support test set forth in this paragraph.

(iv) *Support from the general public.* ''Support'' received from an individual, or from a trust or corporation (other than an exempt organization), shall be taken into account as support from the general public only to the extent that the total amount of the support received from any such individual, trust, or corporation during the period for determining the normal sources of the foundation's support (as set forth in § 53.4942 (b)–3) does not exceed 1 percent of the foundation's total support (other than gross investment income) for such period. In applying this 1-percent limitation, all support received by the foundation from any person and from any other person or persons standing in a relationship to such person which is described in section 4946(a)(1) (C) through (G) and the regulations thereunder shall be treated as received from one person. For purposes of this paragraph, support received from a governmental unit described in section 170(c)(1) shall be treated as support received from the general public, but shall not be subject to the 1-percent limitation.

§ 53.4942(b)–3 Determination of compliance with operating foundation tests.

(a) *In general.* A foundation may satisfy the income test and either the assets, endowment, or support test by satisfying such tests for any 3 taxable years during a 4-year period consisting of the taxable year in question and the three immediately preceding taxable years or on the basis of an aggregation of all pertinent amounts of income or assets held, received, or distributed during such 4-year period. A foundation may not use one method for satisfying the income test described in paragraph (a) of § 53.4942(b)–1 and another for satisfying either the assets, endowment, or support test described in § 53.4942(b)–2. Thus, if a foundation satisfies the income test on the 3-out-of-4-year basis for a particular taxable year, it may not use the aggregation method for satisfying either the assets, endowment, or support test for such particular taxable year. However, the fact that a foundation has chosen one method for satisfying the tests under §§ 53.4942(b)–1 and 53.4942(b)–2 for 1 taxable year will not preclude it from satisfying such tests for a subsequent taxable year by the alternate method. If a foundation fails to satisfy the income test and either the assets, endowment, or support test for a particular taxable year under either the 3-out-of-4-year method or the aggregation method, it shall be treated as a nonoperating foundation for such taxable year and for all subsequent taxable years until it satisfies the tests set forth in §§ 53.4942(b)–1 and 53.4942(b)–2 for a taxable year occurring after the taxable year in which it was treated as a nonoperating foundation.

(b) *New organizations*—(1) *In general.* Except as provided in subparagraph (2) of this paragraph, an organization organized after December 31, 1969, will be treated as an operating foundation only if it has satisfied the tests set forth in §§ 53.4942(b)–1 and 53.4942(b)–2 for its first taxable year of existence. If an organization satisfies such tests for its 1st taxable year, it will be treated as an operating foundation from the beginning of such taxable year. If such is the case, the organization will be treated as an operating foundation for its 2d and 3d taxable years of existence only if it satisfies the tests set forth in §§ 53.4942(b)–1 and 53.4942(b)–2 by the aggregation method for all such taxable years that it has been in existence.

(2) *Special rule.* An organization organized after December 31, 1969, will be treated as an operating foundation prior to the end of its 1st taxable year if such organization has made a good faith determination that it is likely to satisfy the income test set forth in paragraph (a) of § 53.4942(b)–1 and one of the tests set forth in § 53.4942(b)–2 for such 1st taxable year pursuant to subparagraph (1) of this paragraph. Such a

''good faith determination'' ordinarily will be considered as made where the determination is based on an affidavit or opinion of counsel of such organization that such requirements will be satisfied. Such an affidavit or opinion must set forth sufficient facts concerning the operations and support of such organization for the Commissioner to be able to determine that such organization is likely to satisfy such requirements. An organization which, pursuant to this subparagraph, has been treated as an operating foundation for its 1st taxable year, but actually fails to qualify as an operating foundation under subparagraph (1) of this paragraph for such taxable year, will be treated as a private foundation which is not an operating foundation as of the 1st day of its 2d taxable year for purposes of making any determination under the internal revenue laws with respect to such organization. The preceding sentence shall not apply if such organization establishes to the satisfaction of the Commissioner that it is likely to qualify as an operating foundation on the basis of its 2d, 3d, and 4th taxable years. Thus, if such an organization fails to qualify as an operating foundation in its 2d, 3d, or 4th taxable year after having failed in its 1st taxable year, it will be treated as a private foundation which is not an operating foundation as of the 1st day of such 2d, 3d, or 4th taxable year in which it fails to qualify as an operating foundation, except as otherwise provided by paragraph (d) of this section. Such status as a private foundation which is not an operating foundation will continue until such time as the organization is able to satisfy the tests set forth in §§ 53.4942(b)–1 and 53.4942(b)–2 by either the 3-out-of-4-year method or the aggregation method. For the status of grants or contributions made to such an organization with respect to sections 170 and 4942, see paragraph (d) of this section.

(c) *Transitional rule for existing organizations.* An organization organized before December 31, 1969 (including organizations deemed to be so organized by virtue of the principles of paragraph (e)(2) of § 53.4942(a)–2), but which is unable to satisfy the tests under §§ 53.4942(b)–1 and 53.4942(b)–2 for its first taxable year beginning after December 31, 1969 on the basis of its operations for taxable years prior to such taxable year by either the 3-out-of-4-year method or the aggregation method, will be treated as a new organization for purposes of paragraph (b) of this section only if:

(1) The organization changes its methods of operation prior to its first taxable year beginning after December 31, 1972 to conform to the requirements of §§ 53.4942(b)–1 and 53.4942 (b)–2;

(2) The organization has made a good faith determination (within the meaning of paragraph (b) (2) of the section) that it is likely to satisfy the tests set forth in §§ 53.4942(b)–1 and 53.4942(b)–2 prior to its first taxable year beginning after December 31, 1972 on the basis of its income or assets held, received, or distributed during its taxable years beginning in 1970 through 1972; and

(3) Such good faith determination is attached to the return the organization is required to file under section 6033 for its taxable year beginning in 1972.

(d) *Treatment of contributions*—(1) *In general.* The status of grants or contributions made to an operating foundation with respect to sections 170 and 4942 will not be affected until notice of change of status of such organization is made to the public (such as by publication in the Internal Revenue Bulletin), unless the grant or contribution was made after:

(i) The act or failure to act that resulted in the organization's inability to satisfy the requirements of §§ 53.4942 (b)–1 and 53.4942(b)–2, and the grantor or contributor was responsible for, or was aware of, such act or failure to act, or

(ii) The grantor or contributor acquired knowledge that the Commissioner has given notice to such organization that it would be deleted from classification as an operating foundation.

(2) *Exception.* For purposes of subparagraph (1) (i) of this paragraph, a grantor or contributor will not be considered to be responsible for, or aware of, the act or failure to act that resulted in the grantee organization's inability to satisfy the requirements of §§ 53.4942 (b)–1 and 53.4942(b)–2 if such grantor or contributor has made his

grant or contribution in reliance upon a written statement by the grantee organization that such grant or contribution would not result in the inability of such grantee organization to qualify as an operating foundation. Such a statement must be signed by a foundation manager (as defined in section 4946(b)) of the grantee organization and must set forth sufficient facts concerning the operations and support of such grantee organization to assure a reasonably prudent man that his grant or contribution will not result in the grantee organization's inability to qualify as an operating foundation.

Subpart D—Taxes on Excess Business Holdings

AUTHORITY: Secs. 4943 and 7805, Internal Revenue Code of 1954, 68A Stat. 917, 83 Stat. 507; 26 U.S.C. 4943, 7805.

SOURCE: T.D. 7496, 42 FR 46285, Sept. 15, 1977, unless otherwise noted.

§ 53.4943–1 General rule; purpose.

Generally, under section 4943, the combined holdings of a private foundation and all disqualified persons (as defined in section 4946(a)) in any corporation conducting a business which is not substantially related (aside from the need of the foundation for income or funds or the use it makes of the profits derived) to the exempt purposes of the foundation are limited to 20 percent of the voting stock in such corporation. In addition, the combined holdings of a private foundation and all disqualified persons in any unincorporated business (other than a sole proprietorship) which is not substantially related (aside from the need of the foundation for income or funds or the use it makes of the profits derived) to the exempt purposes of such foundation are limited to 20 percent of the beneficial or profits interest in such business. In the case of a sole proprietorship which is not substantially related (within the meaning of the preceding sentence), section 4943 provides that a private foundation shall have no permitted holdings. These general provisions are subject to a number of exceptions and special provisions which will be described in following sections.

§ 53.4943–2 Imposition of tax on excess business holdings of private foundations.

(a) *Imposition of initial tax*—(1) *In general*—(i) *Initial tax*. Section 4943(a)(1) imposes an initial excise tax (the ''initial tax'') on the excess business holdings of a private foundation for each taxable year of the foundation which ends during the taxable period defined in section 4943(d)(2). The amount of such tax is equal to 5 percent of the total value of all the private foundation's excess business holdings in each of its business enterprises. In determining the value of the excess business holdings of the foundation subject to tax under section 4943, the rules set forth in §§ 20.2031–1 through 20.2031–3 of this chapter (Estate Tax Regulations) shall apply.

(ii) *Disposition of certain excess business holdings within ninety days*. In any case in which a private foundation acquires excess business holdings, other than as a result of a purchase by the foundation, the foundation shall not be subject to the taxes imposed by section 4943, but only if it disposes of an amount of its holdings so that it no longer has such excess business holdings within 90 days from the date on which it knows, or has reason to know, of the event which caused it to have such excess business holdings. Similarly, a private foundation shall not be subject to the taxes imposed by section 4943 because of its purchase of holdings where it did not know, or have reason to know of prior acquisitions by disqualified persons, but only if the foundation disposes of its excess holdings within the 90-day period described previously, and its purchase would not have created excess business holding but for such prior acquisitions by disqualified persons. In determining whether for purposes of this (ii) the foundation has disposed of such excess business holdings during such 90-day period, any disposition of holdings, by a disqualified person during such period shall be disregarded.

(iii) *Extension of ninety day period*. The period described in paragraph (a)(1)(ii) of this section, during which no tax shall be imposed under section 4943, shall be extended to include the period during which a foundation is

prevented by federal or state securities laws from disposing of such excess business holdings.

(iv) *Effect of disposition subject to material restrictions.* If a private foundation disposes of an interest in a business enterprise but imposes any material restrictions or conditions that prevent the transferee from freely and effectively using or disposing of the transferred interest, then the transferor foundation will be treated as owning such interest until all such restrictions or conditions are eliminated (regardless of whether the transferee is treated for other purposes of the Code as owning such interest from the date of the transfer). However, a restriction or condition imposed in compliance with federal or state securities laws, or in accordance with the terms or conditions of the gift or bequest through which such interest was acquired by the foundation, shall not be considered a material restriction or condition imposed by a private foundation.

(v) *Foundation knowledge of acquisitions made by disqualified persons.* (A) For purposes of paragraph (a)(1)(ii) of this section, whether a private foundation will be treated as knowing, or having reason to know, of the acquisition of holdings by a disqualified person will depend on the facts and circumstances of each case. Factors which will be considered relevant to a determination that a private foundation did not know or had no reason to know of an acquisition are: the fact that it did not discover acquisitions made by disqualified persons through the use of procedures reasonably calculated to discover such holdings; the diversity of foundation holdings; and the existence of large numbers of disqualified persons who have little or no contact with the foundation or its managers.

(B) The provisions of paragraph (a)(1)(v)(A) of this section may be illustrated by the following example:

Example. By the fifteenth day of the fifth month after the close of each taxable year, the F Foundation sends to each foundation manager, substantial contributor, person holding more than a 20% interest (as described in section 4946(a)(1)(C) in a substantial contributor, and foundation described in section 4946(a)(1)(H), a questionnaire asking such persons to list all holdings, actual or constructive, in each business enterprise in which F had holdings during the taxable year in excess of those permitted by the 2 percent de minimis rule of section 4943(c)(2)(C). In preparing the list of such enterprises, F takes into account its constructive holdings only if, during the taxable year, F (along with all related foundations described in section 4946(a)(1)(H)) owned over 2% of the voting stock, profits interest or beneficial interest in the entity actually owning the holdings constructively held by F. The questionnaire asks each such person to list the holdings in such enterprises of any persons who, because of their relationship to such disqualified person, were themselves disqualified persons (*i.e.*, members of the family (as defined in section 4946(d)), and any corporations, partnerships, trusts and estates described in section 4946(a)(1) (E) through (G) in which such person, or members of his family, had an interest). The questionnaire asks that constructive holdings be listed only if, during the taxable year, the disqualified person owned over 2% of the voting stock, profits interest or beneficial interest in the entity actually owning the holdings constructively held by such person. (Thus a disqualified person owning less than 2% of a mutual fund is not required to list his attributed share of all the securities in the portfolio of the fund.) If no response to the questionnaire is received, the foundation seeks the information requested by the questionnaire by mailing a second (but not a third) questionnaire. If a questionnaire which is returned to the foundation indicates that certain information was unavailable to the person completing the questionnaire, the foundation seeks that information directly. For example, if a disqualified person indicates that he could not find out whether a corporation described in section 4946(a)(1)(E) had holdings in the enterprise listed in the questionnaire, the foundation seeks to obtain this information directly from the corporation by mailing it a questionnaire. In such a case F may be found not to have reason to know of the acquisition of holdings by a disqualified person.

(vi) *Holdings acquired other than by purchases.* See section 4943(c)(6) and § 53.4943–6 for rules relating to the acquisition of certain holdings other than by purchase by the foundation or a disqualified person.

(2) *Special rules.* In applying subparagraph (1) of this paragraph, the tax imposed by section 4943(a)(1):

(i) Shall be imposed on the last day of the private foundation's taxable year, but

(ii) The amount of such tax and the value of the excess business holdings subject to such tax shall be determined

with respect to the foundation's holdings (based upon voting power, profits or beneficial interest, or value, whichever is applicable) in any business enterprise as of that day during the foundation's taxable year when the foundation's excess holdings in such enterprise were the greatest.

In applying subdivision (ii) of this subparagraph, if a foundation's excess business holdings in a business enterprise which constitute such foundation's greatest excess holdings in such enterprise for any taxable year are maintained for 2 or more days during such taxable year, the value of such excess holdings which is subject to tax under section 4943(a)(1) shall be the greatest value of such excess holdings in such enterprise as of any day on which such greatest excess holdings are maintained during such taxable year.

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

Example 1. Y is a private foundation reporting on a calendar year basis. On January 1, 1973, Y has 20 shares of common stock in corporation N, of which five shares constitute excess business holdings. On June 1, 1973, Y disposes of such five shares; however, because of additional acquisitions of N common stock on such date by disqualified persons with respect to Y, the remaining 15 shares of N common stock held by Y now constitute excess business holdings. There are no further acquisitions or dispositions of N common stock during 1973 by Y or its disqualified persons. Although Y's greatest holdings in N during 1973 are held between January 1, 1973, and May 31, 1973, Y's greatest excess holdings in N during 1973 are held between June 1, 1973, and December 31, 1973. Therefore, the tax specified in section 4943(a)(1) shall be computed on the basis of the greatest value of such greatest excess holdings as of any day between June 1 and December 31, 1973.

Example 2. X is a private foundation reporting on a calendar year basis. On January 1, 1972, X has 100 shares of common stock in M corporation which are excess business holdings. On such date each share of M common stock has a fair market value of $100. On February 28, 1972, in an effort to dispose of such excess business holdings, X sells 70 shares of M common stock for $120 per share (the fair market value of each share on such date) to A, an individual who is not a disqualified person within the meaning of section 4946(a). The value of $120 per share is the highest fair market value between January 1 and February 28, 1972. X disposes of no more stock in M for the reminder of calendar year 1972. On December 31, 1972, the fair market value of each share of M common stock is $80. X calculates its tax on its excess business holdings in M for 1972 as follows:

100 shares of M common stock times $120 fair market value per share as of Feb. 28, 1972	$12,000
$12,000 multiplied by rate of tax (percent)	5
Amount of tax on X foundation's excess business holdings for 1972	$600

Example 3. Assume the same facts as in Example (2) except that the sale of X to A occurs on January 7, 1973, when the fair market value of each share of M corporation common stock equals $70. A value of $100 per share is the highest fair market value of the M common stock between January 1 and January 7, 1973. On May 9, 1973, X for the first time has excess business holdings in N corporation in the form of 200 shares of N common stock. The value per share of N common stock on May 9, 1973, equals $200. X makes no disposition of the N common stock during 1973, and the value of each share of N common stock as of December 31, 1973 equals $250 (the highest value of N common stock during 1973). X calculates its tax on its excess business holdings in both M and N for 1973 as follows:

100 shares of M common stock times $100 fair market value per share	$10,000
$250 fair market value per share	$50,000
Total	$60,000
Total	$60,000
$60,000 multiplied by rate of tax (percent)	5
Amount of tax on X foundation's excess business holdings for 1973	$3,000

(b) *Additional tax*. In any case in which the initial tax is imposed under section 4943(a) with respect to the holdings of a private foundation in any business enterprise, if, at the close of the taxable period (as defined in section 4943(d)(2) and § 53.4943–9) with respect to such holdings the foundation still has excess business holdings in such enterprise, there is imposed a tax under section 4943(b) equal to 200 percent of the value of such excess holdings as of the last day of the taxable period.

[T.D. 7496, 42 FR 46285, Sept. 15, 1977, as amended by T.D. 8084, 51 FR 16302, May 2, 1986]

§ 53.4943–3 Determination of excess business holdings.

(a) *Excess business holdings*—(1) *In general*. For purposes of section 4943, the term ''excess business holdings'' means, with respect to the holdings of any private foundation in any business enterprise (as described in section

4943(d)(4)), the amount of stock or other interest in the enterprise which, except as provided in § 53.4943–2(a)(1), the foundation, or a disqualified person, would have to dispose of, or cause the disposition of, to a person other than a disqualified person (as defined in section 4946(a)) in order for the remaining holdings of the foundation in such enterprise to be permitted holdings (as defined in paragraphs (b) and (c) of this section). If a private foundation is required by section 4943 and the regulations thereunder to dispose of certain shares of a class of stock in a particular period of time and other shares of the same class of stock in a shorter period of time, any stock disposed of shall be charged first against those dispositions which must be made in such shorter period.

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

Example. Corporation X has outstanding 100 shares of voting stock, with each share entitling the holder thereof to one vote. F, a private foundation, possesses 20 shares of X voting stock representing 20 percent of the voting power in X. Assume that the permitted holdings of F in X under paragraph (b)(1) of this section are 11 percent of the voting stock in X. F, therefore, possesses voting stock in X representing a percentage of voting stock in excess of the percentage permitted by such paragraph. Such excess percentage is 9 percent of the voting stock in X, determined by subtracting the percentage of voting stock representing the permitted holdings of F in X (*i.e.*, 11 percent) from the percentage of voting stock held by F in X (I.E., 20 percent). (20% − 11% = 9%). The excess business holdings of F in X are an amount of voting stock representing such excess percentage, or 9 shares of X voting stock (9 percent of 100).

(b) *Permitted holdings in an incorporated business enterprise*—(1) *In general*—(i) *Permitted holdings defined*. Except as otherwise provided in section 4943(c) (2) and (4), the permitted holdings of any private foundation in an incorporated business enterprise (including a real estate investment trust, as defined in section 856) are:

(A) 20 percent of the voting stock in such enterprise reduced (but not below zero) by

(B) The percentage of voting stock in such enterprise actually or constructively owned by all disqualified persons.

(ii) *Voting stock*. For purposes of this section, the percentage of voting stock held by any person in a corporation is normally determined by reference to the power of stock to vote for the election of directors, with treasury stock and stock which is authorized but unissued being disregarded. Thus, for example, if a private foundation holds 20 percent of the shares of one class of stock in a corporation, which class is entitled to elect three directors, and such foundation holds no stock in the other class of stock, which is entitled to elect five directors, such foundation shall be treated as holding 7.5 percent of the voting stock because the class of stock it holds has 37.5 percent of such voting power, by reason of being able to elect three of the eight directors, and the foundation holds one-fifth of the shares of such class (20 percent of 37.5 percent is 7.5 percent). The fact that extraordinary corporate action (e.g., charter or by-law amendments) by a corporation may require the favorable vote of more than a majority of the directors, or of the outstanding voting stock, of such corporation shall not alter the determination of voting power of stock in such corporation in accordance with the two preceding sentences.

(2) *Nonvoting stock as permitted holdings*—(i) *In general*. In addition to those holdings permitted by paragraph (b)(1) of this section, the permitted holdings of a private foundation in an incorporated business enterprise shall include any share of nonvoting stock in such enterprise held by the foundation in any case in which all disqualified persons hold, actually or constructively, no more than 20 percent (35 percent where third persons have effective control as defined in paragraph (b)(3)(ii) of this section) of the voting stock in such enterprise. All equity interests which do not have voting power attributable to them shall, for purposes of section 4943, the classified as nonvoting stock. For this purpose, evidences of indebtedness (including convertible indebtedness), and warrants and other options or rights to acquire stock shall not be considered equity interests.

(ii) *Stock with contingent voting rights and convertible nonvoting stock.* Stock carrying voting rights which will vest only when conditions, the occurrence of which are indeterminate, have been met, such as preferred stock which gains such voting rights only if no dividends are paid thereon, will be treated as nonvoting stock until the conditions have occurred which cause the voting rights to vest. When such rights vest, the stock will be treated as voting stock that was acquired other than by purchase, but only if the private foundation or disqualified persons had no control over whether the conditions would occur. Similarly, nonvoting stock which may be converted into voting stock will not be treated as voting stock until such conversion occurs. For special rules where stock is acquired other than by purchase, see section 4943(c)(6) and the regulations thereunder.

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

Example. Assume that F, a private foundation, holds 10 percent of the single class of voting stock of corporation X, and owns 20 shares of nonvoting stock in X. Assume further that A and B, the only disqualified persons with respect to F, hold 10 percent of the voting stock of X. Under the provisions of paragraph (b)(1) of this section the 10 percent of X voting stock held by F will be classified as permitted holdings of F in X since 20 percent less the percentage of voting stock held by A and B in X is 10 percent. In addition, under the provisions of this (2), the 20 shares of X nonvoting stock will qualify as permitted holdings of F in X since the percentage of voting stock held by A and B in X is no greater than 20 percent.

(3) *Thirty-five-percent rule where third person has effective control of enterprise*—(i) *In general.* Except as provided in section 4943(c)(4), paragraph (b)(1) of this section shall be applied by substituting 35 percent for 20 percent if:

(A) The private foundation and all disqualified persons together do not hold, actually or constructively, more than 35 percent of the voting stock in the business enterprise, and

(B) The foundation establishes to the satisfaction of the Commissioner that effective control (as defined in paragraph (b)(3)(ii) of this section) of the business enterprise is in one or more persons (other than the foundation itself) who are not disqualified persons.

(ii) *''Effective control'' defined.* For purposes of this subparagraph, the term ''effective control'' means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a business enterprise, whether through the ownership of voting stock, the use of voting trusts, or contractual arrangements, or otherwise. It is the reality of control which is decisive and not its form or the means by which it is exercisable. Thus, where a minority interest held by individuals who are not disqualified persons has historically elected the majority of a corporation's directors, effective control is in the hands of those individuals.

(4) *Two percent de minimis rule*—(i) *In general.* Under section 4943(c)(2)(C), a private foundation is not treated as having excess business holdings in any incorporated business enterprise in which it (together with all other private foundations (including trusts described in section 4947(a)(2)) which are described in section 4946(a)(1)(H)) actually or constructively owns not more than 2 percent of the voting stock and not more than 2 percent in value of all outstanding shares of all classes of stock. If, however, the private foundation, together with all other private foundations which are described in section 4946(a)(1)(H), actually or constructively owns more than 2 percent of either the voting stock or the value of the outstanding shares of all classes of stock in any incorporated business enterprise, all the stock in such business enterprise classified as excess business holding under section 4943 is treated as excess business holdings. For purposes of this paragraph, any stock owned by a private foundation which is treated as held by a disqualified person under section 4943(c)(4)(B), (5), or (6) shall be treated as actually owned by the private foundation. See paragraph (b)(1) of § 53.4941(d)–4 for the determination of excess business holdings without regard to section 4943(c)(2)(C) for purposes of applying section 101(C)(2)(B) of the Tax Reform Act of 1969 (83 Stat. 533).

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

Example 1. F, a private foundation, owns 1 percent of the single class of voting stock and 1 percent in value of all the outstanding shares of all classes of stock in X corporation. No other private foundation described in section 4946(a)(1)(H) owns any stock in X. All of the stock owned by F in X would be excess business holdings under section 4943 (c)(1) if section 4943(c)(2)(C) were inapplicable. F owns no no other shares of stock in X. Since F owns more than 2 percent of the voting stock and no more than 2 percent in value of all outstanding shares of all classes of stock in X, under section 4943(c)(2)(C) none of the stock in X owned by F is treated as excess business holdings.

Example 2. Assume the facts as stated in Example (1), except that F and T, a controlled private foundation under section 4946 (a)(1)(H), together own 1 percent of all the voting stock and 1 percent in value of all the outstanding shares of all classes of stock in X. All of the stock in X owned by F and T would be excess business holdings under section 4943(c)(1) if section 4943(c)(2)(C) were inapplicable. Since F and T together owned no more than 2 percent of the voting stock and no more than 2 percent in value of all outstanding shares of all classes of stock in X, under section 4943(c)(2)(C) none of the stock in X owned by either F or T is treated as excess business holdings.

Example 3. Assume the facts as stated in Example (1), except that F owns 3 percent of the voting stock in X, 2 percent of which is treated as held by P, a disqualified person of F, under section 4943(c)(4)(B). Under subdivision (i) of this subparagraph, the 2 percent of the stock in X owned by F which is treated as held by P under section 4943(c)(4)(B) is treated as actually owned by F for purposes of section 4943(c)(2)(C). Consequently, all of the X stock owned by F is treated as excess business holdings under section 4943(c)(2)(C). However, only 1 percent of the stock in X is subject to tax under section 4943(a), since the other 2 percent is treated as owned by a disqualified person under section 4943(c)(4)(B) for purposes of determining the tax upon F under section 4943(a).

(c) *Permitted holdings in an unincorporated business enterprise*—(1) *In general.* The permitted holdings of a private foundation in any business enterprise which is not incorporated shall, subject to the provisions of subparagraphs (2), (3), and (4) of this paragraph, be determined under the principles of paragraph (b) of this section.

(2) *Partnership or joint venture.* In the case of a partnership (including a limited partnership) or joint venture. the terms ''profits interest'' and ''capital interest'' shall be substituted for ''voting stock'' and ''nonvoting stock,'' respectively, wherever those terms appear in paragraph (b) of this section. The interest in profits of such foundation (or such disqualified person) shall be determined in the same manner as its distributive share of partnership taxable income. See section 704(b) (relating to the determination of the distributive share by the income or loss ratio) and the regulations thereunder. In the absence of a provision in the partnership agreement, the capital interest of such foundation (or such disqualified person) in a partnership shall be determined on the basis of its interest in the assets of the partnership which would be distributable to such foundation (or such disqualified person) upon its withdrawal from the partnership, or upon liquidation of the partnership, whichever is the greater.

(3) *Sole proprietorship.* For purposes of section 4943, a private foundation shall have no permitted holdings in a sole proprietorship. In the case of a transfer by a private foundation of a portion of a sole proprietorship, see paragraph (c)(2) of this section (relating to permitted holdings in partnerships). For the treatment of a private foundation's ownership of a sole proprietorship prior to May 26, 1969, see § 53.4943–4.

(4) *Trusts and other unincorporated business enterprises*—(i) *In general.* In the case of any unincorporated business enterprise which is not described in paragraph (c) (2) or (3) of this section, the term ''beneficial interest'' shall be substituted for ''voting stock'' wherever the term appears in paragraph (b) of this section. Any and all references to nonvoting stock in paragraph (b) of this section shall be inapplicable with respect to any unincorporated business enterprise described in this subparagraph.

(ii) *Trusts.* For purposes of section 4943, the beneficial interest of a private foundation or any disqualified person in a trust shall be the beneficial remainder interest of such foundation or person determined as provided in paragraph (b) of § 53.4943–8.

(iii) *Other unincorporated business enterprises.* For purposes of section 4943,

the beneficial interest of a private foundation or any disqualified person in an unincorporated business enterprise (other than a trust or an enterprise described in paragraph (c) (2) or (3) of this section) includes any right to receive a portion of distributions of profits of such enterprise, and, if the portion of distributions is not fixed by an agreement among the participants, any right to receive a portion of the assets (if any) upon liquidation of the enterprise, except as a creditor or employee. For purposes of this subparagraph, a right to receive distributions of profits includes a right to receive any amount from such profits (other than as a creditor or employee), whether as a sum certain or as a portion of profits realized by the enterprise. Where there is no agreement fixing the rights of the participants in such enterprise, the interest of such foundation (or such disqualified person) in such enterprise shall be determined by dividing the amount of all equity investments or contributions to the capital of the enterprise made or obligated to be made by such foundation (or such disqualified person) by the amount of all equity investments or contributions to capital made or obligated to be made by all participants in the enterprise.

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

Example 1. Corporation X has outstanding 100 shares of voting stock, with each share entitling the holder thereof to one vote. Assume that F, a private foundation, possesses 30 shares of X voting stock, and that A and B, the only disqualified persons with respect to F, together own 10 shares of X voting stock. The excess business holdings of F in X are 20 shares of X voting stock, determined as follows:

(*i*) *Determination of voting stock percentages*	
(a) Total number of outstanding votes in X	100
(b) Total number of votes in X held by F	30
(c) Total number of votes in X held by A and B	10
(d) Percentage of voting stock in X held by F (item (b) divided by item (a)) (percent)	30
(e) Percentage of voting stock in X held by A and B (item (c) divided by item (a)) (percent)	10
(*ii*) *Determination of permitted holdings of voting stock*	
(a) Percentage of voting stock in X held by A and B (percent)	10
(b) Permitted holdings of voting stock by F in X (20 pct less item (a)) (percent)	10
(*iii*) *Determination of excess business holdings*	
(a) Percentage of voting stock in X held by F (percent)	30
(b) Permitted holdings of voting stock by F in X (percent)	10
(c) Item (a) less item (b) (percent)	20
(d) Excess business holdings of F in X (*i.e.*, an amount of X voting stock representing a percentage of voting stock equivalent to that in item (c)) (shares)	20

Example 2. F, a private foundation, is a partner in P partnership. In addition, A and B, the only disqualified persons with respect to F, are partners in P. The partnership agreement of P contains no provisions regarding the sharing of profits by, and the respective capital interests of, the partners.

(i) assume that, under section 704(b), F's distributive share of P taxable income is determined to be 20 percent. In addition, assume that under such section, A and B are determined to have a 4-percent distributive share each of P taxable income. Accordingly, F holds a 20-percent profits interest in P, and A and B hold an 8-percent profits interest in P. Assuming that the provisions of section 4943(c)(2)(B) do not apply, the permitted holdings of F in P are 12 percent of the profits interest in P, determined by subtracting the percentage of the profits interest held by A and B in P (*i.e.*, 8 percent) from 20 percent. (20 percent − 8 percent = 12 percent.) F, therefore, holds a percentage of the profits interest in P in excess of the percentage permitted by § 53.4943–3(b)(1). The excess business holdings of F in P are a percentage of the profits interest in P equivalent to such excess percentage, or 8 percent of the profits interest in P, determined by subtracting the permitted holdings of F in P (*i.e.*, 12 percent) from the percentage of the profit interest held by F in P (*i.e.*, 20 percent) (20 percent − 12 percent = 8 percent.)

(ii) Assume that, under the partnership agreement, F would be entitled to a distribution of 20 percent of P's assets upon F's withdrawal from P and to a distribution of 30 percent of P's assets upon the liquidation profits interest held by F in P (*i.e.*, 20 percent) (20 percent − 12 percent = 8 percent), of P. F, therefore, holds a 30-percent capital percentage of the assets of P distributable to F upon F's withdrawal from P, or the percentage of

such assets distributable to F upon the liquidation of P. Since the percentage of the profits interest held by A and B in P is less than 20 percent, such 30-percent capital interest will be included in the permitted holdings of F in P.

§ 53.4943–4 Present holdings.

(a) *Introduction*—(1) *Section 4943 (c)(4) in general.* (i) Paragraph (4) of section 4943(c) prescribes transition rules for a private foundation which, but for such paragraph, would have excess business holdings on May 26, 1969. Section 4943(c)(4) provides such a foundation with protection from the initial tax on excess business holdings in two ways. First, the entire interest of such a foundation in any business enterprise in which such a foundation, but for section 4943(c)(4), would have had excess business holdings on May 26, 1969, is treated under section 4943(c)(4)(B) as held by disqualified persons for a certain period of time (the ''first phase''). The effect of such treatment is to prevent a private foundation from being subject to the initial tax with respect to its May 26, 1969, interest during the first phase holding period and also to prevent the foundation from purchasing any additional business holdings in such business enterprise during such period (unless the combined holdings of the foundation and all disqualified persons fall below the 20 percent (or 35 percent, if applicable) figure prescribed by section 4943(c)(2)). Second, section 4943(c)(4)(A)(i) initially increases the percentage of permitted holdings of such a foundation to a percentage equal to the difference between:

(A) The percentage of combined holdings of the foundation and all disqualified persons in such business enterprise on May 26, 1969 (subject to a 50 percent maximum), and

(B) The percentage of holdings of all disqualified persons.

The percentage referred to in paragraph (a)(1)(i)(A) of this section is referred to in this section as the ''substituted level''. This ''substituted level'' is then reduced by the ''downward ratchet rule'' prescribed by section 4943(c)(4)(A)(ii) and paragraph (d)(3) of this section for certain dispositions by such foundation or by disqualified persons. The primary purpose of the substituted level is to indicate what the permitted holdings in such business enterprise will be immediately after the expiration of the first phase holding period. Thereafter, the permitted holdings of a private foundation itself are further limited to a maximum 25 percent interest in such business enterprise by section 4943(c)(4)(D) as soon as the combined holdings of all disqualified persons in such business enterprise exceed 2 percent (of the voting stock). If the combined holdings of all disqualified persons at no time exceed 2 percent (of the voting stock) during the 15 years following the first phase (the ''second phase''), then the substituted level is reduced to a 35 percent maximum after the second phase.

(ii) Paragraph (a)(1)(i) of this section may be illustrated by the following example:

Example. On May 26, 1969, private foundation P held a 5 percent interest in corporation X (voting stock and value). On such date disqualified persons held a 16 percent interest in X (voting stock and value). Assume that except for section 4943(c)(4), P would have had a 1 percent interest in X which would have constituted excess business holdings. Therefore, section 4943(c)(4)(B) applies and P's 5 percent interest in X is treated as held by a disqualified person during the 10-year period beginning May 26, 1969. Since the entire 21 percent held by P and disqualified persons is now treated as held by disqualified persons, P's substituted level is 21 percent and its permitted holdings are zero (21% – 21%). However, P has no excess business holdings in X, because during the 10-year period P is not treated as holding such interest. The only change in the interest in X occurs on January 2, 1972, when P disposes of 2 percent of its interest in X to A, an unrelated person. Since the interest held by P and all disqualified persons (21% – 2% = 19%) has decreased below 20 percent, P's substituted level is reduced to 20 percent and its permitted holdings are 1 percent (20% – 19%) on such date. Therefore, if the other interests in X do not change, P will not have excess business holdings if P purchases no more than an additional 1 percent interest in X.

(2) *Interaction of provisions of section 4943(c) (4), (5), and (6).* During the first phase, a private foundation may acquire additional interests in a business enterprise, other than by purchase, which are entitled to be treated as held by disqualified persons for varying holding periods under section 4943(c) (5)

or (6) (relating respectively to certain holdings acquired pursuant to the terms of a trust or will in effect on May 26, 1969, and to the 5-year period to dispose of certain gifts, bequests, etc.). In any case holdings which the private foundation disposes of shall be charged first against those holdings which it must dispose of in the shortest period in order to avoid the initial tax thereon. Further, acquisitions of a private foundation under a pre-May 27, 1969, will or trust described in section 4943(3)(5) are treated in a manner similar to the treatment of interests actually held by a private foundation on May 26, 1969. See §§ 53.4943–5 and 53.4943–6.

(b) *Present holdings in general.* (1) Section 4943(c)(4)(B) provides that any interest in a business enterprise held by a private foundation on May 26, 1969, if the foundation on such date has excess business holdings (determined without regard to section 4943(c)(4)), shall (while held by the foundation) be treated as held by a disqualified person during a first phase. Therefore, no interest of a private foundation shall be treated as held by a disqualified person under section 4943(c)(4)(B) and this section unless:

(i) The private foundation was an entity (not including a revocable trust) in existence on May 26, 1969, even though it was not then treated as a private foundation under section 509 or section 4947;

(ii) Such interest was actually or constructively owned by such entity on such date; and

(iii) Without regard to section 4943(c)(4) such entity had on such date an interest (considered in connection with the interests actually or constructively owned by all disqualified persons with respect to such entity on that date in the same business enterprise, determined as if the entity were then a private foundation) which exceeded the permitted holdings prescribed by section 4943(c) (2) or (3).

(See, however, section 4943(c)(5) and § 53.4943–5 for similar treatment for certain interests acquired by a private foundation under the terms of a trust or a will which were in effect on May 26, 1969.) If a private foundation owns an interest described by section 4943(c)(4)(B), then the length of the first phase for such an interest is prescribed by paragraph (c) of this section and shall not be affected by any interest acquired by the private foundation or any disqualified person in such business enterprise after May 26, 1969. In addition, the amount of permitted holdings in such business enterprise is prescribed by paragraph (d) of this section. An interest constructively held by a private foundation (or a disqualified person) on May 26, 1969, shall not cease to be an interest to which section 4943(c)(4) applies merely because it is later distributed to such foundation (or to such disqualified person). Nor shall an interest directly held by a private foundation (or to such disqualified person) on May 26, 1969, cease to be treated as an interest to which section 4943(c)(4) applies to the extent it remains actually or constructively held by such foundation (or such disqualified person) upon transfer of such interest, such as upon the incorporation of a sole proprietorship.

(2) The provision of this paragraph may be illustrated by the following example:

Example. A, a nonprofit research organization described in section 501(c)(3), was organized in 1966. On May 26, 1969, A held 50 percent of the stock of corporation B. For its taxable years 1970, 1971, and 1972, A is classified as an organization described in section 509(a)(2). However, for 1973 and subsequent years, A fails to satisfy the gross investment income limitation of section 509(a)(2)(B), and is thus classified as a private foundation. In such a case, section 4943(c)(4) applies, and a disqualified person shall be treated as holding A's stock in B during a first phase that begins on May 26, 1969.

(c) *First Phase holding periods*—(1) *In general.* If, on May 26, 1969, a private foundation has excess business holdings in any business enterprise (determined with regard to the 20 or 35 percent permitted holdings of section 4943(c)(2)), then all interest which such foundation holds, actually or constructively, in such enterprise on May 26, 1969, shall (while held by such foundation) be deemed held by a disqualified person during the following periods:

(i) The 20-year period beginning on May 26, 1969, if the private foundation holds, actually or constructively, more than 95 percent of the voting stock (or

more than a 95 percent profits or beneficial interest in the case of an unincorporated enterprise) in such enterprise on such date;

(ii) Except as provided in paragraph (c)(1)(i) of this section, the 15-year period beginning on May 26, 1969, if the private foundation and all disqualified persons hold, actually or constructively on such date more than 75 percent of the voting stock (or more than a 75 percent profits or beneficial interest in the case of any unincorporated enterprise) or 75 percent of the value of all outstanding shares of all classes of stock in such enterprise (or more than a 75 percent profits and capital interest in the case of a partnership or joint venture); or

(iii) The 10-year period beginning on May 26, 1969, in any case not described in paragraph (c)(1) (i) or (ii) of this section.

The 20-year, 15-year, or 10-year period described in this subdivision (whichever applies) shall, for purposes of section 4943 and this section, be known as the ''first phase.''

(2) *Sole proprietorships.* The 20-year period described in paragraph (c)(1) of this section shall apply with respect to any interest which a private foundation holds in a sole proprietorship on May 26, 1969. See paragraph (b) of this section for the effect of converting such an enterprise to a corporate, partnership, or other form.

(3) *Suspension of first-phase periods.* The 20-year, 15-year, or 10-year period described in paragraph (c)(1) of this section shall be suspended during the dependency of any judicial proceeding which is brought and diligently litigated by the private foundation and which is necessary to reform, or to excuse the foundation from compliance with, its governing instrument or any other instrument (as in effect on May 26, 1969) in order to allow disposition of any excess business holdings held by the foundation on May 26, 1969.

(4) *Election to shorten the period during which certain holdings of private foundations are treated as held by disqualified persons.* If, on May 26, 1969, the combined holdings of a private foundation and all disqualified persons in any one business enterprise are such as to make applicable the 15-year period referred to in paragraph (c)(1)(ii) of this section, and if, on such date, the foundation's holdings do not exceed 95 percent of the voting stock in such enterprise, then such 15-year period is shortened to the 10-year period referred to in paragraph (c)(1)(iii), if at any time before January 1, 1971, one or more individuals:

(i) Who are substantial contributors (as described in section 507(d)(2)), or members of the family within the meaning of section 4946(d) of one or more substantial contributors, to such private foundation, and

(ii) Who on May 26, 1969, held in the aggregate more than 15 percent of the voting stock in the enterprise, made an election in the manner described in 26 CFR 143.6 (rev. as of Apr. 1, 1974).

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

Example 1. Assume that F, a private foundation, owns, on May 26, 1969, 50 shares of voting stock in corporation X representing 50 percent of the voting power in X and 25 percent of the value of all outstanding shares of all classes of stock in X. Assume further that A and B, the only disqualified persons with respect to F, own five shares each of voting stock in X on such date. The 10 shares of voting stock in X owned by A and B together represent 10 percent of the voting power in X and 5 percent of the value of all outstanding shares of all classes of stock in X. Under the provisions of § 53.4943–3, the excess business holdings of F, in X (determined without regard to section 4943(c)(4)) as of such date are, therefore, 40 percent of X voting stock. Accordingly, since the combined holdings of F, A, and B in X are, on such date, less than 75 percent of the voting stock in X and less than 75 percent of the value of all outstanding shares of all classes of stock in X, under the provisions of section 4943(c)(4)(B)(iii), all holdings of F in X (*i.e.*, 50 percent of X voting stock) will be treated as held by a disqualified person through May 25, 1979.

Example 2. Assume the facts as stated in Example (1), except that F, on December 15, 1969, purchases an additional 10 shares of voting stock in X representing 10 percent of X voting power. Assume, further, that there were no other transactions in the stock in X during 1969. While the 50 percent of X voting stock held by F on May 26, 1969, will be deemed held by a disqualified person through May 25, 1979, the additional 10 shares of X voting stock acquired by purchase by F on December 15, 1969, will no be deemed to be so held. Accordingly, since, under the provisions of § 53.4943–3, such 10 shares represent

excess business holding of F in X, such 10 shares will be subject to the imposition of tax under the provisions of section 4943(a).

Example 3. Assume the facts as stated in Example (1), except that F, on December 15, 1971 acquires an additional 10 shares of voting stock in X (representing 10 percent of X voting power) under the terms of a will which was executed before May 26, 1969, to which section 4943(c)(5) applies. While the 50 percent of X voting stock held by F on May 26, 1969, will be deemed held by a disqualified person through May 25, 1979, the additional 10 percent of X voting stock acquired by F on December 15, 1971, will, under the provisions of section 4943(c)(5), be deemed held by a disqualified person through December 14, 1981. See § 53.4943–5.

Example 4. Assume that F, a private foundation, owns on May 26, 1969, 50 shares of voting stock in corporation Y representing 50 percent of the voting power in Y. Assume further that C and D, the only disqualified persons with respect to F, own on such date 15 shares each of Y voting stock and that the 30 shares of Y voting stock owned by C and D together represent 30 percent of the voting power in Y. Under the provisions of § 53.4943–3 the excess business holdings of F in Y (determined without regard to section 4943(c)(4)) as of such date are, therefore, 50 percent of Y voting stock. Accordingly, since the combined holdings of F, C, and D in Y represent, on such date, more than 75 percent of the voting stock in Y, under the provisions of section 4943(c)(4)(B)(ii), all holdings of F in Y (*i.e.*, 50 percent of Y voting stock will be treated as held by a disqualified person through May 25, 1984.

Example 5. M, a private foundation, owns on May 26, 1969, sole proprietorship S. Since, under the provisions of § 53.5954–3, M's ownership of S constitutes excess business holdings (determined without regard to section 4943(c)(4) as of May 26, 1969, and since M's interest in S is greater than 95 percent on such date, under the provisions of this paragraph a disqualified person will be treated as the owner of S for the 20-year period beginning on such date. If S is later incorporated, that percentage of the interest in S retained by M, even though less than a 95-percent interest, shall continue to be treated as held by a disqualified person through May 25, 1989.

Example 6. A and B, individuals, together own on May 26, 1969, 40 shares of voting stock in corporation X representing 40 percent of the voting power in X and 20 percent of the value of all outstanding shares of all classes of stock in X. A and B are both disqualified persons with respect to F, a private foundation, which owns no stock in X on May 26, 1969. On January 1, 1973, A and B donate the 40 shares of X voting stock held by them to F. Since F had no excess business holdings on May 26, 1969, section 4943(c)(4) does not apply. See however, section 4943(c)(6) and § 53.4943–6.

Example 7. Assume the facts as stated in Example (6), except that F, on May 26, 1969, owns 50 shares of voting stock in X, representing 50 percent of the voting power in X and 25 percent of the value of all outstanding shares of all classes of stock in X. Under the provisions of this paragraph, the 50 shares of X voting stock held by F on May 26, 1969 shall be treated in accordance with the provisions of section 4943(c)(4), while the 40 shares of X voting stock acquired by F on January 1, 1973 shall be treated in accordance with the provisions of section 4943(c)(6). See § 53.4943–6.

(d) *Permitted holdings under section* 4943(c)(4)—(1) *In general.* The permitted holdings of a private foundation to which section 4943 (c)(4) applies in a business enterprise shall be as follows:

(i) The excess of the substituted combined voting level over the disqualified person voting level, and separately,

(ii) The excess of the substituted combined value level over the disqualified person value level.

(2) *Definitions.* For purposes of paragraph (d) of this section:

(i) The term *disqualified person voting level* on any given date means the percentage of voting stock held by all disqualified persons together on such date (including stock deemed held by such a person by reason of section 4943(c)(4), (5), or (6)).

(ii) The term *disqualified person value level* on any given date means the percentage of the total value of all outstanding shares of all classes of stock in a business enterprise held by all disqualified persons together on such date (including stock deemed held by such a person by reason of section 4943(c)(4), (5), or (6)).

(iii) The term *foundation voting level* prior to the second phase is equal to zero. After the first phase, such term on any given date means the lowest percentage of voting stock held by a private foundation (without regard to section 4943(c)(4)(B)) in a business enterprise on May 26, 1969, and at all times thereafter up to such date. See section 4943(c)(5) and § 53.4943–5 for the effect of the interests acquired pursuant to the terms of certain wills or trusts in effect on May 26, 1969.

(iv) The term *foundation value level* prior to the second phase is equal to zero. After the first phase, such term

on any given date means the lowest percentage of the total value of all outstanding shares of all classes of stock held by a private foundation (without regard to section 4943(c)(4)(B)) in a business enterprise on May 26, 1969, and at all times thereafter up to such date. See section 4943(c)(5) and § 53.4943–5 for the effect of interests acquired pursuant to the terms of certain wills or trusts in effect on May 26, 1969.

(v) The term *substituted combined voting level* means the lowest percentage to which the sum of the foundation voting level plus the disqualified person voting level has been reduced since May 26, 1969, by paragraph (d)(4) of this section to the following modifications (the ''downward ratchet rule''), subject;

(A) In no event shall such substituted level exceed 50 percent; and

(B) Such substituted level shall be increased (but not above 50 percent) in accordance with section 4943(c)(5) and § 53.4943–5 for certain interests acquired by such foundation pursuant to the terms of a will or trust in effect on May 26, 1969.

(vi) The term *substituted combined value level* means the lowest percentage to which the sum of the foundation value level plus the disqualified person value level has been reduced since May 26, 1969, by paragraph (d)(4) of this section (the ''downward ratchet rule''), subject to the following modifications:

(A) In no event shall such substituted level exceed 50 percent; and

(B) Such substituted level shall be increased (but not above 50 percent) in accordance with section 4943(c)(5) and § 53.4943–5 for certain interests acquired by such foundation pursuant to the terms of a will or trust in effect on May 26, 1969.

(vii) In the case of an interest in a partnership or joint venture, definitions (i) through (iv) of this subparagraph shall be applied by substituting ''profit interests'' for ''voting stock'' and ''all partnership interests'' for ''all outstanding shares of all classes of stock.''

(viii) In the case of an interest in a business enterprise other than a corporation, partnership or joint venture, definitions (i) through (iv) of this subparagraph shall be applied by substituting ''beneficial remainder interests'' for ''voting stock'' and ''all beneficial remainder interests'' and ''all outstanding shares of all classes of stock.''

(ix) Each level defined in paragraph (d)(2)(iii), (iv) and (v) and (vi) as of any date shall be carried over to the subsequent date subject to any adjustments prescribed for such level.

(3) *Permitted holdings—First phase.* Since during the first phase the substituted combined voting level generally does not exceed the disqualified person voting level, and the substituted combined value level generally does not exceed the disqualified person value level, the permitted holdings during the first phase are generally equal to zero. The permitted holdings during the first phase exceed zero only where the 20 percent (or 35 percent) limitation on the downward ratchet rule contained in paragraph (d)(4)(ii)(B) of this section applies.

(4) *Downward ratchet rule*—(i) *In general.* Except as provided in paragraph (d)(4)(ii) of this section and section 4943(c)(5):

(A) *Scope of rule.* In general, when the percentage of the holdings in a business enterprise held by a private foundation and all disqualified persons together to which section 4943(c)(4) applies decreases, or when the percentage of the holdings of the private foundation alone in such business enterprise decreases, such holdings may not be increased (except as provided under section 4943(c) (5) or (6)). This so-called ''downward ratchet rule'' is designed to prevent the private foundation from purchasing additional holdings in the business enterprise until the substituted combined voting level reduced to the 20-percent (or 35 percent) figure prescribed by section 4943(c)(2).

(B) *Levels affected.* Under the downward ratchet rule any decrease after May 26, 1969, in the percentage of holdings comprising either the substituted combined voting level, the substituted combined value level, the foundation voting level or the foundation value level shall cause the respective level to be decreased to such decreased percentage for purposes of determining the foundation's permitted holdings.

(C) *Implementation of reductions.* Thus, if at any time the sum of the foundation voting level and the disqualified person voting level is less than the immediately preceding substituted combined voting level, the substituted level shall be decreased so that it equals such sum. For example, if on May 26, 1969, a foundation and all disqualified persons together have holdings in a business enterprise equal to 50 percent, on such date the substituted combined voting level and the disqualified person voting level equal 50 percent (since such holdings of the foundation are treated as held by a disqualified person). If the private foundation or a disqualified person on May 27, 1969, sold 2 percent of such holdings to a nondisqualified person, the disqualified person voting level would be decreased to 48 percent (50% − 2%), causing the substituted combined voting level to be decreased to 48 percent. As a further example, assume that on May 26, 1969, a foundation and all disqualified persons together have holdings in a business enterprise equal to 50 percent, and when the first phase expires on May 26, 1979, the substituted combined voting level is still 50 percent, the foundation voting level is 10 percent, and the disqualified person voting level is 40 percent. If a disqualified person thereafter sells 2 percent to a nondisqualified person so that the sum of the disqualified person voting level (40% − 2% = 38%) and the foundation voting level (10%) equals 48 percent (38% + 10%), then the substituted combined voting level is decreased to 48 percent. Similarly, if at any time the sum of the foundation value level and the disqualified person value level is less than the immediately preceding substituted combined value level, the substituted combined value level shall be decreased so that it equals such sum.

(D) *Restrictions on increases in levels.* In addition, none of the four levels referred to in paragraph (d)(4)(i)(B) of this section may be adjusted upward to reflect any increase in the holdings comprising such level, except as provided in section 4943(c)(5) and § 53.4943–5. As a result, any transfer of May 26, 1969, holdings from a disqualified person to a private foundation shall not increase the foundation voting level or the foundation value level (unless the transfer qualifies under section 4943(c)(5)), and thus may reduce the substituted combined value level (and where appropriate, the substituted combined voting level). Thus, in the last preceding example, if the disqualified person, instead of selling the 2 percent interest to a nondisqualified person, had sold such interest to the foundation, the substituted combined voting level would still be reduced to 48 percent, since the disqualified person voting level would be reduced by 2 percent (to 38%) but the foundation voting level would not be increased by 2 percent (remaining at 10%). However, any transfer of May 26, 1969, holdings from a private foundation to a disqualified person under section 101(1)(2)(B) of the Tax Reform Act of 1969, shall reduce the foundation value level (and, where appropriate, the foundation voting level), but will not reduce the substituted combined value level or the substituted combined voting level. The disqualified person voting level and disqualified person value level are correspondingly increased, not being limited to interest held since May 26, 1969. In addition, a transfer of May 26, 1969, holdings from one disqualified person to another, for example, by bequest, shall not reduce the substituted combined voting level nor the substituted combined value level.

(ii) *Exceptions*—(A) *One percent de minimis rule.* If after May 26, 1969, there are one or more decreases in the holdings comprising any of the four levels referred to in paragraph (d)(4)(i)(B) of this section during any taxable year of a private foundation, and if such decreases are attributable to issuances of stock (or such issuances coupled with redemptions), then, unless the aggregate of such decreases equals or exceeds 1 percent, the determination of whether there is a decrease in such level for purposes of this paragraph (d)(4) shall be made only at the close of such taxable year. If, however, the aggregate of such decreases equals or exceeds 1 percent, such level shall be decreased at that time as if the previous sentence has never applied.

(B) *Twenty percent (or 35 percent) floor.* In no event shall the downward rachet rule contained in paragraph (d)(4)(i) of

this section decrease the substituted combined voting level or the substituted combined value level below 20 percent, or, for purposes of section 4943(c)(2)(B), below 35 percent.

(iii) *Special rules*—(A) *Change of foundation managers.* In the case of a foundation manager (as defined in section 4946(b)) who on May 26, 1969, owns holdings in a business enterprise and who is replaced by another foundation manager, the decrease in the substituted combined voting or value levels shall be limited to the excess, if any, of the departing foundation manager's holdings over his successor's holdings.

(B) *Termination of private foundation status under section 507.* If an organization gives the notification described in section 507(b)(1)(B)(ii) of the commencement of a 60-month termination period and fails to meet the requirements of section 509(a)(1), (2) or (3) for the entire period, then such organization will be treated as a private foundation during the entire 60-month period for purposes of this paragraph (d)(4) and section 4946(a)(1)(H). For example, X, a private foundation gives notification of the commencement of a 60-month termination commencing on January 1, 1972. X and Y, another private foundation, are effectively controlled by the same persons within the meaning of section 4946(a)(1)(H). X and Y hold 25 percent each of the voting stock of Z corporation on May 26, 1969, so that the substituted combined voting level for X or Y is 50 percent on such date. If X meets the requirements of section 509(a) (1), (2), or (3) for the entire 60-month period, section 4946(a)(1)(H) is inapplicable to X, and, under the downward ratchet rule, the substituted combined voting level for Y is decreased by 25 percent. On the other hand, if X meets the requirements of section 509(a)(2) for its taxable years 1972 and 1973, but fails to meet the requirements of section 509(a)(1), (2), or (3) in 1974, 1975, and 1976, then solely for purposes of section 4943(c)(4)(A)(ii) and this paragraph (d)(4), X will be treated as a disqualified person with respect to Y, and Y will be treated as a disqualified person with respect to X, for taxable years 1972 through 1976 pursuant to section 4946(a)(1)(H). Thus, for purposes of section 4943(c)(4)(A)(ii) the substituted combined voting level for X or Y will not be decreased by reason of the fact that X was attempting to terminate under section 507(b)(1)(B), and assuming no other transportations, such level; will remain at 50 percent.

(iv) *Examples.* The provisions of this paragraph (d)(4) may be illustrated by the following examples:

Example 1. F, a private foundation, owns on May 26, 1969, 50 shares of voting stock in corporation X representing to 50 percent of the voting stock in X and 25 percent of the value of all outstanding shares of all classes of stock in X. A and B, the only disqualified persons with respect to F, together own, on such date, 2 shares of voting stock in X representing 2 percent of the voting shock in X and 1 percent of the value of all outstanding shares of all classes of stock in X. In addition, on such date, F owns 30 shares of nonvoting stock in X, representing 30 percent of the value of all outstanding shares of all classes of stock in X, and A and B together own 15 shares of nonvoting stock in X representing 15 percent of the value of all outstanding shares of classes of stock in X. The provisions of section 4943(c)(4)(B)(iii) apply and during the 10-year period beginning on May 26, 1969, a disqualified person is deemed to hold all interests of F in X. Assume that on February 1, 1972, F sells to C, unrelated in individual, 12 shares of voting stock in X representing 12 percent of the voting stock in X and 6 percent of the value of all outstanding shares of all classes of stock in X.

(i) Beginning on May 26, 1969, the disqualified person voting level is 52 percent, the foundation voting level is zero, and the substituted combined voting level is 50 percent; the disqualified person value level is 71 percent, the foundation value level is zero, and the substituted combined value level is 50 percent.

(ii) Beginning on February 1, 1972, the disqualified person voting level is 40 percent (52% − 12%), the foundation voting level is zero, and the substituted combined voting level is 40 percent; the disqualified person value level is 65 percent (71% − 6%), the foundation value level is zero and the substituted combined value level is 50 percent.

Example 2. F, a private foundation on the calendar year basis, holds, on May 26, 1969, 30 percent of the voting stock in corporation Y. C and D, the only disqualified persons with respect to F, together hold, on such date, 10 percent of the voting stock in Y. The provisions of section 4943(c)(4)(B)(iii) apply with respect to F, and disqualified persons are deemed to hold all interests of F in Y for the 10-year period beginning on May 26, 1969, so that the substituted combined voting level as of such date is 40 percent. On February 1,

1973, a stock issuance by Y causes the combined holdings of voting power by F, C, and D in Y to decrease by 0.3 percent. on June 1, 1973, another such issuance causes such combined holdings to decrease by 0.5 percent. In September 1, 1973, an unrelated stock redemption by Y causes such combined holdings to increase by 0.4 percent. Under this paragraph the determination whether there is a decrease in the substituted combined voting level for purposes of the downward ratchet rule shall not be made before January 1, 1974, since the aggregate of the decreases occurring on February 1 and June 1 of 1973 is less than 1 percent (0.3% + 0.5%). Therefore, the substituted combined voting level as of January 1, 1974, is 39.6 percent (40% − [(0.3% + 0.5%) − 0.4%].)

Example 3. Assume the facts as stated in Example (2), except that, on October 1, 1973, a stock issuance by Y causes the combined holdings of voting power by F, C, and D in Y to decrease by 0.3 percent. Since the aggregate of the decreases occurring on February 1, June 1, and October 1 of 1973 exceeds 1 percent, the determination whether there is a decrease in the substituted combined voting level shall be made as of October 1, 1973. At that time the substituted combined voting level shall be reduced to 39.2 percent (40% − 0.3% − 0.5%), the lowest actual combined holdings during the period that the de minimis rule was in effect.

(5) *Permitted holdings—Second phase*—(i) *In general.* For purposes of section 4943 and this section, the term ''second phase'' means the 15-year period immediately following the first phase. Upon the expiration of the first phase with respect to an interest to which section 4943(c)(4) applies, such interest shall no longer be treated as held by a disqualified person under section 4943(c)(4)(B). During the second phase, the manner of determining the permitted holdings of a private foundation to which section 4943(c)(4) applies shall be the same as applicable to the first phase, except that a 25 percent maximum shall apply under certain conditions specified in paragraph (d)(5)(ii) of this section. For these purposes the substituted combined voting level and the substituted combined value level in effect for the foundation at the end of the first phase shall be carried over to the second phase. The substituted levels are carried over because although there is a decrease in the disqualified person levels (since holdings are no longer treated as held by disqualified persons under section 4943(c)(4)(B)), a corresponding increase in the foundation levels occurs. For example, if a private foundation on May 26, 1969, held 10 percent of the voting stock in a corporation and disqualified persons held 40 percent of the voting stock, both the disqualified person voting level and the substituted combined voting level equal 50 percent (10% + 40%). Assuming no transactions during the first phase, on May 26, 1979, the disqualified person voting level would be decreased to 40 percent (50% − 10%), but the foundation voting level would be increased to 10 percent so that the substituted combined voting level would remain at 50 percent. In addition, the downward ratchet rule of paragraph (d)(4) of this section shall continue to apply, to prevent the foundation and disqualified persons from purchasing any additional interest in the same enterprise until the substituted combined voting level decreases below 20 percent.

(ii) *25 percent maximum on foundation holdings.* If, or as soon as, the disqualified person voting level exceeds 2 percent after the expiration of the first phase, the permitted holdings shall not thereafter exceed 25 percent of the voting stock or 25 percent of the value of all outstanding shares of all classes of stock, even though the holdings of the foundation and all disqualified persons combined do not exceed the substituted level. Solely for purposes of determining whether the 25 percent limitation of this subdivision (ii) applies, the disqualified person voting level shall not be treated as exceeding 2 percent solely as a result of the holdings of a private foundation which are treated as held by a disqualified person by reason of section 4943(c) (5) or (6). For example, where under the constructive ownership rules for trusts in § 53.4943–8(b), a private foundation is deemed to own more than 2 percent of the voting stock of a business enterprise but such stock is treated as held by a disqualified person under section 4943(c)(5), the determination of the substituted percentage for permitted holdings in the second phase will be as if the foundation owned the stock held by the trust. Similarly, where a private foundation is the only remainder beneficiary of a trust that is a disqualified person

under section 4946(a)(1)(H), the disqualified person voting level shall not be treated as exceeding 2 percent solely as a result of the holdings of such a trust.

(6) *Permitted holdings—Third phase.* For purposes of section 4943 and this section, the term ''third phase'' means the entire period following the second phase. During the third phase the manner of determining the permitted holdings of a private foundation to which section 4943(c)(4) applies shall be the same as applicable to the second phase under paragraph (d)(5) of this section (including the carryover of levels from the earlier phase). However, if the 25 percent limit of paragraph (d)(5)(ii) of this section never applied during the second phase, the substituted combined voting level and the substituted combined value level each shall not exceed 35 percent during the third phase.

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

Example 1. F, a private foundation, owns on May 26, 1969, 30 shares of voting stock in corporation Z representing 30 percent of the voting power in Z and 15 percent of the value of all outstanding shares of all classes of stock in Z, and owns, on such date, 10 shares of nonvoting stock in Z representing 10 percent of the value of all outstanding shares of all classes of stock in Z. E and G, the only disqualified persons with respect to F, own, on such date, 5 shares each of nonvoting stock in Z. The 10 shares of nonvoting stock in Z owned by E and G together represent 10 percent of the value of all outstanding shares of all classes of stock in Z. Assume further that F cannot meet the requirements for the 35 percent test of section 4943(c)(2)(B). For purposes of applying section 4943(c)(4)(B) and this paragraph, F has excess business holdings in Z (determined without regard to section 4943(c)(4)), because under section 4943(c)(2)(A) F's permitted holdings are 20 percent (20% − 0%) of the voting stock since disqualified persons have no holdings of voting stock. Therefore, section 4943(c)(4)(B) and this paragraph apply, and a disqualified person is treated as holding F's shares of both voting and nonvoting stock in Z for the 10-year period through May 25, 1979. Thus, since all holdings by F in Z are treated as held by a disqualified person during the first phase, F cannot be subject to tax under section 4943(a) on its May 26, 1969, holdings prior to the termination of the first phase, regardless of whether or not disqualified persons purchase additional shares of Z during the first phase.

Example 2. Assume the same facts as in Example (1), and further assume that there were no transactions in the stock of Z during the first phase (May 26, 1969 through May 25, 1979). During the first phase the permitted holdings by F in Z for both the voting stock and the value is zero. The disqualified person voting level and the substituted combined voting level are each 30 percent, and the disqualified person value level and the substituted combined value level are each 35 percent (15% + 10% + 10%). The substituted levels are carried over into the second phase. The disqualified person voting level on May 26, 1979, the beginning of the second phase, is zero, because the voting shares held by F are no longer treated as held by a disqualified person. Therefore, F's permitted holdings on such date are 30 percent of the voting stock, because such percentage is equal to the excess of the substituted combined voting level (30%) over the disqualified person voting level (0%). The disqualified person value level on May 26, 1979, is 10 percent, because the voting and nonvoting shares held by F are no longer treated as held by a disqualified person. Therefore, F's permitted holdings on such date are 25 percent of the value of Z stock, because such percentage is equal to the excess of the substituted combined value level (35%) over the disqualified person value level (10%) as of such date.

Example 3. Assume the facts as stated in Example (2), except that E and G acquire, on February 1, 1970, 10 shares of Z voting stock representing 10 percent of the voting power in Z and 5 percent of the value of all outstanding shares of all classes of stock in Z. During the first phase such permitted holdings remain zero, and prior to May 25, 1979, the substituted combined voting level and substituted combined value level remain 30 and 35 percent, respectively, because such levels may not be increased by acquisitions by disqualified persons. However, the disqualified person voting level and the disqualified person value level are each increased to 40 percent (30% + 10%) and 40 percent (35% + 5%) respectively. During the first phase the excess of the disqualified person voting level over the substituted combined voting level (40% − 30%) and the excess of the disqualified person value level over the substituted combined value level (40% − 35%) indicate how much stock F must dispose of during the first phase to avoid the initial tax when it expires. On May 25, 1979, the last day of the first phase, F disposes of 12 shares of Z voting stock, representing 12 percent of the voting power in Z and 6 percent of the value of all such outstanding shares. The disposition by F reduces the interest F owns to 18 percent (30% − 12%) of the voting power, and 19 percent (25% − 6%) of the value of all outstanding shares of all classes of stock, in Z. Since the disqualified person voting level decreases to 28 percent

(40% − 12%), the substituted combined voting level as of May 25, 1979, accordingly is decreased to 28 percent under the downward ratchet rule. Similarly, the substituted combined value level is decreased to 34 percent, as the disqualified person value level as of such date is 34 percent (40% − 6%). On May 26, 1979, the disqualified person voting level is 10 percent (28% − 18%), and the disqualified person value level is 15 percent (34% − 19%), since the shares owned by F are no longer treated as held by a disqualified person as of such date. Accordingly, on May 26, 1979, the permitted holdings by F and Z are 18 percent of the voting power in Z, because such percentage is equal to the excess of the substituted combined voting level (28%) over the disqualified person voting level (10%) as of such date. Similarly, the permitted holdings of F in Z by value are 19 percent (34% − 15%). If F had not disposed of the 12 shares, then on May 26, 1979, F's permitted holdings in voting power and value would be 20 percent (30% − 10%) and 20 percent (35% − 15%), respectively.

Example 4. F, a private foundation, owns on May 26, 1969, 35 shares of voting stock in corporation Y representing 35 percent of the voting stock in Y and 17.5 percent of the value of all classes of stock in Y, and owns on such date 45 shares of nonvoting stock representing 22.5 percent of the value of all outstanding shares of all classes of stock in Y. No disqualified person with respect to F owns, on such date, any stock in Y. Assume further that Y cannot meet the requirements of the 35 percent test of section 4943(c)(2)(B). For purposes of applying section 4943(c)(4)(B) and this paragraph, F has excess business holdings in Y (determined without regard to section 4943(c)(4)), because under section 4943(c)(2)(A) F's permitted holdings are 20 percent (20% − 0%) of the voting stock since disqualified persons have no holdings of voting stock. Therefore, section 4943(c)(4)(B) and this paragraph apply, and a disqualified person is treated as holding F's shares of both voting and nonvoting stock in Y for the 10-year period through May 25, 1979. During the first phase the permitted holdings by F in Y of both the voting stock and of value are zero. The disqualified person voting level and the substituted combined voting level are each 35 percent, and the disqualified person value level and the substituted combined value level are each 40 percent (17.5% + 22.5%). The substituted levels are carried over into the second phase. The disqualified person voting level and value level on May 26, 1979, are both zero, because the shares held by F are no longer treated as held by a disqualified person. Therefore, F's permitted holdings on such date are 35 percent of the voting power (35% − 0%) and 40 percent of the value (40% − 0%). Assume that on February 1, 1981, A, a disqualified person, acquires 6 percent of the voting stock in Y representing 3 percent of the value of all outstanding shares of all classes of stock in Y. The permitted holdings by F in Z on February 1, 1981, are thus reduced to 25 percent of the voting stock (the lesser of the separate 25% second phase limitation or 29% (35% substituted combined voting level minus 6% disqualified person voting level)) and 25 percent of the value (the lesser of the separate 25% second phase limitation or 37% (40% substituted combined value level minus 3% disqualified person value level)). But see paragraph (d)(8) of this section for limitations on restrictions with respect to nonvoting stock.

Example 5. Assume the same facts as in Example (4) except that A does not acquire the 6 shares of voting stock until February 1, 1996 (in the third phase), rather than on February 1, 1981. Thus, F's permitted holdings in Y would remain at 35 percent of the voting stock and 40 percent of the value during the second phase, which expired on May 25, 1994. Assume that on May 25, 1994, the last day of the second phase, F disposes of 10 shares of nonvoting stock representing 5 percent of the value of all outstanding shares in Y to meet the 35 percent third phase limit. In accordance with the downward ratchet rule, the substituted combined value level and F's permitted holdings in Y would be reduced to 35 percent of value. On February 1, 1996, F's permitted holdings in Y would be reduced to 25 percent of the voting stock (the lesser of the separate 25% third phase limitation or 29% (35% substituted combined voting level minus 6% disqualified person level)) and 25 percent of the value (the lesser of the separate 25% third phase limitation or 32% (35% substituted combined value level minus 3% disqualified person value level)). But see paragraph (d)(8) of this section for limitations on restrictions with respect to nonvoting stock.

(8) *Special rule where all holdings are permitted under section 4943(c)(2).* (i) Since section 4943(c)(4) and this paragraph provide transitional rules for foundations which would otherwise have had excess business holdings on May 26, 1969, no holdings shall cease to be permitted holdings under this paragraph where such holdings would be permitted holdings under section 4943(c)(2) and § 53.4943–3. Thus, for example, where the substituted combined voting level had been reduced to 20 percent, the provisions of § 53.4943–3(b)(2) concerning nonvoting stock as permitted holdings generally apply.

(ii) The provisions of this paragraph (d)(8) may be illustrated by the following example:

Example. (A) F, a private foundation, owns, on May 26, 1969, 40 shares of voting stock in corporation X representing 40 percent of the voting stock in X and 20 percent of the value of all outstanding shares of all classes of stock in X, and owns, on such date, 60 shares of nonvoting stock in X, representing 30 percent of the value of all outstanding shares of all classes of stock in X. A, the only disqualified person with respect to F, owns, on such date, 10 shares of voting stock in X, representing 10 percent of the voting stock in X and 5 percent of the value of all outstanding shares of all classes of stock in X. Under section 4943(c)(4)(B)(iii), a disqualified person is deemed the owner of all holdings by F in X for the 10–year period beginning on May 26, 1969.

(B) Assume that the only transaction in X stock during the first phase is the disposition of 30 shares of voting stock by F on May 1, 1975. The voting stock held by F is permitted holdings under § 53.4943–3 and under such section since all disqualified persons together do not own more than 20 percent of the voting stock in X, all nonvoting stock held by F shall also be treated as permitted holdings. Therefore, all the stock held by F is permitted holdings.

(C) Assume that on May 1, 1975, F had disposed of only 15 shares of voting stock and also had disposed of 35 shares of nonvoting stock. On May 26, 1979, at the beginning of the second phase, this paragraph (d)(8) would not apply since F would have excess business holdings under § 53.4943–3. Under the provisions of this section, the permitted holdings by F in X on such date are 25 percent of the voting stock (35% substituted combined voting level minus 10% disqualified person voting level) and 25 percent of the value (30% substituted combined value level minus 5% disqualified person value level).

(9) *Special rule for certain private foundations*. In the case of a private foundation:

(i) Which was incorporated before January 1, 1951.

(ii) Substantially all of the assets of which on May 26, 1969, consisted of more than 90 percent of the stock of an incorporated business enterprise which is licensed and regulated, the sales or contracts of which are regulated, and the professional representatives of which are licensed, by State regulatory agencies in at least 10 States;

(iii) Which acquired such stock solely by gift, devise, or bequest;

(iv) Which does not purchase any stock or other interest in such enterprise after May 26, 1969, and does not acquire any stock or other interest in any other business enterprise which constitutes excess business holdings under § 53.4943–3; and

(v) Which, in the last 5 taxable years ending on or before December 31, 1970, expended substantially all of its adjusted net income (as defined in section 4942(f)) for the purpose or function for which it is organized and operated;

paragraph (d) (1) through (5) of this section (permitted holdings during the first and second phase) shall be applied with respect to the holdings of such foundation in such incorporated business enterprise by substituting ''51 percent'' for ''50 percent,'' and section 4943(c)(4)(D) (third phase) shall not apply with respect to such holdings. For purposes of the preceding sentence, stock of such enterprise in a trust created before May 27, 1969, of which the foundation is the remainder beneficiary shall be deemed to be held by such foundation on May 26, 1969, if such foundation held (without regard to such trust) more than 20 percent of the stock of such enterprise on May 26, 1969.

(10) *Special rule for changes in the relative values of stock of different classes*. (i) In the case of a corporation that has more than one class of stock outstanding, if the percentage of value held by the private foundation, its disqualified persons, or both, increases over a period of time solely as a result of changes in the relative values of the stock of different classes, then the foundation value level, the disqualified person value level, and the substituted combined value level, as defined in paragraph (d)(2) of this section, shall be adjusted to reflect such increase. An increase in the percentage of value held shall not be considered to have occurred solely as a result of changes in the relative values of the stock of different classes if:

(A) There has been any increase during the period in the percentage of any class of stock held by the private foundation, its disqualified persons, or both, or

(B) There has been any issuance, redemption, or purchase by the issuing corporation of any stock during the period.

See § 53.4943–6(d) for rules relating to increases caused by readjustments.

(ii) *Example.* The provisions of this paragraph (b)(10) may be illustrated by the following example:

Example. (i) At all times since May 26, 1969, F, a private foundation, has held 25% (500,000 shares) of the outstanding class of voting stock of X corporation. No disqualified person with respect to F holds any voting stock of X. In addition X has had outstanding since May 26, 1969, a class of non-voting preferred stock, none of which is held by F or a disqualified person. X is an active business corporation and third parties do not have effective control of X. On May 26, 1969, the voting stock (2 million shares outstanding) was trading for $5 a share on the New York Stock Exchange. The non-voting preferred stock, not publicly traded, was valued at $1 million. The total value of all outstanding stock was $11 million ($10 million voting stock plus $1 million non-voting preferred). On May 26, 1969, F held 22.73% of the value of X's outstanding stock ($2.5 million/$11 million).

(ii) On October 31, 1982, X's voting stock is trading for $20 a share and the nonvoting stock is valued at $3 million. At all times during the period May 26, 1969, through October 31, 1982, F has held 25 percent of the voting stock and none of the nonvoting stock of X. No stock of X is owned by disqualified persons. No stock of X has been issued, redeemed or purchased by X during this period. On October 13, 1982, the total value of X's outstanding stock (is $43 million ($40 million voting stock and $3 million nonvoting stock) and F holds 23.26 percent of the value of X's outstanding stock ($10 million/$43 million). F's foundation value level and the substituted combined value level are increased from 22.73 percent to 23.26 percent to reflect this change.

(iii) On November 1, 1982, X corporation distributes the stock of Y corporation, a wholly-owned subsidiary, to X's shareholders. Y is a business enterprise. Under this paragraph (d)(10), all of F's stock in X is permitted holdings under section 4943 (c)(4) even though the percentage of value held by F has increased from 22.73 percent on May 26, 1969, to 23.26 percent on November 1, 1982. F's permitted holdings in Y will be determined by reference to F's permitted holdings in X under § 53.4943–7. Therefore, assuming no prohibited transaction occurs, F's permitted holdings in Y stock equal 25 percent of Y's voting stock and, separately, 23.26 percent of the value of all of Y's outstanding stock.

[T.D. 7496, 42 FR 46285, Sept. 15, 1977, as amended by T.D. 7944, 49 FR 6478, Feb. 22, 1984]

§ 53.4943–5 Present holdings acquired by trust or a will.

(a) *Interests to which section 4943(c)(5) applies—(1) In general.* Section 4943(c)(5) provides that section 4943(c)(4) (other than the 20-year first phase holding period) applies to an interest in a business enterprise acquired after May 26, 1969 by a private foundation under the terms of a trust which was irrevocable on May 26, 1969, or under the terms of a will executed on or before May 26, 1969, which were in effect on May 26, 1969, and at all times thereafter, as if such interest were held on May 26, 1969. However the first phase holding period prescribed by § 53.4943–4(c)(1) (ii) or (iii) shall commence for such an interest on the date of distribution to the foundation. Unlike section 4943(c)(4) and § 53.4943–4, section 4943(c)(5) and this section treat only the interest so acquired (and not the entire interest held by the foundation in such enterprise on the date of distribution) as held by a disqualified person during a first phase holding period. (See, however, section 4943(c)(6) and paragraph (b)(2) of § 53.4943–6 for the treatment of other holdings of the foundation in the same enterprise if an interest to which section 4943(c)(5) applies is acquired from a person who was not a disqualified person prior to the acquisition.) In addition, section 4943(c)(5) and this section shall not apply if after the acquisition of such an interest the foundation would not have excess business holdings (determined without regard to section 4943(c) (4), (5), or (6)).

(2) *After-acquired interests.* Section 4943(c)(5) and this section shall not apply to any interest acquired after May 26, 1969, by an estate or trust, other than by reason of the death of the decedent. For example, where a foundation is a residuary beneficiary under the terms of a will executed before May 26, 1969, and the residue of the estate consists of cash, then stock subsequently purchased with cash for distribution to the foundation will not be treated as an interest acquired under the terms of a will executed on or before May 26, 1969.

(3) *Certain revocable trusts.* If an interest in a business enterprise actually passes to a private foundation under a trust which would have met the tests referred to in paragraph (a)(1) of this section but for the fact that the trust was revocable (even though it was not in fact revoked) and such interest

would have passed to such foundation under a will that meets those tests but for the fact that the grantor died without having revoked the trust, then for purposes of section 4943(c)(5) and this section, such an interest shall be treated as having been acquired by the foundation under the will.

(4) *Modification of will*—(i) *In general.* For purposes of section 4943(c)(5) and this section, an amendment or republication of a will which was executed on or before May 26, 1969, does not prevent any interest in a business enterprise which was to pass under the terms (which were in effect on May 26, 1969, and at all times there- after) of such will from being treated as a present holding under section 4943(c) (4) or (5):

(A) Solely because there is a reduction in the interest in the business enterprise which the foundation was to receive under the terms of the will (for example, if the foundation is to receive the residuary estate, and if one class of stock is disposed of by the decedent during his lifetime or by a subsequent codicil);

(B) Solely because such amendment or republication is necessary in order to comply with section 508(e) and the regulations thereunder;

(C) Solely because there is a change in the executor of the will; or

(D) Solely because of any other change which does not otherwise change the rights of the foundation with respect to such interest in the business enterprise.

However, if under such amendment or republication there is an increase in the interest in the business enterprise which the foundation was to receive under the terms of the will in effect on May 26, 1969, such increase shall not be treated as present holdings under section 4943(c) (4) or (5). Under such circumstances the interest which would have been acquired before such increase shall remain present holdings. See section 4943(c)(6) and § 53.4943–6 with respect to the treatment of such increase in holdings of a private foundation.

(ii) *Examples.* The provisions of this paragraph (a)(4) may be illustrated by the following examples:

Example 1. On May 9, 1985, A modifies by codicil his will which was in effect on May 26, 1969, and was unchanged until such modification. The purpose of the codicil was, in the event of A's death, to increase the number of shares in X Corporation that would pass to the W foundation from 70 percent of all the voting power and value to 80 percent. Under these facts, if A dies without further modifying the terms of the will which apply to W's interest in X, section 4943(c)(5) will apply to 70 percent of the X voting power and value and section 4943(c)(6) will apply to 10 percent of the X voting power and value, since 10 percent of the X voting power and value would not pass under a provision of the will which was in effect on May 26, 1969, and at all times thereafter. Accordingly, if the stock is distributed to W on July 6, 1988, then, assuming that on May 26, 1969, W and all disqualified persons owned less than 75% of the voting stock in X, an amount of such stock representing 70 percent of X voting power and value shall be treated as held by a disqualified person through July 5, 1998, and an amount of such stock representing 10 percent of X voting power and value shall be treated as held by a disqualified person through July 5, 1993.

Example 2. Assume the facts as stated in Example (1), except that the sole purpose of the codicil was to change the executor of the will. Under paragraph (a)(4)(i) of this section, such codicil will not prevent the X voting stock which was bequeathed to W from being treated as held by a disqualified person through July 5, 1998.

(b) *Holding periods*—(1) *In general.* An interest to which section 4943(c)(5) applies shall be entitled to a 15-year holding period starting on the date of distribution only if the interests actually or constructively owned by a private foundation and all disqualified persons on May 26, 1969, in a business enterprise exceed 75 percent of the voting stock (or of the profits or beneficial interest) or 75 percent of the value of all outstanding shares of all classes of stock (or of the profits and capital interest) in such enterprise. For purposes of the preceding sentence, interests held by the foundation on May 26, 1969, shall be deemed to include an interest to which section 4943(c)(5) applies and which has been acquired (on or before the date of distribution for the interest in question) from a person who was not a disqualified person on May 26, 1969. Therefore, if under the terms of a will in effect on May 26, 1969, and at all times thereafter, a private foundation is created on July 1, 1975, and receives 76 percent of the voting stock of a business enterprise on that date, such stock

shall be treated as held by a disqualified person until June 30, 1990. Any interest to which section 4943(c)(5) applies but which is not entitled to a 15-year holding period shall be entitled to a 10-year holding period starting on the date of distribution. For purposes of this paragraph the date of distribution shall be deemed to occur no later than the date on which the trust or estate is considered to be terminated under § 1.641(b)–(3) of this chapter (Income Tax Regulations).

(2) *Constructive ownership prior to date of distribution.* To the extent that an interest to which section 4943(c)(5) applies is constructively held by a private foundation under section 4943(d)(1) and § 53.4943–8 prior to the date of distribution, it shall be treated as held by a disqualified person prior to such date by reason of section 4943(c)(5). In addition, in the case of a foundation's interest in a trust which was irrevocable on May 26, 1969, and to which both sections 4943 (c)(4) and (c)(5) apply, the first phase holding period for such interest shall end with whichever such period under section 4943(c) (4) or (5) ends later. For example, if under the terms of such a trust, 96 percent of the voting stock in a business enterprise was constructively held by a private foundation on May 26, 1969, and was distributed to such foundation on June 30, 1970, such interest is entitled to a 20-year holding period beginning on May 26, 1969.

(c) *Permitted holdings*—(1) *In general.* The permitted holdings of a private foundation which has an interest in a business enterprise to which section 4943(c)(5) applies shall be determined in accordance with the rules of paragraph (d) of § 53.4943–4. The levels referred to in such paragraph shall be adjusted to take into account the acquisition of such an interest as if it were treated as held by a disqualified person from May 26, 1969, until the date of acquisition. See also § 53.4943–6(b)(2) for the special rule for interests held by a private foundation at the time it acquires a section 4943(c)(5) interest from a nondisqualified person. Thus, for example, if on June 30, 1975, the disqualified person voting level and the substituted combined voting level in corporation X with respect to foundation F are 45 percent, and a nondisqualified person's 10 percent voting interest in X is acquired by F on July 1, 1975, in a transaction to which section 4943(c)(5) applies, the above-mentioned levels shall be increased to 55 and 50 percent respectively, on July 1, 1975. However, if such interest had been acquired from a person who was a disqualified person on May 26, 1969, rather than from a nondisqualified person, no adjustments in such levels would have taken place on July 1, 1975. In such a case, though, at the beginning of the second phase on July 1, 1985, the foundation voting level would be increased by 10 percent, and the disqualified person voting level decreased by 10 percent (assuming that none of the acquired stock had been disposed of prior to such date).

(2) *Separate phases.* The phases for each interest to which section 4943(c)(5) applies start independently from those for any other interest of the foundation in the same enterprise to which section 4943(c) (4) or (5) applies. Therefore, until an interest enters its own second phase, the 25 percent limit described in paragraph (d)(5) of § 53.4943–4 shall not apply to such interest since such interest (and any subsequently acquired section 4943(c)(5) interest in the first phase) is still treated as held by a disqualified person for purposes of that 25 percent limit. In addition, if such an interest enters its second phase and at such time all disqualified persons together do not have holdings in excess of 2 percent of the voting stock in the same business enterprise, then the 25 percent limit of section 4943(c)(4)(D)(i) shall not then apply to such interest, even though such limit may have been applicable to an interest with an earlier second phase. Moreover, the 35 percent limit of section 4943(c)(4)(D)(ii) shall cause only interests which have entered the third phase to become excess business holdings, taking into account, however, interests in prior phases in determining the holdings subject to such limit.

(3) *Examples.* The provisions of this paragraph may be illustrated by the following examples: (After each example is a chart setting forth the chronological changes in the various levels referred to in paragraph (d) of § 53.4943–4.)

Example 1. On May 26, 1969, F, a private foundation, owns no stock in M Corporation, and A, a disqualified person owns 40 percent of the voting stock (voting power and value) in M. A dies on May 1, 1971, leaving 30 percent of the voting stock in M to F and leaving the other 10 percent to a disqualified person. Distribution is made on June 1, 1972, and assume that section 4943(c)(5) applies. No transactions in the stock of M, other than those described in this example, occur. On May 26, 1969, the substituted combined voting level is 40 percent, the disqualified person voting level is deemed to be 40 percent, and the permitted holdings by F in M is deemed to be 0 percent (40% − 40%). On May 1, 1971 (the date that F acquired the M stock by reason of its constructive ownership of A's estate), the various levels remain unchanged. On May 1, 1971, the 30 percent interest is treated as held by a disqualified person for a period extending through May 31, 1982. On June 1, 1981, F disposes of 6 percent of the voting stock to a nondisqualified person. The substituted combined voting level and the disqualified person voting level thereby are reduced to 34 percent (40% − 6%) each. On June 1, 1982, at the beginning of the second phase, the foundation voting level increases to 24 percent (30% − 6%) and the disqualified person voting level is reduced to 10 percent (34% − 10%). The substituted combined voting level as of June 1, 1982, remains at 34 percent. The permitted holdings as of such date are 24 percent (34% − 10%). If F had not disposed of any holdings prior to June 1, 1982, F's permitted holdings would have been 25 percent, the lesser of 25 percent (the limitation of section 4943(c)(4)(D)(i)), or 30 percent (40% − 10%). Since on such date the 30 percent interest would no longer have been treated as held by a disqualified person, F would have had excess business holdings of 5 percent (30% − 25%).

Date	F owns (percent)	Interest treated as held by disqualified person (percent)	Disqualified persons own (percent)	Foundation voting level (percent)	Substituted combined voting level (percent)	Disqualified person voting level (percent)	Permitted holdings (percent)	Comments
May 26, 1969	0	0	40	0	40	40	0	
May 1, 1971	*+ 30*	*+ 30*	*− 30*	.....	.....	.....	.....	A dies.
Do	30	30	10	0	40	40	0	
June 1, 1972	30	30	10	0	40	40	0	Distribution.
June 1, 1981	*− 6*	*− 6*	.....	.....	*− 6*	*− 6*	.....	F sells 6 pct.
Do	24	24	10	0	34	34	0	
June 1, 1982	.....	*− 24*	.....	*+ 24*	.....	*− 24*	*+ 24*	2d phase begins.
Do	24	0	10	24	34	10	24	

Example 2. (i) On May 26, 1969, F, a private foundation, owns 30 percent of the voting stock of N Corporation (voting power and value) and disqualified persons own 20 percent of the voting stock of N Corporation. On May 1, 1971, B, a disqualified person, dies leaving 15 percent of the voting stock to F. Assume the distribution was made on June 1, 1972, and that section 4943(c)(5) applies. On May 26, 1969, the substituted combined voting level and the disqualified person voting levels are each 50 percent and the permitted holdings are 0 percent (50% − 50%). On May 1, 1971, and June 1, 1972, these levels remain unchanged. On May 1, 1971, the 15 percent interest is treated as held by a disqualified person for a period extending through May 31, 1982.

(ii) On July 1, 1978, F sells 6 percent of the F stock to a nondisqualified person, thereby reducing the disqualified person voting level and the substituted combined voting level to 44 percent (50% − 6%). On May 26, 1979, at the beginning of the second phase for F's 1969 holdings, the foundation voting level is 24 percent (30% − 6%), the substituted combined voting level is still 44 percent, and the disqualified person voting level is 20 percent (44% − 24%). The permitted holdings are 24 percent (44% − 20%). In addition F's 24 percent holdings do not exceed the 25 percent limitation of section 4943(c)(4)(D)(i) and paragraph (d)(5)(ii) of § 53.4943–4.

(iii) On August 1, 1981, F sells 16 percent of the N stock to a nondisqualified person, thereby reducing the foundation voting level to 8 percent (24% − 16%), and reducing the substituted combined voting level to 28 percent (44% − 16%). The disqualified person voting level remains at 20 percent. On June 1, 1982, at the beginning of the second phase for F's holdings acquired by will, the substituted combined voting level is still 28 percent, the foundation voting level is 23 percent (8% + 15%), the disqualified person voting level is 5 percent (20% − 15%), and the permitted holdings are 23 percent (28% − 5%).

(iv) If F had not disposed of the 6 percent on July 1, 1978, then on May 26, 1979, at the beginning of the second phase for F's 1969 holdings, F's permitted holdings would have been 25 percent, the lesser of 25 percent (the limitation of section 4943(c)(4)(D)(i), or 30 percent (50% − 20%). Since F's 30 percent interest would no longer have been treated as

held by a disqualified person on May 26, 1979, F would have had excess business holdings of 5 percent (30% − 25%). Similarly, if F had not disposed of the 16 percent interest on August 1, 1981 (but had disposed of the 6 percent interest), on July 1, 1982, at the beginning of the second phase for F's holdings acquired by will, F's permitted holdings would have been 25 percent, the lesser of 25 percent (under section 4943(c)(4)(D)(i)), or 39 percent (44% − 5%). Since as of such date F's entire holdings of 39 percent would no longer have been treated as held by a disqualified person, F would have had excess business holdings of 14 percent (39% − 25%).

Date	F owns (percent)	F's interest 1969 (percent)	F's interest 1971 (percent)	Interest treated as held by disqualified person (percent)	Disqualified persons own (percent)	Foundation voting level (percent)	Substituted combined voting level (percent)	Disqualified person voting level (percent)	Permitted holdings (percent)	Comments
May 26, 1969.	30	30	.....	30	20	0	50	50	0	
May 1, 1971	*+ 15*	.....	*+ 15*	*+ 15*	*− 15*	.....	.....	.....	.....	B dies.
Do	45	30	15	45	5	0	50	50	0	
June 1, 1972.	45	30	15	45	5	0	50	50	0	Distribution.
July 1, 1978	*− 6*	*− 6*	.....	*− 6*	.....	.....	*− 6*	*− 6*	.....	F sells 6 pct.
Do	39	24	15	39	5	0	44	44	0	
May 16, 1979.	.....	.....	.....	*− 24*	.....	*+ 24*	.....	*− 24*	*+ 24*	2d phase for 24 pct.
Do	39	24	15	15	5	24	44	20	24	
Aug. 1, 1981.	*− 16*	*− 16*	.....	.....	.....	*− 16*	*− 16*	.....	*− 16*	F sells 16 pct.
D0	23	8	15	15	5	8	28	20	8	
July 1, 1982	.....	.....	.....	*− 15*	.....	*+ 15*	.....	*− 15*	*+ 15*	All in 2d phase.
Do	23	8	15	0	5	23	28	5	23	

Example. (3). (i) On May 26, 1969, F, a private foundation owns 5 percent of the voting stock of O Corporation (voting power and value), and disqualified persons own 45 percent of the voting stock. C, a disqualified person, dies on May 1, 1971, and leaves 41 percent of the voting stock of O to F. Assume that distribution is made on June 1, 1972, and that section 4943(c)(5) applies. On May 26, 1969, the substituted combined voting level and the disqualified person voting level are 50 percent and the permitted holdings are 0 percent (50% − 50%). On May 1, 1971, and June 1, 1972, the various levels remain unchanged. On May 1, 1971, the 41 percent interest is treated as held by a disqualified person for a period extending through May 31, 1982. On May 26, 1979, at the beginning of the second phase for F's 1969 holdings of 5 percent, the 5 percent is no longer treated as held by a disqualified person, the foundation voting level is 5 percent, the disqualified person voting level is reduced to 45 percent (50% − 5%), and the substituted combined voting level remains at 50 percent. On such date F's permitted holdings are 5 percent (50% − 45%). Since the 41 percent interest is treated as held by a disqualified person, the interest treated as held by F (5%) does not exceed the 25 percent limitation of section 4943(c)(4)(D)(i).

(ii) On August 1, 1981, F sells 22 percent of the O stock to a nondisqualified person, thereby reducing the foundation voting level to 0 percent. Since the reductions are first applied to the 1969 holdings of 5 percent, 17 percent (22% − 5%) applies to the 41 percent interest, reducing such interest to 24 percent (41% − 17%), and reducing the disqualified person voting level to 28 percent (45% − 17%). The substituted combined voting level is reduced to 28 percent (0% + 28%). On June 1, 1982, at the beginning of the second phase for F's holdings acquired by will, the substituted combined voting level remains at 28 percent, the foundation voting level is 24 percent, the disqualified person voting level is reduced to 4 percent (28% − 4%).

(iii) If F had not disposed of the 22 percent interest prior to June 1, 1982, F's permitted holdings would have been 25 percent, the lesser of 25 percent, (under section 4943(c)(4)(D)(i)), or 46 percent (50% − 4%). Since as of such date, F's entire holdings of 46 percent would no longer have been treated as held by a disqualified person, F would have had excess business holdings of 21 percent (46% − 25%).

Date	F owns (percent)	F's interest 1969 (percent)	F's interest 1971 (percent)	Interest treated as held by disqualified person (percent)	Disqualified persons own (percent)	Foundation voting level (percent)	Substituted combined voting level (percent)	Disqualified person voting level (percent)	Permitted holdings (percent)	Comments
May 26, 1969.	5	5	.....	5	45	0	50	50	0	
May 1, 1971	*+ 41*	.....	*+ 41*	*+ 41*	*− 41*	.....	.....	.....	.....	C dies.
Do	46	5	41	46	4	0	50	50	0	
June 1, 1972.	46	5	41	46	4	0	50	50	0	Distribution.
May 26, 1979.	.....	.....	.....	*− 5*	.....	*+ 5*	.....	*− 5*	*+ 5*	2d phase for 5 pct.
Do	46	5	41	41	4	5	50	45	5	
Aug. 1, 1981.	*− 22*	*− 5*	*− 17*	*− 17*	.....	*− 5*	*− 22*	*− 17*	*− 5*	F sells 22 pct.
Do	24	0	24	24	4	0	28	28	0	
June 1, 1982.	.....	.....	.....	*− 24*	.....	*+24*	.....	*− 24*	*+24*	2d phase for 24 pct.
Do	24	0	24	0	4	24	28	4	24	

Example 4. (i) On May 26, 1969, F, a private foundation, owns 30 percent of the voting stock in P Corporation (voting power and value), and disqualified persons own 20 percent. On May 1, 1971, D, a disqualified person, dies leaving 18 percent of the voting stock to F. Assume that distribution was made on June 1, 1972, and that section 4943 (c)(5) applies. On May 26, 1969, the substituted combined voting level and the disqualified person voting level are each 50 percent and the permitted holdings are 0 percent (50% − 50%). On May 1, 1971, and June 1, 1972, these levels remain unchanged. On May 1, 1971, the 18 percent interest is treated as held by a disqualified person for a period extending through May 31, 1982. On May 26, 1979, the foundation voting level increases to 30 percent, the disqualified person voting level decreases to 20 percent (50% − 30%), and the permitted holdings are 30 percent (50% − 20%). On June 1, 1982, the foundation voting level increases to 48 percent, the disqualified person voting level decreases to 2 percent and the permitted holdings are 48 percent (50% − 2%). Since at no time during the second phase for F's 1969 holdings did all disqualified persons together have holdings in excess of 2 percent of the voting stock of P, the 25 percent limitation of section 4943(c)(4)(D)(i) did not apply to F's 1969 holdings.

(ii) On July 1, 1993, F disposes of 16 percent of the stock in P, thereby reducing the substituted combined voting level to 34 percent (50% − 16%), and reducing the permitted holdings to 32 percent (34% − 2%). If F had not disposed of the 16 percent of the stock of P prior to May 26, 1994, on such date, under section 4943(c)(4)(D)(ii), F's substituted combined voting level for its 1969 holdings would have been 35 percent, and the permitted holdings would have been 33 percent (35% − 2%). Since none of F's holdings of 48 percent would have been treated as held by a disqualified person on such date (the beginning of the third phase for F's 1969 holdings), F would have had excess business holdings of 15 percent, the lesser of 30 percent (F's 1969 holdings in the third phase), of 15 percent (the excess of F's 48 percent holdings over the permitted holdings of 33 percent).

Date	F owns (percent)	F's interest 1969 (percent)	F's interest 1971 (percent)	Interest treated as held by disqualified person (percent)	Disqualified persons own (percent)	Foundation voting level (percent)	Substituted combined voting level (percent)	Disqualified person voting level (percent)	Permitted holdings (percent)	Comments
May 26, 1969.	30	30	.....	30	20	0	50	50	0	
May 1, 1971	*+ 18*	.....	*+ 18*	*+ 18*	*− 18*	.....	.....	.....	.....	D dies.
Do	48	30	18	48	2	0	50	50	0	
June 1, 1972.	48	30	18	48	2	0	50	50	0	Distribution.
May 26, 1979.	.....	.....	.....	*− 30*	.....	*+ 30*	.....	*− 30*	*+ 30*	2d phase for 30 pct.
Do	48	30	18	18	2	30	50	20	30	

Date	F owns (percent)	F's interest 1969 (percent)	F's interest 1971 (percent)	Interest treated as held by disqualified person (percent)	Disqualified persons own (percent)	Foundation voting level (percent)	Substituted combined voting level (percent)	Disqualified person voting level (percent)	Permitted holdings (percent)	Comments
June 1, 1982.	.....	.....	.....	*−18*	.....	*+18*	.....	*−18*	*+18*	2d phase for 18 pct.
Do	48	30	18	0	2	48	50	2	48	
July 1, 1993	*−16*	*−16*	.....	.....	.....	*−16*	*−16*	.....	*−16*	F disposes of 16 pct.
Do	32	14	18	0	2	32	34	2	32	
May 26, 1994.	32	14	18	0	2	32	34	2	32	3d phase for 14 pct.
June 1, 1997.	32	14	18	0	2	32	34	2	32	3d phase for 18 pct.

Example 5. (i) On May 26, 1969, F, a private foundation, owns 5 percent of the voting stock in Q Corporation (voting power and value), and disqualified persons own 45 percent. On May 1, 1971, E, a disqualified person, dies leaving 43 percent of the voting stock to F. Assume that distribution was made on June 2, 1972, and that section 4943(c)(5) applies. On May 26, 1969, the substituted combined voting level and the disqualified person voting level are each 50 percent and the permitted holdings are 0 percent (50% − 50%). On May 1, 1971, and June 1, 1972, these levels remain unchanged. On May 1, 1971, the 43 percent interest is treated as held by a disqualified person for a period extending through May 31, 1982. On May 26, 1979, the foundation voting level increases to 5 percent, the disqualified person voting level decreases to 45 percent, and the permitted holdings are 5 percent (50% − 45%). On June 1, 1982, the foundation voting level increases to 48 percent, the disqualified person voting level decreases to 2 percent, and the permitted holdings are 48 percent (50% − 2%). At no time during the second phase for F's 1969 holdings did all disqualified persons together have holdings in excess of 2 percent of the voting stock of Q. Therefore, the 25 percent limitation of section 4943(c)(4)(D)(i) did not apply.

(ii) On July 1, 1993, F sells 6 percent of the stock in Q to a nondisqualified person. This reduces the substituted combined voting level to 44 percent and reduces the permitted holdings to 42 percent (44% − 2%). If F had not disposed of the 6 percent of the stock in 1993, on May 26, 1994, at the beginning of the third phase for F's 1969 holdings, F would have had 5 percent excess business holdings. The excess business holdings are 5 percent because although the excess business holdings computed for the third phase are 15 percent (the excess of F's actual holdings (48%) over the permitted holdings of 33 percent (35% − 2%)), only 5 percent of the holdings are in this phase and subject to the 35 percent combined holdings limitation.

(iii) On July 1, 1995, F sells 10 percent of the stock in Q, thereby reducing the substituted combined voting level to 34 percent and reducing the permitted holdings to 32 percent (34% − 2%). If F had not disposed of the 10 percent of the stock, on June 1, 1997, at the beginning of the third phase for F's acquired holdings, F would have had 9 percent excess business holdings (the excess of F's total holdings in the third phase (42%) over the permitted holdings of 33 percent (35% − 2%)).

Date	F's owns (percent)	F's interest 1969 (percent)	F's interest 1971 (percent)	Interest treated as held by disqualified person (percent)	Disqualified persons own (percent)	Foundation voting level (percent)	Substituted combined voting level (percent)	Disqualified person voting level (percent)	Permitted holdings (percent)	Comments
May 26, 1969.	5	5	.....	5	45	0	50	50	0	
May 1, 1971	*+43*	.....	*+43*	*+43*	*−43*	.....	.....	.....	.....	E dies.
Do	48	5	43	48	2	0	50	50	0	
June 1, 1972.	48	5	43	48	2	0	50	50	0	Distribution.
May 26, 1979.	.....	.....	.....	*−5*	.....	*+5*	.....	*−5*	*+5*	2d phase for 5 pct
Do	48	5	43	43	2	5	50	45	5	

Date	F's owns (percent)	F's interest 1969 (percent)	F's interest 1971 (percent)	Interest treated as held by disqualified person (percent)	Disqualified persons own (percent)	Foundation voting level (percent)	Substituted combined voting level (percent)	Disqualified person voting level (percent)	Permitted holdings (percent)	Comments
June 1, 1982.	.....	.....	.....	*−43*	.....	*+43*	.....	*−43*	*+43*	2d phase for 43 pct.
Do	48	5	43	0	2	48	50	2	43	
July 1, 1993	*−6*	*−5*	*−1*	.....	.....	*−6*	*−6*	.....	*−6*	F sells 6 pct.
Do	42	0	42	0	2	42	44	2	42	
July 1, 1995	*−10*	.....	*−10*	.....	.....	*−10*	*−10*	.....	*−10*	F sells 10 pct.
Do	32	0	32	0	2	32	34	2	32	
June 1, 1997.	32	0	32	0	2	32	34	2	32	3d phase for 32 pct.

Example 6. (i) On May 26, 1969, F, a private foundation, owns 30 percent of the voting stock in R Corporation (voting power and value), and disqualified persons own 20 percent. On August 1, 1978, F disposes of 6 percent of the stock to a nondisqualified person. On May 1, 1981, G, a disqualified person, dies leaving 15 percent of the voting stock to F. Assume that distribution was made on June 1, 1982, and that section 4943(c)(5) applies. On May 26, 1969, the substituted combined voting level and the disqualified person voting level are each 50 percent, and the permitted holdings are 0 percent (50% − 50%). On August 1, 1978, these levels decrease to 44 percent (50% − 6%). On May 26, 1979, the foundation voting level increases to 24 percent (30% − 6%), the disqualified person voting level decreases to 20 percent (44% − 24%), and the permitted holdings are 24 percent (44% − 20%). If F had not disposed of the 6 percent of the stock prior to May 26, 1979, on May 26, 1979, the beginning of the second phase for F's 1969 holdings, F's permitted holdings would have been 25 percent, the lesser of 25 percent (under section 4943(c)(4)(D)(i)) or 30 percent (50% − 20%). Since the 30 percent interest would no longer have been treated as held by a disqualified person on such date, F would have had excess business holdings of 5 percent (30% − 25%).

(ii) On May 1, 1981, and June 1, 1982 (assuming F had disposed of the 6 percent holdings), the foundation voting level, the disqualified person voting level, the substituted combined voting level and permitted holdings remain respectively 24 percent, 20 percent, 44 percent and 24 percent. On May 1, 1981, the 15 percent interest is treated as held by a disqualified person for a period extending through May 31, 1992. On July 1, 1991, F sells 16 percent of the voting stock in R to a nondisqualified person, thereby reducing the substituted combined voting level to 28 percent (44% − 16%), and reducing the foundation voting level to 8 percent (24% − 16%). The disqualified person voting level remains at 20 percent. On June 1, 1992, at the beginning of the second phase for F's holdings acquired by will, the substituted combined voting level remains at 28 percent, the foundation voting level increases to 23 percent (8% + 15%) and the disqualified person voting level decreases to 5 percent (20% − 15%). The permitted holdings on such date are 23 percent (28% − 5%). If F had not disposed of the 16 percent interest prior to June 1, 1992, F's permitted holdings would have been 25 percent, the lesser of 25 percent (under section 4943 (c)(4)(D)(i)) or 39 percent (44% − 5%). Since as of such date, F's entire holdings of 39 percent would no longer have been treated as held by a disqualified person, F would have had excess business holdings of 14 percent (39% − 25%).

Date	F's owns (percent)	F's interest 1969 (percent)	F's interest 1981 (percent)	Interest treated as held by disqualified person (percent)	Disqualified persons own (percent)	Foundation voting level (percent)	Substituted combined voting level (percent)	Disqualified person voting level (percent)	Permitted holdings (percent)	Comments
May 26, 1969	30	30	.....	30	20	0	50	50	0	
Aug. 1, 1978	*−6*	*−6*	.....	*−6*	.....	.....	*−6*	*−6*	.....	F disposes of 6 pct.
Do	24	24	.....	24	20	0	44	44	0	
May 26, 1979	.....	.....	.....	*−24*	.....	*+24*	.....	*−24*	*+24*	2d phase for 24 pct.
Do	24	24	.....	0	20	24	44	20	24	
May 1, 1981	*+15*	.....	*+15*	*+15*	*−15*	.....	.....	.....	.....	G dies.

Date	F's owns (percent)	F's interest 1969 (percent)	F's interest 1981 (percent)	Interest treated as held by disqualified person (percent)	Disqualified persons own (percent)	Foundation voting level (percent)	Substituted combined voting level (percent)	Disqualified person voting level (percent)	Permitted holdings (percent)	Comments
Do	39	24	15	15	5	24	44	20	24	
June 1, 1982	39	24	15	15	5	24	44	20	24	Distribution.
July 1, 1991	*−16*	*−16*	.....	.....	.....	*−16*	*−16*	.....	*−16*	F disposes of 16 pct.
Do	23	8	15	15	5	8	28	20	8	
June 1, 1992	.....	.....	.....	*−15*	.....	*+15*	.....	*−15*	*+15*	2d phase for 15 pct.
Do	23	8	15	0	5	23	28	5	23	

Example 7. (i) On May 26, 1969, F, a private foundation, owns 5 percent of the voting stock in S Corporation (voting power and value), and disqualified persons own 45 percent. On May 1, 1980, H, a disqualified person, dies leaving 41 percent of the voting stock to F. Assume that distribution is made on June 1, 1981, and that section 4943(c)(5) applies. On May 26, 1969, the substituted combined voting level and disqualified person voting levels are each 50 percent. On May 26, 1979, the disqualified person voting level decreases to 45 percent, the foundation voting level increases to 5 percent, and the permitted holdings are 5 percent (50% − 45%). On May 1, 1980, and June 1, 1981, the levels remain the same. Since the 41 percent holdings are treated as held by a disqualified person for the period beginning on May 1, 1980, and extending through May 31, 1991, F's remaining holdings of 5 percent do not exceed the 25 percent limitation of section 4943(c)(4)(D)(i).

(ii) On August 1, 1990, F sells 22 percent of the voting stock of S to a nondisqualified person, reducing the 5 percent foundation voting level to zero, leaving 17 percent (22% − 5%) to reduce the disqualified person voting level to 28 percent (45% − 17%) so that the substituted combined voting level equals 28 percent (50% − 22%). On June 1, 1991, the beginning of the second phase for the remaining 24 percent (41% − 17%) of F's holdings acquired by will, the foundation voting level increases from zero to 24 percent, the disqualified person voting level decreases to 4 percent (28% − 24%), the substituted combined voting level remains at 28 percent, and the permitted holdings equal 24 percent (28% − 4%).

(iii) If F had not disposed of the 22 percent holdings prior to June 1, 1991, F's permitted holdings would have been 25 percent, the lesser of 25 percent (under section 4943(c)(4)(D)(i)) or 46 percent (50% − 4%). Since as of such date, F's entire holdings of 46 percent would no longer have been treated as held by a disqualified person, F would have had excess business holdings of 21 percent (46% − 25%).

Date	F owns (percent)	F's interest 1969 (percent)	F's interest 1980 (percent)	Interest treated as held by disqualified person (percent)	Disqualified persons own (percent)	Foundation voting level (percent)	Substituted combined voting level (percent)	Disqualified person voting level (percent)	Permitted holdings (percent	Comments
May 26, 1969.	5	5	.....	5	45	0	50	50	0	
Do	.....	.....	.....	*−5*	.....	*+5*	.....	*−5*	*+5*	2d phase for 5 pct.
May 26, 1969.	5	5	.....	0	45	5	50	45	5	
May 1, 1980	*+41*	.....	*+41*	*+41*	*−41*	.....	.....	.....	.....	H dies.
Do	46	5	41	41	4	5	50	45	5	
June 1, 1981.	46	5	41	41	4	5	50	45	5	Distribution.
Aug. 1, 1990.	*−22*	*−5*	*−17*	*−17*	.....	*−5*	*−22*	*−17*	*−5*	F disposes of 22 pct.
Do	24	0	24	24	4	0	28	28	0	
June 1, 1991.	.....	.....	.....	*−24*	.....	*+24*	.....	*−24*	*+24*	2d phase for 24 pct.
Do	24	0	24	0	4	24	28	4	24	

§ 53.4943–6 Five-year period to dispose of gifts, bequests, etc.

(a) *In general*—(1) *Application*. (i) Paragraph (6) of section 4943(c) prescribes transition rules for a private foundation, which, but for such paragraph, would have excess business holdings as a result of a change in the holdings in a business enterprise after May 26, 1969 (other than by purchase by such private foundation or by a disqualified person) to the extent that section 4943(c)(5) (relating to certain holdings acquired under a pre-May 27, 1969, will on trust) does not apply.

(ii) Subparagraph (A) of section 4943(c)(6) applies where, immediately prior to a change in holdings described in paragraph (a)(1)(i) of this section, the foundation has no excess business holdings in such enterprise (determined without regard to section 4943(c) (4), (5), or (6)). In such a case, the entire interest of the foundation in such enterprise (immediately after such change) shall (while held by the foundation) be treated as held by a disqualified person (rather than by the foundation) during the five-year period beginning on the date of such change.

(iii) Subparagraph (B) of section 4943(c)(6) applies where the foundation has excess business holdings in such enterprise (determined without regard to section 4943(c) (4), (5), or (6)) immediately prior to a change in holdings described in paragraph (a)(1)(i) of this section. In such a case, the interest of the foundation in such enterprise (immediately after such change) shall (while held by the foundation) be treated as held by a disqualified person (rather than the foundation) during the five-year period beginning on the date of such change, except that if and as soon as any holdings in such enterprise become excess business holdings during such period (determined without regard to such change (and the resulting application of section 4943(c)(6) to the foundation's interest in such enterprise)), such holdings shall no longer be treated as held by a disqualified person under this section, but shall constitute excess business holdings subject to the initial tax. In applying the preceding sentence, if holdings of the foundation which (but for such change in holdings (and the resulting application of section 4943(c)(6) to the foundation's interest in such enterprise)) would be subject to the 25 percent limit prescribed by section 4943(c)(4)(D) after the expiration of the first phase, such holdings shall be treated as subject to such percentage limitation for purposes of determining excess business holdings. For example, if a private foundation in 1978 has present holdings of 28 percent in a business enterprise to which section 4943(c)(4) applies, and such holdings would exceed the 25 percent limit of section 4943(c)(4)(D)(i) on May 26, 1979, a gift of 5 percent to the foundation in 1978 of an interest in such enterprise shall not prevent the 3 percent (28% − 25%) excess over the 25 percent limit from constituting excess business holdings on May 26, 1979, if on such date disqualified persons hold more than a 2 percent interest in such enterprise (and no other transaction has taken place).

(2) *Acquisitions that are not purchases*. Section 4943(c)(6) does not apply if a change in holdings in a business enterprise is the result of a purchase by the private foundation or a disqualified person. For purposes of subparagraph (a) of this paragraph, the term ''purchase'' shall not include any acquisition by gift, devise, bequest, legacy, or interstate succession. Paragraph (d) of this section provides rules for the treatment of increases in holdings received in a readjustment (as defined in § 53.4943–7(d)(1)).

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

Example 1. On January 4, 1985, A, an individual, makes a contribution to F, a private foundation, of 200 shares of X Corporation common stock. Assume that F had no X stock before January 4, 1985, and under section 4943(c)(1) the receipt of the X stock by F would cause some or all of the 200 shares of the X stock to be classified as excess business holdings. Under the provisions of section 4943(c)(6)(A) and this paragraph (a), since the contribution of the X stock to F is a gift and not a purchase, the X stock in F's hands is treated as held by disqualified persons and not by F through January 3, 1990.

Example 2. Assume the facts as stated in Example (1) except that F receives the X stock as a bequest pursuant to the terms of A's will executed on April 1, 1980. A dies on June 3, 1984, and the stock is distributed to F on February 16, 1985. As in Example (1), the

bequest of X to F is not a purchase under this paragraph (a). Consequently, the X stock in F's hands is treated as held by disqualified persons and not by F through February 15, 1990.

Example 3. On February 1, 1980, F, a private foundation, owns 15 percent of the voting stock of X Corporation, and disqualified persons own 4 percent of the voting stock of X Corporation. On February 2, 1980, B, a nondisqualified person, contributes 8 percent of the voting stock of X to F in a transaction to which section 4943(c)(5) does not apply. Assuming that the 35 percent limit of section 4943(c)(2)(B) does not apply, under the provisions of section 4943(c)(6)(A) and paragraph (a) of this section the 23 percent voting stock owned by F on such date is treated as held by a disqualified person through February 1, 1985, since F would have had excess business holdings of 7 percent as a result of the contribution (23% actual holdings less 16% (20% − 4%) permitted holdings). On March 1, 1984, C, another nondisqualified person, contributes 6 percent of the voting stock of X Corporation to F. But for this second contribution and the resulting application of section 4943(c)(6) to F's interest in X, F would have excess business holdings of 7 percent (23% − 16%) within the five-year period beginning on the date of such contribution. Accordingly, under section 4943(c)(6)(B) and paragraph (a) of this section, all 29 percent (6% + 23%) of the stock held by F on March 1, 1984, will be treated as held by a disqualified person until March 1, 1989, except that 7 percent will cease to be so treated on February 2, 1985. If prior to February 2, 1985, no further transactions occurred in the stock of X, F would have excess business holdings of 7 percent subject to the initial tax, since the amount still treated as held by disqualified persons (29% − 7%) plus the amount actually held by disqualified persons (4%) already exceed 20 percent.

(b) *Special rules for acquisitions by will or trust*—(1) *In general.* In the case of an acquisition of holdings in a business enterprise by a private foundation pursuant to the terms of a will or trust, the five-year period described in section 4943(c)(6) and in this section shall not commence until the date on which the distribution of such holdings from the estate or trust to the foundation occurs. See § 53.4943–5(b)(1) for rules relating to the determination of the date of distribution under the terms of a will or trust. For purposes of this subparagraph, holdings in a business enterprise will not be treated as acquired by a private foundation pursuant to the terms of a will where the holdings in the business enterprise were not held by the decedent. Thus, in the case of after-acquired property, this subparagraph shall not apply, the five-year period described in section 4943(c)(6) and this section shall commence on the date of acquisition of such holdings by the estate, and such five-year period may expire prior to the date of distribution of such holdings from the estate. To the extent that an interest to which section 4943(c)(6) and this paragraph (b)(1) apply is constructively held by a private foundation under section 4943(d)(1) and § 53.4943–8 prior to the date of distribution, it shall be treated as held by a disqualified person prior to such date by reason of section 4943(c)(6). See § 53.4943–8 for rules relating to constructive holdings held in an estate or trust for the benefit of the foundation.

(2) *Special rule for section 4943(c)(5) interests acquired from a nondisqualified person.* (i) In the case of holdings of a private foundation in a business enterprise to which section 4943(c)(5) (relating to certain holdings acquired under a pre-May 27, 1969, will or trust) applies which are acquired from a nondisqualified person, the interest of the foundation in such enterprise (immediately after such acquisition) shall (while held by the foundation) be treated as held by a disqualified person (rather than the foundation) under section 4943(c)(6)(B) and paragraph (a)(1)(iii) of this section from the date of acquisition until the end of the fifth year following the date of distribution of such holdings. Thereafter, only the holdings to which section 4943(c)(5) and § 53.4943–5(a)(1) apply shall continue to be treated as held by a disqualified person until the end of the first phase with respect thereto.

(ii) The provisions of paragraph (b)(2)(i) of this section may be illustrated by the following examples:

Example 1. On May 26, 1969, F, a private foundation, owns 5 percent of the voting stock of Corporation X and no disqualified persons own any stock in X. On June 30, 1977, a nondisqualified person bequeaths to F 33 percent of the voting stock in X to which section 4943(c)(5) applies. This 33 percent interest is distributed to F on August 17, 1978. Under section 4943(c)(6)(A) the entire 38 percent (5% + 33%) of the X voting stock shall be treated as held by a disqualified person

from June 30, 1977 (the date the 33 percent interest is constructively acquired by F) until August 17, 1983 (five years after the date of distribution of the 33 percent interest to F). However, assuming that the 35 percent limit of section 4943(c)(2)(B) does not apply, the substituted combined voting level on June 30, 1977 is only 33 percent because there was no interest to which section 4943(c) (4) or (5) applied immediately before that date and thus there was no substituted combined voting level at that time. In that case, since the 3-phase holding period is only available for the interest acquired by will (33%) under section 4943(c)(5), the substituted combined voting level on June 30, 1977 is only 33 percent, not 38 percent. Assuming that the substituted combined voting level remains 33 percent at all relevant times, and prior to August 17, 1983, no further transactions occur in the stock of X, F on that date would have excess business holdings of 5 percent subject to the initial tax. The amount treated as held by disqualified persons at that time (33%) would equal the substituted combined voting level at that time (33%), and thus permitted holdings would be zero. Under section 4943(c)(5) the 33 percent interest will continue to be treated as held by a disqualified person until August 17, 1988 (10 years after the date of distribution).

Example 2. On May 26, 1969, F, a private foundation, owns 29 percent of the stock (voting power and value) of Corporation X, and on June 30, 1977, a nondisqualified person bequeaths to F 23 percent of the stock (voting power and value) in X to which section 4943(c)(5) does apply. This 23 percent interest is distributed to F on August 17, 1978. Disqualified persons hold no stock of X. Although the substituted combined voting and value levels cannot exceed 50 percent on May 26, 1979 (at the start of the second phase with respect to the 29 percent interest), under section 4943(c)(6)(B) the entire 52 percent (29% + 23%) of the X voting stock shall be treated as held by a disqualified person from June 30, 1977 (the date the 23% interest is constructively acquired by F) until August 17, 1983 (five years after the date of distribution of the 23% interest to F). On June 1, 1980, during such second phase, D, a disqualified person, purchases 3 percent of the X stock (voting power and value). On such date, but for the acquisition by F of the 23 percent interest, F would have had excess business holdings of 4 percent. The purchase by D of more than 2 percent of the voting stock of X causes the 25 percent limit of section 4943(c)(4)(D)(i) to apply to the 29 percent interest (29% − 25% = 4%). Thus, on June 1, 1980, 4 percent of the X voting stock held by F since May 27, 1969, shall cease to be treated as held by a disqualified person under section 4943(c)(6)(B) and become excess business holdings subject to the initial tax. See § 53.4943–2(a)(1)(ii) for the 90-day period in which to dispose of these excess business holdings resulting from the purchase by the disqualified person.

(c) *Exceptions.* (1) Section 4943(c)(6) and this section shall not apply to any transfer of holdings in a business enterprise by one private foundation to another private foundation which is related to the first foundation within the meaning of section 4946(a)(1)(H).

(2) Section 4943(c)(6) and this section shall not apply to an increase in the holdings of a private foundation in a business enterprise that is part of a plan whereby disqualified persons will purchase additional holdings in the same enterprise during the five-year period beginning on the date of such change, e.g., to maintain control of such enterprise, since such increase shall be treated as caused in part by the purchase of such additional holdings.

(3) The purchase of holdings by an entity whose holdings are treated as constructively owned by a foundation, its disqualified persons, or both, under section 4943(d)(1) shall be treated as a purchase by a disqualified person if the foundation, its disqualified persons or both have effective control of the entity or otherwise can control the purchase. For example, if a foundation is the beneficiary of a specific bequest of $20,000 and its consent is required for the estate to make a purchase using such cash, then a purchase by the estate using such cash would be treated as a purchase by a disqualified person. Similarly, if an executor of an estate is a disqualified person with respect to a private foundation, any purchase by the estate would be treated as a purchase by a disqualified person.

(4) If a private foundation, its disqualified persons, or both, hold an interest in specific property under the terms of a will or trust, and if the private foundation, its disqualified persons, or both, consent or otherwise agree to the substitution of holdings in a business enterprise for such specific property, such holdings shall be treated as acquired by purchase by a disqualified person. For example, if a private foundation is the beneficiary of a

specific bequest of $20,000 and the private foundation agrees to accept certain of the estate's holdings in a business enterprise in satisfaction of such specific bequest, such holdings will be treated as acquired by purchase by a disqualified person even if such holdings were held by the decedent.

(d) *Readjustments and distributions*—(1) *General rule.* Except as otherwise provided in subparagraph (2) of this paragraph, any increase in holdings in a business enterprise that is the result of a readjustment (as defined in § 53.4943–7(d)(1)) shall be treated as acquired other than by purchase. However, holdings that are attributable to holdings owned by the private foundation that would have been excess business holdings except for the fact that such holdings were treated as held by a disqualified person prior to the readjustment shall in no event be treated as held by a disqualified person after the date on which the holdings to which the change is attributable would have ceased to be treated as held by a disqualified person.

(2) *Exceptions.* Any increase in holdings in a business enterprise that is the result of a readjustment (as defined in § 53.4943–7(d)(1)), including any change resulting from application of the rule in § 53.4943–8(c)(3), shall be treated as occurring by purchase by a disqualified person:

(i) To the extent the increase is attributable to holdings that were excess business holdings prior to the readjustment, and separately

(ii) To the full extent of the increase if the readjustment includes a prohibited transaction, unless the foundation establishes to the satisfaction of the Commissioner that effective control of all parties to the transaction was, at the time of the transaction, in one or more persons (other than the foundation) who are not disqualified persons with respect to the foundation. See § 53.4943–7(d)(2) for the definition of prohibited transaction.

(3) *Section 4943(c)(6) holdings.* If, immediately prior to a readjustment (as defined in § 53.4943–7(d)(1)), a private foundation has holdings in a business enterprise that are treated under section 4943(c)(6) as held by a disqualified person, then any holdings in a business enterprise that are received in the readjustment in exchange for such section 4943(c)(6) holdings shall be treated as the holdings surrendered in the exchange to the same extent as provided in § 53.4943–7 with respect to exchanges involving holdings to which section 4943(c) (4) or (5) applies. Rules similar to those in § 53.4943–7(a)(2) shall be applied to determine when holdings are treated as surrendered or received in a readjustment for purposes of this paragraph.

(4) *Redemption by a corporation that is a disqualified person.* If a foundation holds an interest in a corporation that is a disqualified person, an increase in the holdings of the private foundation, its disqualified person, or both, as a result of a redemption or a purchase of stock of the disqualified person corporation by such corporation shall not be treated as acquired by purchase by a disqualified person based solely on the status of the corporation as a disqualified person.

(5) *One percent rule for redemptions.* If the holdings of a foundation, its disqualified persons, or both, in a business enterprise are increased as a result of one or more redemptions during any taxable year then, unless the aggregate of such increases equals or exceeds one percent of the outstanding voting stock or one percent of the value of all outstanding shares of all classes of stock, the determination of whether such increases cause the foundation to have excess business holdings shall be made only at the close of the private foundation's taxable year. The five-year period described in section 4943(c)(6) or the 90-day period described in § 53.4943–2(a)(1)(ii), whichever is applicable, shall begin on the last day of such taxable year. If, however, the aggregate of such increases equals or exceeds one percent of the outstanding voting stock or one percent of the value of all outstanding shares of all classes of stock, the determination of whether such increases cause the foundation to have excess business holdings shall be made, and the applicable five-year or 90-day period shall begin, as of the date the increases, in the aggregate, equal or exceed one percent.

(6) *Examples*. The provisions of this paragraph are illustrated in § 53.4943–7(f) and by the following examples:

Example 1. (i) F, a private foundation, holds 20% of the voting stock of X corporation, an active business enterprise. No disqualified person with respect to F holds any X stock. In 1980, X redeems 10% of its outstanding shares, increasing F's holdings to 22% of the X stock. Assume the redemption by X is not a prohibited transaction.

(ii) All of F's holdings before the redemption are permitted holdings under section 4943(c)(2). There is no effective control of X by third parties so the 35% permitted holdings rule is inapplicable. F's holdings after the redemption exceed the permitted holdings under section 4943 (c)(2) (20%). Because the increase is attributable to stock that was permitted holdings prior to the readjustment, and the readjustment does not involve a prohibited transaction, the 2% increase in F's holdings of X stock is treated as acquired other than by purchase. Therefore, under section 4943(c)(6) and this section, F will have 5 years from the date of the redemption to dispose of the 2% excess.

Example 2. (i) Assume the same facts as in *Example (1)* except that the 20% of X stock held by F was donated by X corporation, was worth more than $5,000 and represented 20% of the contributions received by the foundation through the end of the taxable year in which the gift of stock was made.

(ii) X corporation is a disqualified person with respect to F under section 4946(a)(1)(A). Under subparagraph (4), the redemption of X stock is not treated as a purchase by a disqualified person merely because X is a disqualified person with respect to F. Therefore the rules of this paragraph apply as if the redemption were made by a corporation which is not a disqualified person. The analysis and result are the same as in *Example (1)*.

Example 3. (i) On May 1, 1990, F, a private foundation, received a donation of 40% of the stock of X corporation, a business enterprise. Neither F nor any disqualified person with respect to F holds any other interest in X. On June 1, 1992, the X corporation redeemed F's 40% interest in exchange for 100% of the stock of Y corporation, a wholly-owned subsidiary of X. Assume the redemption by X is not a prohibited transaction.

(ii) Under section 4943(c)(6), the X stock acquired by gift is treated as held by disqualified persons through April 30, 1995. Under subparagraph (3) of this paragraph (d), 40% of the 100% interest in Y received in exchange for F's 40% interest in X is treated as F's 40% interest in X and is therefore treated as held by disqualified persons through April 30, 1995. In addition, under subparagraph (1) of this paragraph (d), the 60% interest in Y that represents an increase in holdings above the 40% held before the readjustment will be treated as acquired other than by purchase. However, F's 20% interest in X in excess of 20% permitted holdings under 4943(c)(2) would have been excess business holdings if such interest had not been treated as held by as disqualified person on June 1, 1992. Therefore, to the extent of a 30% interest in Y, (*i.e.* , the portion of the increased holdings in *Y* attributable to F's 20% holdings in X) the increased holdings will be treated as held by disqualified person only through April 30, 1995, since this is the latest date on which F's original 40% interest in X would have been treated as held by disqualified persons. The remaining 30% interest in Y will be treated as held by disqualified persons for five years from the date of the exchange (through May 31, 1997).

(e) *Constructive holdings*. Any change in holdings in a business enterprise that occurs because a corporation ceases to be actively engaged in a trade or business, thus causing its holdings to be constructively owned by its shareholders, shall be treated as acquired other than by purchase.

(f) *Certain transactions treated as purchases; cross references*. For the application of section 4943(c)(6) to holdings that were not an interest in a business enterprise when acquired but that subsequently become holdings in a business enterprise, see § 53.4943–10(d)(2).

[T.D. 7496, 42 FR 46285, Sept. 15, 1977, as amended by T.D. 7944, 49 FR 6479, Feb. 22, 1984]

§ 53.4943–7 Special rules for readjustments involving grandfathered holdings.

(a) *General rules*—(1) *Readjustments*. Except to the extent provided in paragraph (b) of this section, if a private foundation, its disqualified persons, or both together have holdings in a corporation to which section 4943(c) (4) or (5) applies, stock of a corporation received by the foundation, its disqualified persons, or both together in a readjustment (as defined in paragraph (d)(1) of this section) in exchange for such holdings to which section 4943 (c) (4) or (5) applies shall be treated, for purposes of section 4943 (c) (4) or (5), as the stock surrendered in the exchange.

(2) *No exchange necessary*. Paragraph (a)(1) of this section shall apply to all readjustments even if no exchange occurs. For purposes of this section, all stock held (directly or indirectly) before a readjustment in any corporation

involved in the readjustment shall be treated as stock surrendered in the readjustment and all stock held (directly or indirectly) after the readjustment in any corporation involved in the readjustment shall be treated as stock received in the readjustment in exchange for the stock treated as surrendered.

(b) *Exceptions and limitations*—(1) *Limitation on increases in percentage of voting stock.* (i) If the percentage of voting stock in a business enterprise owned (directly or indirectly) by a private foundation by reason of its ownership of stock received in an exchange described in paragraph (a) of this section exceeds the greatest percentage of voting stock in any business enterprise owned (directly or indirectly) by the private foundation prior to such exchange by reason of its ownership of the stock surrendered by it in the exchange, then:

(A) That portion of the stock received by the private foundation in the exchange which represents such excess is to be treated as an increase in the holdings of the private foundation in accordance with § 53.4943–6 (d), and

(B) Only the remaining portion of the stock received by the private foundation in the exchange shall be treated as the stock surrendered by the private foundation in the exchange.

(ii) If the sum of the percentage of voting stock in a business enterprise owned (directly or indirectly) by disqualified persons by reason of their ownership of stock received in an exchange described in paragraph (a) of this section plus the percentage of voting stock in the business enterprise owned (directly or indirectly) by the private foundation by reason of its ownership of stock received in the exchange and treated as the stock surrendered under paragraph (b) (1) (i) of this section exceeds the greatest percentage of voting stock in any business enterprise owned (directly or indirectly) by the private foundation and its disqualified person in combination by reason of their ownership of the stock surrendered by them in the exchange, then:

(A) That portion of the stock received by the disqualified persons in the exchange which represents such excess is to be treated as an increase in the holdings of the disqualified persons in accordance with § 53.4943–6(d), and

(B) Only the remaining portion of the stock received by the disqualified persons in the exchange is to be treated as the stock surrendered by the disqualified persons in the exchange.

(2) *Limitation on increase in percentage of value.* (i) If the percentage of value of all outstanding shares of all classes of stock in a business enterprise owned (directly or indirectly) by a private foundation by reason of its ownership of stock received in an exchange described in paragraph (a) of this section exceeds the greatest percentage of such value in any business enterprise owned (directly or indirectly) by the private foundation prior to such exchange by reason of its ownership of the stock surrendered by it in the exchange, then:

(A) That portion of the stock received by the private foundation in the exchange which represents such excess is to be treated as an increase in the holdings of the private foundation in accordance with § 53.4943–6(d), and

(B) Only the remaining portion of the stock received by the private foundation in the exchange shall be treated as the stock surrendered by the private foundation in the exchange.

(ii) If the sum of the percentage of value of all outstanding shares of all classes of stock in a business enterprise owned (directly or indirectly) by disqualified persons by reason of their ownership of stock received in an exchange described in paragraph (a) of this section plus the percentage of such value in the business enterprise owned (directly or indirectly) by the private foundation by reason of its ownership of stock received in the exchange and treated as the stock surrendered under paragraph (b)(2)(i) of this section exceeds the greatest percentage of such value in any business enterprise owned (directly or indirectly) by the private foundation and its disqualified persons in combination prior to the exchange by reason of their ownership of the stock surrendered by them in the exchange, then:

(A) That portion of the stock received by the disqualified persons in the exchange which represents such excess is to be treated as an increase in

the holdings of the disqualified persons in accordance with § 53.4943–6(d), and

(B) Only the remaining portion of the stock received by the disqualified persons in the exchange is to be treated as the stock surrendered by the disqualified persons in the exchange.

(3) *Increases in percentage of both voting stock and value.* (i) If, as the result of an exchange described in paragraph (a) of this section, a private foundation has excesses determined under both paragraphs (b)(1)(i) and (b)(2)(i) of this section, then:

(A) That portion of the stock received by the private foundation in the exchange that represents the larger excess is to be treated as an increase in the holdings of the private foundation in accordance with § 53.4943–6(d), and

(B) Only the remaining portion of the stock received by the private foundation in the exchange is to be treated as the stock surrendered by the private foundation in the exchange.

(ii) If as the result of an exchange described in paragraph (a) of this section, disqualified persons have excesses determined under both paragraphs (b)(1)(ii) and (b)(2)(ii) of this section, then:

(A) That portion of the stock received by the disqualified persons in the exchange that represents the larger excess is to be treated as an increase in the holdings of the disqualified persons in accordance with § 53.4943–6(d), and

(B) Only the remaining portion of the stock received by disqualified persons in the exchange is to be treated as the stock surrendered by disqualified persons in the exchange.

(4) *Exception for prohibited transactions.* If a readjustment includes a prohibited transaction, as defined in paragraph (d)(2) of this section, then this paragraph shall be applied substituting, for purposes of paragraph (b)(1) and (b)(2), the lowest percentage of voting power or value owned prior to the exchange in any business enterprise involved in the readjustment to which the exchange relates for the greatest percentage of voting power or value in any business enterprise owned by reason of ownership of the stock surrendered in the exchange.

(5) *Voting and value levels.* After an exchange described in paragraph (a) of this section, the private foundation voting and value levels, and the substituted combined voting and value levels (as defined in § 53.4943–4(d)(2)) shall be the lesser of each respective level immediately prior to the exchange with respect to the stock surrendered in the exchange and each such respective level determined immediately after the exchange by taking into account only the stock received in the exchange that is treated under this paragraph as the stock surrendered in the exchange. If the stock of more than one corporation is surrendered in exchange for stock of one corporation, the highest of each voting or value level determined immediately prior to the exchange with respect to the stock of the corporations surrendered in the exchange shall be treated as such level immediately prior to the exchange.

(6) *Determination of phases*—(i) *In general.* Stock received in an exchange described in paragraph (a) of this section that is treated as stock surrendered in the exchange under this paragraph shall be treated as subject to the same first, second, and third phases that were applicable to the stock surrendered for it. For purposes of determining the applicable phases, stock received in an exchange shall be treated as received in exchange for particular holdings of stock surrendered based on the terms of the exchange. Where only a portion of the stock received is treated as the stock surrendered, such portion of the stock received shall be treated as exchanged for particular holdings of stock surrendered in the same proportions as the total stock received was exchanged for particular holdings of stock surrendered. For example, if 20 shares of X stock owned by a private foundation, subject to a first phase beginning on January 1, 1978 and ending on December 31, 1987, are exchanged for 20 shares of Y stock, and 40 shares of X stock owned by the private foundation, subject to a first phase beginning on June 1, 1980 and ending on May 31, 1990, are exchanged for 40 shares of Y stock, then ⅓ of the Y stock received by the private foundation is treated as received in exchanged for X stock having the January 1, 1978–December 31, 1987 first phase and ⅔ of the Y stock received by the private

foundation is treated as received in exchange for the X stock having the June 1, 1980–May 31, 1990 first phase. If only 30 shares of the Y stock received by the private foundation are treated as the stock surrendered, then ⅓ (10 Y shares) will be subject to the January 1, 1978–December 31, 1987 first phase and ⅔ (20 Y shares) will be subject to the June 1, 1980–May 31, 1990 first phase.

(ii) *Transitional rule.* In any case in which holdings subject to section 4943(c)(4) or 4943(c)(5) have been consolidated prior to May 22, 1984, then the longest first phase applicable to any of the holdings surrendered in the consolidation shall be applied to the holdings received by the foundation in the consolidation that are treated as the holdings surrendered in the consolidation. For purposes of this clause, a consolidation is any readjustment that results in a reduction in the number of entities in which the foundation has direct holdings.

(c) *Plan to dispose of excess business holdings.* (1) Notwithstanding § 53.4943–4(d)(i)(4)(D) (relating to restrictions on increases in levels) and paragraphs (a) and (b) of this section, if a readjustment occurs under an approved plan to dispose of stock to which section 4943(c) (4) or (5) applies, in order to meet the requirements of section 4943(c)(4) (*i.e.*, to meet the reduced limits that will be applicable after the first phase holding period described in § 53.4943–4(c)) or to meet the requirements of section 4943(c)(2), all of the stock received in the readjustment shall be treated as held by disqualified persons through the end of the longest first phase holding period applicable to stock surrendered in the readjustment. The foundation and substituted combined voting and value levels shall not be increased on account of the readjustment.

(2) For purposes of this paragraph, a plan is an approved plan only if it is approved by the Commissioner and may be subject to such conditions as the Commissioner determines. A plan must be approved prior to any exchange or distribution pursuant to the plan except for a showing of good cause such as a business emergency.

(d) *Definitions*—(1) *Readjustments.* For purposes of this section, the term ''readjustment'' includes, but is not limited to:

(i) A merger or consolidation;

(ii) A recapitalization;

(iii) An acquisition of stock or assets;

(iv) A transfer of assets;

(v) A change in identity, form, or place of organization, however effected;

(vi) A redemption;

(vii) A distribution of assets or of stock, including a distribution to which section 301, 302, 331, or 355 applies or a distribution of stock of the distributing corporation.

(2) *Prohibited transaction.* A prohibited transaction is any transaction involving a private foundation that has holdings in a business enterprise which:

(i) Acquires stock (or similar interest in the case of an unincorporated entity) or assets of a business enterprise or redeems its own stock (or similar interest in the case of an unincorporated entity) using cash or other property transferred to the acquiring business enterprise (e.g., as a contribution to capital) by the private foundation, its disqualified persons, or both;

(ii) Acquires stock (or similar interest in the case of an unincorporated entity) or assets of a business enterprise or redeems its own stock (or similar interest in the case of an unincorporated entity) using the proceeds of a loan made to, or guaranteed by, the private foundation, its disqualified persons, or both;

(iii) Acquires 40 percent or more of the voting stock (or similar interest in the case of an unincorporated entity), 40 percent or more of the value of all outstanding shares of all classes of stock (or similar interest in the case of an unincorporated entity), or 40 percent or more of the assets of a business enterprise if the acquiring business enterprise's net assets used in its trade or business prior to such acquisition are insubstantial when compared to the net assets acquired or when compared to the net assets of the business enterprise, the stock (or similar interest in the case of an unincorporated entity) of which was acquired. For this purpose, an insubstantial ratio means a ratio that is 15% or less; or

(iv) Is used as a device to acquire or expand excess business holdings. The

determination of whether a business enterprise is used as a device to acquire or expand excess business holdings shall be determined based on all the facts and circumstances. A business enterprise shall be presumed to have been used as a device to acquire or expand excess business holdings if it acquires 40 percent or more of the voting stock (or similar interest in the case of an unincorporated entity), 40 percent or more of the value of all outstanding shares of all classes of stock (or similar interest in the case of an unincorporated entity), or 40 percent or more of the assets of a business enterprise if the consideration for the acquisition consists primarily of nonvoting stock (or similar interest in the case of an unincorporated entity) of the acquiring business enterprise.

(3) *Corporation involved in a readjustment.* A corporation shall be treated as involved in a readjustment if, as part of the readjustment, any stock of the corporation is issued or redeemed, or any stock or assets of the corporation are distributed, exchanged, purchased, sold, acquired, or otherwise transferred.

(e) *Application to unincorporated business enterprise.* The rules of this section shall apply equally to partnerships and other unincorporated business enterprises, applying the rules and substitutions provided in § 53.4943–3(c)(2), (3), and (4).

(f) *Examples.* The provisions of this section and § 53.4943–6(d) are illustrated by the following examples, which assume no prohibited transactions are involved unless otherwise stated:

Example 1. (i) F, a private foundation, has owned 80% of the one outstanding class of stock of X corporation since 1965. The X is subject to section 4943(c)(4) with a first phase ending on May 25, 1984. On January 1, 1982, X merges with Y corporation to form Z corporation. X, Y, and Z are active business corporations. F owns no Y stock. No disqualified person with respect to F owns any stock in Y.Y, or Z. After the merger, F owns 25% of the one outstanding class of Z stock. Third parties do not control Z so that the 35% permitted holdings rule under section 4943(c)(2) is inapplicable

(ii) F's percentage of voting power and value in Z after the merger (25%) are less than F's percentages of voting power and value in X before the merger (80%). Therefore, under paragraph (a)(1) of this section, all of F's holdings in Z are treated as the X stock surrendered. Therefore, the Z stock is treated as subject to section 4943(c)(4) with a first phase ending on May 25, 1984. Under downward ratchet of paragraph (a)(5) of this section, the foundation voting and value levels and the substituted combined voting and value levels are reduced to 25%.

Example 2. (i) F, a private foundation, owns 100% of the one outstanding class of stock in X corporation and 30% of the one outstanding class of stock in Y corporation. F has held this stock continuously since 1960, and no disqualified person has even owned any stock in X or Y. Under section 4943(c)(4), F's holdings in X are treated as held by disqualified persons through the end of the first phase on May 25, 1989, and F's holdings in Y are permitted holdings during the second phase, which began on May 25, 1989, and F's holdings in Y are permitted holdings during the second phase, which began on May 26, 1979. On January 1, 1985, X and Y consolidate, forming a new corporation Z. In the consolidation, F acquires 50% of the one class of outstanding stock of Z, 40% in exchange for F's 100% interest in X and 10% in exchange for F's 30% interest in Y. Unrelated parties hold the remaining 50% of Z.

(ii) F's percentage of voting power and value in Z after the merger (50%) are less than F's percentages of voting power and value in X before the merger (100%). Thus, under paragraph (a)(1) of this section, the 50% interest in Z held by F is treated as the stock surrendered in the exchange for purposes of section 4943(c)(4). Under paragraph (b)(6) of this section, the 10% interest in Z received for the Y stock is subject to the same second phase period as the surrendered Y stock. The 40% interest first phase period as the surrendered X stock.

Example 3. (i) F, a private foundation, owns 50% of the one class of outstanding stock in X corporation which F has held continuously since 1935. No disqualified person with respect to F owns any stock in X. Neither F nor any disqualified person with respect to F owns any stock in Y corporation. On July 1, 1982, X and Y enter into an agreement to consolidate their businesses in a reorganization to which section 368(a)(1)(A) will apply. As a result of the contemplated consolidation, F will own 60% of the voting stock in Z, the resulting corporation. In addition, parties unrelated to F will own the remaining 40% of the Z voting stock and 100% of a new issue of nonvoting preferred stock in Z. Assume for purposes of this example, that the 60% of the voting stock to be held by F in Z will represent 50% of the fair market value of the outstanding Z stock.

(ii) Under the provisions of paragraph (b)(1) of this section, that portion of the Z stock held by F which represents a percentage of voting power equivalent to that held by F in X immediately prior to the consolidation

(*i.e.*, 50%) will be treated as the X stock held by F on May 26, 1969, for purposes of section 4943(c)(4). Therefore, 50% of the Y stock will be treated as subject to a second phase ending on May 25, 1994. The remaining portion of the Z voting stock held by F (10%) is subject to the provisions of § 53.4943–6(d)(1). F will have five years from the date of the merger in which to dispose of 10% of the Z stock without incurring the tax on excess business holdings.

Example 4. (i) F, a private foundation, owns 80% of the one class of outstanding stock in X corporation, an active business corporation. F has held this stock continuously since 1960 and no disqualified person with respect to F owns any stock in X. X has two operating divisions, one which manufacturers shoes and the other which manufactures refrigerators. On January 1, 1978, in a section 351(a) exchange, X transferred all of the assets of its shoe manufacturing division to Y, a corporation which X has formed for this purpose, and receives 100% of the stock of Y so that Y is a wholly-owned subsidiary of X. X then transfers all of the Y stock to F in exchange for all of F's holdings of X stock in a distribution to which section 355 applies.

(ii) Under paragraph (b)(1) of this section, 80% of the Y stock is treated as the X stock surrendered in the exchange for purposes of section 4943(c)(4). The 80% is treated under § 53.4943–4(c) as held by disqualified persons through May 25, 1984, which constitutes the 15-year first phase holding period applicable to the 80% holding in X. The 80% of the Y stock must be reduced to the permitted holdings allowed during the second and third phase as provided by section 4943(c)(4)(D) in the same manner as F's holdings of X stock would have had to have been reduced.

(iii) Under § 53.4943–6(d)(1), the remaining 20% of Y stock is treated as held by a disqualified person for five years from the date of the exchange. F will have five years from the date of the exchange in which to dispose of 20% of the Y stock without incurring the tax on excess business holdings.

Example 5. (i) X corporation, an active business corporation, has outstanding 1,000 shares of one class of stock, of which 600 shares have been held by F1, a private foundation; 100 shares have been held by F2, another private foundation; and 100 shares have been held by D, a disqualified person with respect to both F1 and F2. Unrelated parties hold the remaining 200 shares. F1 and F2 are disqualified persons with respect to each other under section 4946(a)(1)(H). Thus, F1 holds 60% of the X stock (600/1000); F2 and D each hold 10% (100/1000); and the foundation group (F1, F2 and D) holds 80% of X (800/1000). The holdings of F1 and F2 were acquired on January 1, 1980 pursuant to a pre-1969 will and are subject to section 4943(c)(5). There have been no changes in holdings since January 1, 1980.

(ii) On January 1, 1985, pursuant to a plan to dispose of excess business holdings approved by the Commissioner under paragraph (c) of this section, X redeems for cash the 600 shares held by F1. After the redemption, D and F2 each hold 25% of X (100/400). F1 no longer holds any X stocks. The foundation group's holdings (F1, F2 and D) have decreased from 80% to 50% while holdings of unrelated parties have increased from 20% to 50%. At the same time F2's and D's holdings each have increased from 10% to 25%.

(iii) Notwithstanding the increase in F2's and D's holdings, under paragraph (c) of this section, all of the X stock held by F2 will be treated as held by a disqualified person through the end of the first phase (December 31, 1994). However, the foundation voting and value levels do not increase. Therefore, after the end of the first phase, F2's holdings in X may not exceed 10 percent (if the combined holdings of F1, F2 and D exceed the permitted holdings under section 4943(c)(2)).

Example 6. (i) X corporation, an active business corporation, has outstanding 1,000 shares of its one class of stock. Since 1960, 100 shares (10%) have been held by F, a private foundation and 350 shares (35%) have been held by D, a disqualified person with respect to F. All of the stock held by F is permitted holdings under section 4943(c)(4) and the substituted combined voting and value levels are 45% (10% + 35%). Because of disagreements concerning management of X between D and A, an unrelated party who holds 300 shares (30%) of the X stock, X redeems all of A's shares on December 1, 1981.

(ii) After the redemption, F holds 14.3% (100/700) of the X stock and D holds 50% (350/700), for combined holdings of 64.3%. Because the combined holdings exceed the substituted combined voting level (45%) by more than F's entire holdings, all of the F stock is excess business holdings. However, all of F's stock will be treated as acquired other than by purchase under § 53.4943–6(d)(1) and therefore will be treated under section 4943(c)(6) and this section, as held by a disqualified person for five years from the date of the redemption (through November 30, 1986). If the combined holdings of F and its disqualified person are reduced to 45 percent by the end of the five year period, F may retain a portion of its holdings in X (limited to no more than the foundation voting and value level of 10 percent).

Example 7. Assume the same facts as in *Example (6)*, except that D loaned the money to X that was used to redeem A's shares. Under these facts, the increased holdings result from a prohibited transaction described in paragraph (d)(2) of this section. Therefore, all of F's stock will be treated as acquired by purchase by a disqualified person under § 53.4943–6(d)(2). F will have 90 days after the

redemption in which to dispose of its holdings or to reduce its holdings and the combined holdings to the levels held prior to the redemption as discussed in *Example (6)*.

Example 8. (i) F, a private foundation, has held 100% of the outstanding stock of X corporation since 1960. F also holds 15% of the voting stock of Y corporation. Both X and Y are active business corporations. X has $1 million in net assets used in its trade or business and Y has $6.7 million used in its trade or business. On June 1, 1985, Y is merged into X. After the merger F holds 25% of the voting stock of X. No person other than F controls X after the merger.

(ii) Because more than 40% of Y was acquired and the net assets of X, the acquiring corporation, used in its trade or business prior to the merger represent less than 15% of the net assets of Y used in its trade or business, the merger is a prohibited transaction described in paragraph (d)(2)(iii). Therefore, only 15% of the stock X is treated, pursuant to paragraph (b), as the stock held by F prior to the redemption. F's holding of 5% (the excess of F's 25% holdings over the 20% permitted holdings in X (determined under section 4943(c)(2)) are treated as purchased by a disqualified person pursuant to § 53.4943–6(d)(2). F will have 90 days after June 1, 1985, in which to dispose of the 5% excess holdings.

[T.D. 7944, 49 FR 6480, Feb. 22, 1984]

§ 53.4943–8 Business holdings; constructive ownership.

(a) *Constructive ownership*—(1) *In general*. For purposes of section 4943, in computing the holdings in a business enterprise of a private foundation, or a disqualified person (as defined in section 4946), any stock or other interest owned, directly or indirectly, by or for a corporation, partnership, estate or trust shall be considered as being owned proportionately by or for its shareholders, partners, or beneficiaries except as otherwise provided in paragraphs (b), (c) and (d) of this section. Any interest in a business enterprise actually or constructively owned by a shareholder of a corporation, a partner of a partnership, or beneficiary of an estate or trust shall not be considered as constructively held by the corporation, partnership, trust or estate. Further, if any corporation, partnership, estate or trust has a warrant or other option to acquire an interest in a business enterprise, such interest is not deemed to be constructively owned by such entity until the option is exercised. (See paragraph (b)(2) of § 53.4943–3 for rules that options are not stock for purposes of determining excess business holdings.)

(2) *Powers of appointment*. Any interest in business enterprise over which a foundation or a disqualified person has a power of appointment exercisable in favor of the foundation or a disqualified person shall be considered owned by the foundation or disqualified person holding such power of appointment.

(3) *Determination of extent of constructive ownership*. If an interest in a business enterprise owned by a corporation is constructively owned by a shareholder, each shareholder's proportion of ownership is generally computed on the basis of the voting stock each shareholder has in the corporation. In determining holdings permitted under section 4943(c) (4) and (5), each shareholder's proportion of ownership in the business enterprise shall also be computed on the basis of value, taking into account both voting and nonvoting stock held by the shareholder.

(4) *Nonvoting stock*. If a private foundation, its disqualified persons, or both, own (directly or constructively) nonvoting stock of a parent corporation, the holdings of which are treated as constructively owned by its shareholders by reason of section 4943(d)(1) and this section, such nonvoting stock shall be treated as nonvoting stock of any corporation in which the parent corporation holds an interest for purposes of the limitation on the holding of nonvoting stock under section 4943(c)(2)(A) and § 53.4943–3(b)(2).

(5) *Interests held by certain disqualified persons*. In the case of an entity that is a disqualified person (other than an entity described in section 4946(a)(1)(H)), the holdings of which are treated as constructively owned by its shareholders, partners, or beneficiaries, for purposes of determining the total holdings of disqualified persons the holdings of the entity shall be considered held by a disqualified person only to the extent such holdings are treated as constructively owned by disqualified persons who are shareholders, partners, or beneficiaries of the entity. In the case of an entity described in section 4946(a)(1)(H) or an entity, the holdings

of which are not treated as constructively owned by its shareholders, partners, or beneficiaries, all holdings of such entity shall be treated as held by a disqualified person if and only if the entity itself is a disqualified person.

(b) *Estates and trusts*—(1) *In general*. Any interest actually or constructively owned by an estate or trust is deemed constructively owned, in the case of an estate, by its beneficiaries or, in the case of a trust, by its remainder beneficiaries except as provided in paragraphs (b) (2), (3) and (4) of this section (relating to certain split-interest trusts described in section 4947(a)(2), to trusts of qualified pension, profit-sharing, and stock bonus plans described in section 401(a) and to revocable trusts). Thus, if a trust owns 100 percent of the stock of a corporation A, and if, on an actuarial basis, W's life interest in the trust is 15 percent, Y's life interest is 25 percent, and Z's remainder interest is 60 percent, under this paragraph (b), Z will be considered to be the owner of 100 percent of the stock of corporation A. See § 53.4943–4, § 53.4943–5 and § 53.4943–6 for rules relating to certain actual or constructive holdings of a foundation being treated as held by a disqualified person. For the treatment of certain property acquired by an estate or trust after May 26, 1969, see paragraph (a)(2) of § 53.4943–5.

(2) *Split-interest trusts*—(i) *Amounts transferred in trust after May 26, 1969*. In the case of an interest in a business enterprise which was transferred to a trust described in section 4947(a)(2) after May 26, 1969, for the benefit of a private foundation, no portion of such interest shall be considered as owned by the private foundation:

(A) If the foundation holds only an income interest in the trust, or

(B) If the foundation holds only a remainder interest in the trust (unless the foundation can exercise primary investment discretion with respect to such interest)

until such trust ceases to be so described. See section 4947(a)(2) and (b)(3) and the regulations thereunder for rules relating to such trusts. See also sections 4946(a)(1) (G) and (H) and the regulations thereunder for rules relating to when a trust described in this paragraph (b)(2) is itself a disqualified person.

(ii) *Amounts transferred in trust on or before May 26, 1969*. In the case of an interest in a business enterprise which was transferred to a trust described in section 4947(a)(2) (without regard to section 4947(a)(2)(C)) on or before May 26, 1969, for the benefit of a private foundation, no portion of such interest shall be considered as owned by the foundation until it is actually distributed to the foundation or until the trust ceases to be so described. See section 4943(c)(5) and § 53.4943–5 for rules relating to certain trusts which were irrevocable on May 26, 1969.

(3) *Employee benefit trusts*. An interest in a business enterprise owned by a trust described in section 401(a) (pension and profit-sharing plans) shall not be considered as owned by its beneficiaries, unless disqualified persons (within the meaning of section 4946) control the investment of the trust assets.

(4) *Revocable trusts*. An interest in a business enterprise owned by a revocable trust shall be treated as owned by the grantor of such trust.

(5) *Estates*. For purposes of applying section 4943(d)(1) to estates, the term ''beneficiary'' includes any person (including a private foundation) entitled to receive property of a decedent pursuant to a will or pursuant to laws of descent and distribution. However, a person shall no longer be considered a beneficiary of an estate when all the property to which he is entitled has been received by him, when he no longer has a claim against the estate and when there is only a remote possibility that it will be necessary for the estate to seek the return of property or to seek payment from him by contribution or otherwise to satisfy claims against the estate or expenses of administration. When pursuant to the preceding sentence, a person (including a private foundation) ceases to be a beneficiary, stock or another interest in a business enterprise owned by the estate shall not thereafter be considered owned by such person. If any person is the constructive owner of an interest in a business enterprise actually held by an estate, the date of death of the testator or decedent intestate shall

be the first day on which such person shall be considered a constructive owner of such interest. See § 53.4943–5 for rules relating to wills executed on or before May 26, 1969.

(c) *Corporation actively engaged in a trade or business*—(1) *In general*. Except as provided in paragraphs (c)(2) and (3) of this section, any interest (whether or not in a separate entity) owned by a corporation which is actively engaged in a trade or business shall not be deemed to be constructively owned by such corporation's shareholders.

(2) *Actively engaged in a trade or business*. For purposes of paragraph (c)(1) of this section:

(i) A corporation shall not be considered to be actively engaged in a trade or business if the corporation is not a business enterprise by reason of section 4943(d)(3) (A) or (B) and § 53.4943–10 (b) or (c);

(ii) In the case of a corporation which owns passive holdings and is actively engaged in a trade or business, such corporation shall not be considered to be actively engaged in a trade or business if the net assets used in such trade or business are insubstantial when compared to passive holdings.

(3) *Exceptions*. If a corporation has been involved in a prohibited transaction, any interest in a business enterprise owned by such corporation shall be treated as constructively owned by its shareholders, whether or not such corporation is actively engaged in a trade or business. For a definition of prohibited transaction, see § 53.4943–7 (d)(2).

(4) *Affiliated group*. In applying this paragraph to the common parent in an affiliated group (as defined in § 53.4943–10 (c)(3)(ii)), the assets and activities of the affiliated group shall be treated as the assets and activities of the common parent.

(d) *Partnerships*. Any interest in a business enterprise which is owned by a partnership shall be deemed to be constructively owned by the partners in such partnerships.

(e) *Examples*. The provisions of this section are illustrated by the following examples.

Example 1. F, a private foundation, directly owns voting stock of X, a holding company described in section 4943(d)(3)(B). That stock represents 40% of the voting power in X and 20% of the value of all outstanding shares of all classes of stock in X. F also owns nonvoting stock in X that represents 10% of the value of all outstanding shares of all classes of stock in X. D, a disqualified person, owns voting stock of X that represents 40% of the voting power in X and 20% of the value. D does not own any nonvoting stock in X. X corporation's only holding is stock of Y corporation. The Y voting stock held by X represents 50% of the voting power in Y and 25% of the value of all outstanding shares of all classes of stock in Y. X also owns nonvoting stock in Y that represents 25% of the value of all outstanding shares of all classes of stock in Y. Under paragraph (a)(3) of this section, F and D each constructively owns 20% of the voting power in Y through their voting interest in X (40% of X's 50% of Y). F also constructively owns 15% of the value of all outstanding shares of all classes of stock in Y through F's interest in X (F's 30% of the value of X multiplied by X's 50% of the value of Y), while D constructively owns 10% of the value of Y (D's 20% of the value of X multiplied by X's 50% of the value of Y).

Example 2. (i) F, a private foundation, owns 50% of the one class of nonvoting stock of X corporation, a corporation described in section 4943(d)(3)(B) and paragraph (c)(2)(i) above. D, a disqualified person with respect to F as described in section 4946(a)(1)(A), owns 40% of the one class of voting stock of X. X corporation is a disqualified person with respect to F because D owns more than 35% of the voting of X. (See section 4946(a)(1)(E)). On January 1, 1980, X purchases for cash 40% of the only class of stock of Y corporation, a retail clothing store, from unrelated third parties.

(ii) Under paragraph (a)(4) of this section, F is treated as owning nonvoting stock of Y. Although X is a disqualified person, its holdings are not treated as held by disqualified persons except as constructive holdings. Therefore, the ''deemed'' nonvoting stock in Y is a permitted holding because D, a disqualified person with respect to F, constructively owns only 16% of the voting stock of Y (less than 20% permitted under section 4943(c)(2)).

Example 3. (i) The facts are the same as in *Example (2)*, except that X purchases 100% of this stock of Y corporation. Under paragraph (a)(4) of this section, F is treated as owning nonvoting stock of Y. The ''deemed'' nonvoting stock in Y is not a permitted holdings because D, a disqualified person with respect to F, constructively owns 40% of the voting stock of Y.

Example 4. (i) D, a disqualified person with respect to F, owns 40% of the one class of stock in X corporation, an active business. X is a disqualified person with respect to F. X

acquires 40% of the voting stock in Y corporation. Under paragraph (a)(5) of this section, the holdings of X in Y are treated as held by a disqualified person. F cannot hold any Y stock, voting or nonvoting.

[T.D. 7496, 42 FR 46285, Sept. 15, 1977, as amended by T.D. 7944, 49 FR 6484, Feb. 22, 1984]

§ 53.4943–9 Business holdings; certain periods.

(a) *Taxable period*—(1) *In general*. For purposes of section 4943, the term ''taxable period'' means, with respect to any excess business holdings of a private foundation in a business enterprise, the period beginning with the first day on which there are such excess business holdings and ending on the earliest of:

(i) The date of mailing of a notice of deficiency under section 6212 with respect to the tax imposed on the holdings by the section 4943(a);

(ii) The date on which the excess is eliminated; or

(iii) The date on which the tax imposed by section 4943(a) is assessed.

For example, *M*, a private foundation, first has excess business holdings in *X*, a corporation, on February 5, 1972. A notice of deficiency is mailed under section 6212 to *M* on June 1, 1974. With respect to *M*'s excess business holdings in *X*, the taxable period begins on February 5, 1972, and ends on June 1, 1974.

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

(3) *Suspension of taxable period for 90 days*. In any case in which a private foundation has excess business holdings solely because of the acquisition of an interest in a business enterprise to which paragraph (a)(1) (ii) or (iii) of § 53.4943–2 applies, the taxable period described in paragraph (a) of this section shall be suspended for the 90-day period (as extended) starting with the date on which the foundation knows or has reason to know of the acquisition, provided that at the end of such period the foundation has disposed of such excess holdings.

(b) *Cross reference*. For rules relating to taxable events that are corrected within the correction period, defined in section 4863(e), see section 4861(a) and the regulations thereunder.

(c) *Correction*. For purposes of section 4943, correction shall be considered as made when no interest in the enterprise held by the foundation is classified as an excess business holdings under section 4943(c)(1). In any case where the private foundation has excess business holdings which are constructively held for it under section 4943(c)(1), correction shall be considered made when either a corporation, partnership, estate, or trust in which holdings in such enterprise are constructively held for the foundation or a disqualified person; the foundation itself; or a disqualified person disposes of a sufficient interest in the enterprise so that no interest in the enterprise held by the foundation is classified as excess business holdings under section 4943(c)(1).

[T.D. 7496, 42 FR 46285, Sept. 15, 1977, as amended by T.D. 8084, 51 FR 16302, May 2, 1986]

§ 53.4943–10 Business enterprise; definition.

(a) *In general*. (1) Except as provided in paragraph (b) or (c) of this section under section 4943(d)(4) the term ''business enterprise'' includes the active conduct of a trade or business, including any activity which is regularly carried on for the production of income from the sale of goods or the performance of services and which constitutes an unrelated trade or business under section 513. For purposes of the preceding sentence, where an activity carried on for profit constitutes an unrelated trade or business, no part of such trade or business shall be excluded from the classification of a business enterprise merely because it does not result in a profit.

(2) Notwithstanding paragraph (a)(1) of this section, a bond or other evidence of indebtedness does not constitute a holding in a business enterprise unless such bond or evidence of indebtedness is otherwise determined

to be an equitable interest in such enterprise. Similarly, a lease-hold interest in real property does not constitute an interest in a business enterprise, even though rent payable under such lease is dependent, in whole or in part, upon the income or profits derived by another from such property, unless such leasehold interest constitutes an interest in the income or profits of an unrelated trade or business under section 513.

(b) *Certain program-related activities.* For purposes of section 4943(d)(4) the term ''business enterprise'' does not include a functionally related business as defined in section 4942(j)(5). See § 53.4942(a)–2(c)(3)(iii). In addition, business holdings do not include program-related investments (such as investments in small businesses in central cities or in corporations to assist in neighborhood renovation) as defined in section 4944(c) and the regulations thereunder.

(c) *Income derived from passive sources*—(1) *In general.* For purposes of section 4943(d)(4), the term ''business enterprise'' does not include a trade or business at least 95 percent of the gross income of which is derived from passive sources; except that if in the taxable year in question less than 95 percent of the income of a trade or business is from passive sources, the foundation may, in applying this 95 percent test, substitute for the passive source gross income in such taxable year the average gross income from passive sources for the 10 taxable years immediately preceding the taxable year in question (or for such shorter period as the entity has been in existence). Thus, stock in a passive holding company is not to be considered a holding in a business enterprise even if the company is controlled by the foundation. Instead, the foundation is treated as owning its proportionate share of any interests in a business enterprise held by such company under section 4943(d)(1).

(2) *Gross income from passive sources.* Gross income from passive sources, for purposes of this paragraph, includes the items excluded by section 512(b)(1) (relating to dividends, interest, and annuities), 512(b)(2) (relating to royalties), 512(b)(3) (relating to rent) and 512(b)(5) (relating to gains or losses from the disposition of certain property). Any income classified as passive under this paragraph does not lose its character merely because section 512(b)(4) or 514 (relating to unrelated debt-financed income) applies to such income. In addition, income from passive sources includes income from the sale of goods (including charges or costs passed on at cost to purchasers of such goods or income received in settlement of a dispute concerning or in lieu of the exercise of the right to sell such goods) if the seller does not manufacture, produce, physically receive or deliver, negotiate sales of, or maintain inventories in such goods. Thus, for example, where a corporation purchases a product under a contract with the manufacturer, resells it under contract at a uniform markup in price, and does not physically handle the product, the income derived from that markup meets the definition of passive income for purposes of this paragraph. On the other hand, income from individually negotiated sales, such as those made by a broker, would not meet such definition even if the broker did not physically handle the goods.

(3) *Affiliated group.* (i) For a common parent corporation in an affiliated group, substitute ''consolidated gross income'' in subparagraph (1) of this paragraph.

(ii) For purposes of this section, the term *affiliated group* shall have the same meaning as in section 1504(a), without regard to section 1504 (b) through (e).

(iii) Section 53.4943–11(d) provides a transitional rule for certain parent corporations.

(d) *Application of section 4943(c)(6)*—(1) *Program related activities.* If a private foundation holds an interest which is not an interest in a business enterprise because of paragraph (b) of this section (relating to program related activities), and such interest later becomes an interest in a business enterprise solely by reason of failing to meet the requirements of such paragraph (b), such interest will then be subject to section (regardless of when it was originally acquired) and will be treated as having been acquired other than by

purchase for purposes of section 4943(c)(6).

(2) *Passive holdings, etc.* (i) Except as provided in subdivision (ii), if a private foundation holds an interest that is not an interest in a business enterprise, and the interest later becomes an interest in a business enterprise (other than by reason of a readjustment as defined in § 53.4943–7(d)(1)), the interest will be treated as having been acquired by purchase by a disqualified person at the time the interest becomes an interest in a business enterprise. The treatment of an interest that becomes an interest in a business enterprise by reason of a readjustment shall be determined under § 53.4943–6 and § 53.4943–7.

(ii) If a private foundation establishes that the events which caused an interest not originally a business enterprise to become a business enterprise were not effectively controlled by the private foundation, then such interest shall be treated as acquired other than by purchase from the time of the change for purposes of section 4943(c)(6).

(iii) See § 53.4943–3(b)(3)(ii) for the definition of effective control.

(e) *Sole proprietorship.* For purposes of section 4943 and the regulations thereunder, the term ''sole proprietorship'' means any business enterprise (as defined in paragraphs (a), (b), and (c) of this section:

(1) Which is actually and directly owned by a private foundation,

(2) In which the foundation has a 100 percent equity interest, and

(3) Which is not held by a corporation, trust, or other business entity for such foundation.

A foundation may be considered to own a sole proprietorship even though the foundation is itself a corporation or a trust. However, a sole proprietorship which is owned by a foundation shall cease to be treated as a sole proprietorship when the foundation no longer has a 100-percent interest in the equity of the business enterprise. Thus, if and when a foundation sells a 10-percent interest in a sole proprietorship, such business enterprise shall be treated as a partnership under section 4943 and the regulations thereunder.

[T.D. 7496, 42 FR 46285, Sept. 15, 1977, as amended by T.D. 7944, 49 FR 6484, Feb. 22, 1984]

§ 53.4943–11 Effective/applicability date.

(a) *In general.* Section 4943 and §§ 53.4943–1 through 53.4943–11 shall take effect for taxable years beginning after December 31, 1969, except as otherwise provided by such sections.

(b) *Special transitional rule.* In the case of any acquisition of excess holdings prior to February 2, 1973, section 4943(a)(1) shall not apply if correction occurs (within the meaning of paragraph (c) of § 53.4943–9) within a period ending 90 days after July 5, 1977 extended (prior to the expiration of the original period) by any period which the Commissioner determines is reasonable and necessary (within the meaning of paragraph (b) of § 53.4943–9) to bring about such correction.

(c) *Special transitional rule for acquisition by will, etc.* (1) The rule in § 53.4943–6(b)(1) whereby holdings not held by a decedent are not treated as acquired under a will shall not apply to acquisitions of after-acquired property of a decedent's estate occurring on or before May 22, 1984.

(2) The rule in § 53.4943–6(b)(1) treating a purchase by an estate as a purchase by a disqualified person where the executor is a disqualified person shall not apply to purchases occurring on or before May 22, 1984.

(d) *Special transitional rule for affiliated groups.* If on or before May 22, 1984 a foundation holds an interest in a common parent corporation in an affiliated group, as defined in § 53.4943–10(c)(3)(ii), the foundation may elect to have both § 53.4943–8(c)(4) and § 53.4943–10(c)(3) not apply to such common parent corporation. No election may be made to have only one section not apply. Such election shall be made by the governing body of the private foundation at any time prior to February 22, 1985.

(e) *Special transitional rule for changes to a business enterprise.* Any interest that is not an interest in a business enterprise which becomes an interest in a business enterprise under § 53.4943–

10(d)(2) prior to May 22, 1984 will be treated as having been acquired other than by purchase for purposes of section 4943(c)(6).

(f) *Special transitional rule for private foundations that qualified as Type III supporting organizations before August 17, 2006.* The present holdings of a private foundation that qualified as a Type III supporting organization under section 509(a)(3) immediately before August 17, 2006, and that was reclassified as a private foundation under section 509(a) on or after August 17, 2006, solely as a result of the rules enacted by section 1241 of the Pension Protection Act of 2006, Public Law 109–280 (120 Stat. 780), will be determined using the same rules that apply to Type III supporting organizations under section 4943(f)(7).

(g) *Special transitional rule for Type III supporting organizations created as trusts before November 20, 1970.* A trust that qualifies as a Type III supporting organization under section 509(a)(3) and meets the requirements of §1.509(a)–4(i)(9) of this chapter will be treated as a ''functionally integrated Type III supporting organization'' for purposes of section 4943(f)(3)(A).

[T.D. 7496, 42 FR 46285, Sept. 15, 1977, as amended by T.D. 7944, 49 FR 6485, Feb. 22, 1984; T.D. 9605, 77 FR 76400, Dec. 28, 2012]

Subpart E—Taxes on Investments Which Jeopardize Charitable Purpose

SOURCE: T.D. 7240, 37 FR 28747, Dec. 27, 1972, unless otherwise noted.

§ 53.4944–1 Initial taxes.

(a) *On the private foundation*—(1) *In general.* If a private foundation (as defined in section 509) invests any amount in such a manner as to jeopardize the carrying out of any of its exempt purposes, section 4944(a) (1) of the Code imposes an excise tax on the making of such investment. This tax is to be paid by the private foundation and is at the rate of 5 percent of the amount so invested for each taxable year (or part thereof) in the taxable period (as defined in section 4944(e) (1)). The tax imposed by section 4944(a)(1) and this paragraph shall apply to investments of either income or principal.

(2) *Jeopardizing investments.* (i) Except as provided in section 4944(c), § 53.4944–3, § 53.4944–6(a), and subdivision (ii) of this subparagraph, an investment shall be considered to jeopardize the carrying out of the exempt purposes of a private foundation if it is determined that the foundation managers, in making such investment, have failed to exercise ordinary business care and prudence, under the facts and circumstances prevailing at the time of making the investment, in providing for the long- and short-term financial needs of the foundation to carry out its exempt purposes. In the exercise of the requisite standard of care and prudence the foundation managers may take into account the expected return (including both income and appreciation of capital), the risks of rising and falling price levels, and the need for diversification within the investment portfolio (for example, with respect to type of security, type of industry, maturity of company, degree of risk and potential for return). The determination whether the investment of a particular amount jeopardizes the carrying out of the exempt purposes of a foundation shall be made on an investment by investment basis, in each case taking into account the foundation's portfolio as a whole. No category of investments shall be treated as a per se violation of section 4944. However, the following are examples of types or methods of investment which will be closely scrutinized to determine whether the foundation managers have met the requisite standard of care and prudence: Trading in securities on margin, trading in commodity futures, investments in working interests in oil and gas wells, the purchase of ''puts,'' ''calls,'' and ''straddles,'' the purchase of warrants, and selling short. The determination whether the investment of any amount jeopardizes the carrying out of a foundation's exempt purposes is to be made as of the time that the foundation makes the investment and not subsequently on the basis of hindsight. Therefore, once it has been ascertained that an investment does not jeopardize the carrying out of a foundation's exempt purposes, the investment shall

never be considered to jeopardize the carrying out of such purposes, even though, as a result of such investment, the foundation subsequently realizes a loss. The provisions of section 4944 and the regulations thereunder shall not exempt or relieve any person from compliance with any Federal or State law imposing any obligation, duty, responsibility, or other standard of conduct with respect to the operation or administration of an organization or trust to which section 4944 applies. Nor shall any State law exempt or relieve any person from any obligation, duty, responsibility, or other standard of conduct provided in section 4944 and the regulations thereunder.

(ii)(*a*) Section 4944 shall not apply to an investment made by any person which is later gratuitously transferred to a private foundation. If such foundation furnishes any consideration to such person upon the transfer, the foundation will be treated as having made an investment (within the meaning of section 4944(a)(1)) in the amount of such consideration.

(*b*) Section 4944 shall not apply to an investment which is acquired by a private foundation solely as a result of a corporate reorganization within the meaning of section 368(a).

(iii) For purposes of section 4944, a private foundation which, after December 31, 1969, changes the form or terms of an investment (regardless of whether subdivision (ii) of this subparagraph applies to such investment), will be considered to have entered into a new investment on the date of such change, except as provided in subdivision (ii)(*b*) of this subparagraph. Accordingly, a determination, under subdivision (i) of this subparagraph, whether such change in the investment jeopardizes the carrying out of the foundation's exempt purposes shall be made at such time.

(iv) It is not intended that the taxes imposed under Chapter 42 be exclusive. For example, if a foundation purchases a sole proprietorship in a business enterprise within the meaning of section 4943(d)(4), in addition to tax under section 4943, the foundation may be liable for tax under section 4944 if the investment jeopardizes the carrying out of any of its exempt purposes.

(b) *On the management*—(1) *In general.* In any case in which a tax is imposed by section 4944(a)(1) and paragraph (a) of this section, section 4944 (a)(2) of the Code imposes on the participation of any foundation manager in the making of the investment, knowing that it is jeopardizing the carrying out of any of the foundation's exempt purposes, a tax equal to 5 percent of the amount so invested for each taxable year of the foundation (or part thereof) in the taxable period (as defined in section 4944(e)(1)), subject to the provisions of section 4944(d) and § 53.4944–4, unless such participation is not willful and is due to reasonable cause. The tax imposed under section 4944(a)(2) shall be paid by the foundation manager.

(2) *Definitions and special rules*—(i) *Knowing.* For purposes of section 4944, a foundation manager shall be considered to have participated in the making of an investment ''knowing'' that it is jeopardizing the carrying out of any of the foundation's exempt purposes only if:

(*a*) He has actual knowledge of sufficient facts so that, based solely upon such facts, such investment would be a jeopardizing investment under paragraph (a)(2) of this section,

(*b*) He is aware that such an investment under these circumstances may violate the provisions of federal tax law governing jeopardizing investments, and

(*c*) He negligently fails to make reasonable attempts to ascertain whether the investment is a jeopardizing investment, or he is in fact aware that it is such an investment.

For purposes of this part and Chapter 42, the term *knowing* does not mean ''having reason to know''. However, evidence tending to show that a foundation manager has reason to know of a particular fact or particular rule is relevant in determining whether he had actual knowledge of such fact or rule. Thus, for example, evidence tending to show that a foundation manager has reason to know of sufficient facts so that, based solely upon such facts, an investment would be a jeopardizing investment is relevant in determining whether he has actual knowledge of such facts.

(ii) *Willful.* A foundation manager's participation in a jeopardizing investment is willful if it is voluntary, conscious, and intentional. No motive to avoid the restrictions of the law or the incurrence of any tax is necessary to make such participation willfull. However, a foundation manager's participation in a jeopardizing investment is not willful if he does not know that it is a jeopardizing investment under paragraph (a)(2) of this section.

(iii) *Due to reasonable cause.* A foundation manager's actions are due to reasonable cause if he has exercised his responsibility on behalf of the foundation with ordinary business care and prudence.

(iv) *Participation.* The participation of any foundation manager in the making of an investment shall consist of any manifestation of approval of the investment.

(v) *Advice of counsel.* If a foundation manager, after full disclosure of the factual situation to legal counsel (including house counsel), relies on the advice of such counsel expressed in a reasoned written legal opinion that a particular investment would not jeopardize the carrying out of any of the foundation's exempt purposes (because, as a matter of law, the investment is excepted from such classification, for example, as a program-related investment under section 4944(c)), then although such investment is subsequently held to be a jeopardizing investment under paragraph (a)(2) of this section, the foundation manager's participation in such investment will ordinarily not be considered ''knowing'' or ''willfull'' and will ordinarily be considered ''due to reasonable cause'' within the meaning of section 4944(a)(2). In addition, if a foundation manager, after full disclosure of the factual situation to qualified investment counsel, relies on the advice of such counsel, such advice being derived in a manner consistent with generally accepted practices of persons who are such a qualified investment counsel and being expressed in writing that a particular investment will provide for the long and short term financial needs of the foundation under paragraph (a)(2) of this section, then although such investment is subsequently held not to provide for such long and short term financial needs, the foundation manager's participation in failing to provide for such long and short term financial needs will ordinarily not be considered ''knowing'' or ''willful'' and will ordinarily be considered ''due to reasonable cause'' within the meaning of section 4944(a)(2). For purposes of this subdivision, a written legal opinion will be considered ''reasoned'' even if it reaches a conclusion which is subsequently determined to be incorrect so long as such opinion addresses itself to the facts and applicable law. However, a written legal opinion will not be considered ''reasoned'' if it does nothing more than recite the facts and express a conclusion. However, the absence of advice of legal counsel or qualified investment counsel with respect to the investment shall not, by itself, give rise to any inference that a foundation manager participated in such investment knowingly, willfully, or without reasonable cause.

(vi) *Cross reference.* For provisions relating to the burden of proof in cases involving the issue whether a foundation manager has knowingly participated in the making of a jeopardizing investment, see section 7454(b).

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

Example 1. A is a foundation manager of B, a private foundation with assets of $100,000. A approves the following three investments by B after taking into account with respect to each of them B's portfolio as a whole: (1) An investment of $5,000 in the common stock of corporation X; (2) an investment of $10,000 in the common stock of corporation Y; and (3) an investment of $8,000 in the common stock of corporation Z. Corporation X has been in business a considerable time, its record of earnings is good and there is no reason to anticipate a diminution of its earnings. Corporation Y has a promising product, has had earnings in some years and substantial losses in others, has never paid a dividend, and is widely reported in investment advisory services as seriously undercapitalized. Corporation Z has been in business a short period of time and manufactures a product that is new, is not sold by others, and must compete with a well-established alternative product that serves the same purpose. Z's stock is classified as a high-risk investment by most investment advisory services with the possibility of substantial long-term appreciation but with little prospect of

a current return. A has studied the records of the three corporations and knows the foregoing facts. In each case the price per share of common stock purchased by B is favorable to B. Under the standards of paragraph (a)(2)(i) of this section, the investment of $10,000 in the common stock of Y and the investment of $8,000 in the common stock of Z may be classified as jeopardizing investments, while the investment of $5,000 in the common stock of X will not be so classified. B would then be liable for an initial tax of $500 (*i.e.*, 5 percent of $10,000) for each year (or part thereof) in the taxable period for the investment in Y, and an initial tax of $400 (*i.e.*, 5 percent of $8,000) for each year (or part thereof) in the taxable period for the investment in Z. Further, since A had actual knowledge that the investments in the common stock of Y and Z were jeopardizing investments, A would then be liable for the same amount of initial taxes as B.

Example 2. Assume the facts as stated in Example (1), except that: (1) In the case of corporation Y, B's investment will be made for new stock to be issued by Y and there is reason to anticipate that B's investment, together with investments required by B to be made concurrently with its own, will satisfy the capital needs of corporation Y and will thereby overcome the difficulties that have resulted in Y's uneven earnings record; and (2) in the case of corporation Z, the management has a demonstrated capacity for getting new businesses started successfully and Z has received substantial orders for its new product. Under the standards of paragraph (a) (2) (i) of this section, neither the investment in Y nor the investment in Z will be classified as a jeopardizing investment and neither A nor B will be liable for an initial tax on either of such investments.

Example 3. D is a foundation manager of E, a private foundation with assets of $200,000. D was hired by E to manage E's investments after a careful review of D's training, experience and record in the field of investment management and advice indicated to E that D was well qualified to provide professional investment advice in the management of E's investment assets. D, after careful research into how best to diversify E's investments, provide for E's long-term financial needs, and protect against the effects of long-term inflation, decides to allocate a portion of E's investment assets to unimproved real estate in selected areas of the country where population patterns and economic factors strongly indicate continuing growth at a rapid rate. D determines that the short-term financial needs of E can be met through E's other investments. Under the standards of paragraph (a)(2)(i) of this section, the investment of a portion of E's investment assets in unimproved real estate will not be classified as a jeopardizing investment and neither D nor E will be liable for an initial tax on such investment.

[T.D. 7240, 37 FR 28747, Dec. 29, 1972, as amended by T.D. 7299, 38 FR 35304, Dec. 27, 1973]

§ 53.4944–2 Additional taxes.

(a) *On the private foundation.* Section 4944(b)(1) of the Code imposes an excise tax in any case in which an initial tax is imposed by section 4944(a)(1) and § 53.4944–1(a) on the making of a jeopardizing investment by a private foundation and such investment is not removed from jeopardy within the taxable period (as defined in section 4944(e)(1)). The tax imposed under section 4944(b)(1) is to be paid by the private foundation and is at the rate of 25 percent of the amount of the investment. This tax shall be imposed upon the portion of the investment which has not been removed from jeopardy within the taxable period.

(b) *On the management.* Section 4944(b)(2) of the Code imposes an excise tax in any case in which an additional tax is imposed by section 4944 (b)(1) and paragraph (a) of this section and a foundation manager has refused to agree to part or all of the removal of the investment from jeopardy. The tax imposed under section 4944(b)(2) is at the rate of 5 percent of the amount of the investment, subject to the provisions of section 4944(d) and § 53.4944–4. This tax is to be paid by any foundation manager who has refused to agree to the removal of part or all of the investment from jeopardy, and shall be imposed upon the portion of the investment which has not been removed from jeopardy within the taxable period.

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

Example 1. X is a foundation manager of Y, a private foundation. On the advice of X, Y invests $5,000 in the common stock of corporation M. Assume that both X and Y are liable for the taxes imposed by section 4944(a) on the making of the investment. Assume further that no part of the investment is removed from jeopardy within the taxable period and that X refused to agree to such removal. Y will be liable for an additional tax of $1,250 (*i.e.*, $5,000 × 25%). X will be liable for an additional tax of $250 (*i.e.*, $5,000 × 5%).

Example 2. Assume the facts as stated in Example (1), except that X is not liable for the tax imposed by section 4944(a)(2) for his participation in the making of the investment, because such participation was not willful and was due to reasonable cause. X will nonetheless be liable for the tax of $250 imposed by section 4944(b)(2) since an additional tax has been imposed upon Y and since X refused to agree to the removal of the investment from jeopardy.

Example 3. Assume the facts as stated in Example (1), except that Y removes $2,000 of the investment from jeopardy within the taxable period, with X refusing to agree to the removal from jeopardy of the remaining $3,000 of such investment. Y will be liable for an additional tax of $750, imposed upon the portion of the investment which has not been removed from jeopardy within the taxable period (*i.e.*, $3,000 × 25%). Further X will be liable for an additional tax of $150, also imposed upon the same portion of the investment (*i.e.*, $3,000 × 5%).

[T.D. 7240, 37 FR 28747, Dec. 27, 1972, as amended by T.D. 8084, 51 FR 16302, May 2, 1986]

§ 53.4944–3 Exception for program-related investments.

(a) *In general.* (1) For purposes of section 4944 and §§ 53.4944–1 through 53.4944–6, a ''program-related investment'' shall not be classified as an investment which jeopardizes the carrying out of the exempt purposes of a private foundation. A *program-related investment* is an investment which possesses the following characteristics:

(i) The primary purpose of the investment is to accomplish one or more of the purposes described in section 170(c)(2)(B);

(ii) No significant purpose of the investment is the production of income or the appreciation of property; and

(iii) No purpose of the investment is to accomplish one or more of the purposes described in section 170(c)(2)(D).

(2)(i) An investment shall be considered as made primarily to accomplish one or more of the purposes described in section 170(c)(2)(B) if it significantly furthers the accomplishment of the private foundation's exempt activities and if the investment would not have been made but for such relationship between the investment and the accomplishment of the foundation's exempt activities. For purposes of section 4944 and §§ 53.4944–1 through 53.4944–6, the term *purposes described in section 170(c)(2)(B)* shall be treated as including purposes described in section 170(c)(2)(B) whether or not carried out by organizations described in section 170(c).

(ii) An investment in an activity described in section 4942(j)(4)(B) and the regulations thereunder shall be considered, for purposes of this paragraph, as made primarily to accomplish one or more of the purposes described in section 170(c)(2)(B).

(iii) In determining whether a significant purpose of an investment is the production of income or the appreciation of property, it shall be relevant whether investors solely engaged in the investment for profit would be likely to make the investment on the same terms as the private foundation. However, the fact that an investment produces significant income or capital appreciation shall not, in the absence of other factors, be conclusive evidence of a significant purpose involving the production of income or the appreciation of property.

(iv) An investment shall not be considered as made to accomplish one or more of the purposes described in section 170(c)(2)(D) if the recipient of the investment appears before, or communicates to, any legislative body with respect to legislation or proposed legislation of direct interest to such recipient, provided that the expense of engaging in such activities would qualify as a deduction under section 162.

(3)(i) Once it has been determined that an investment is ''program-related'' it shall not cease to qualify as a ''program-related investment'' provided that changes, if any, in the form or terms of the investment are made primarily for exempt purposes and not for any significant purpose involving the production of income or the appreciation of property. A change made in the form or terms of a program-related investment for the prudent protection of the foundation's investment shall not ordinarily cause the investment to cease to qualify as program-related. Under certain conditions, a program-related investment may cease to be program-related because of a critical

change in circumstances, as, for example, where it is serving an illegal purpose or the private purpose of the foundation or its managers. For purposes of the preceding sentence, an investment which ceases to be program-related because of a critical change in circumstances shall in no event subject the foundation making the investment to the tax imposed by section 4944(a)(1) before the 30th day after the date on which such foundation (or any of its managers) has actual knowledge of such critical change in circumstances.

(ii) If a private foundation changes the form or terms of an investment, and if, as a result of the application of subdivision (i) of this subparagraph, such investment no longer qualifies as program-related, the determination whether the investment jeopardizes the carrying out of exempt purposes shall be made pursuant to the provisions of § 53.4944–1(a)(2).

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

Example 1. X is a small business enterprise located in a deteriorated urban area and owned by members of an economically disadvantaged minority group. Conventional sources of funds are unwilling or unable to provide funds to X on terms it considers economically feasible. Y, a private foundation, makes a loan to X bearing interest below the market rate for commercial loans of comparable risk. Y's primary purpose for making the loan is to encourage the economic development of such minority groups. The loan has no significant purpose involving the production of income or the appreciation of property. The loan significantly furthers the accomplishment of Y's exempt activities and would not have been made but for such relationship between the loan and Y's exempt activities. Accordingly, the loan is a program-related investment even though Y may earn income from the investment in an amount comparable to or higher than earnings from conventional portfolio investments.

Example 2. Assume the facts as stated in Example (1), except that after the date of execution of the loan Y extends the due date of the loan. The extension is granted in order to permit X to achieve greater financial stability before it is required to repay the loan. Since the change in the terms of the loan is made primarily for exempt purposes and not for any significant purpose involving the production of income or the appreciation of property, the loan shall continue to qualify as a program-related investment.

Example 3. X is a small business enterprise located in a deteriorated urban area and owned by members of an economically disadvantaged minority group. Conventional sources of funds are unwilling to provide funds to X at reasonable interest rates unless it increases the amount of its equity capital. Consequently, Y, a private foundation, purchases shares of X's common stock. Y's primary purpose in purchasing the stock is to encourage the economic development of such minority group, and no significant purpose involves the production of income or the appreciation of property. The investment significantly furthers the accomplishment of Y's exempt activities and would not have been made but for such relationship between the investment and Y's exempt activities. Accordingly, the purchase of the common stock is a program-related investment, even though Y may realize a profit if X is successful and the common stock appreciates in value.

Example 4. X is a business enterprise which is not owned by low-income persons or minority group members, but the continued operation of X is important to the economic well-being of a deteriorated urban area because X employs a substantial number of low-income persons from such area. Conventional sources of funds are unwilling or unable to provide funds to X at reasonable interest rates. Y, a private foundation, makes a loan to X at an interest rate below the market rate for commercial loans of comparable risk. The loan is made pursuant to a program run by Y to assist low-income persons by providing increased economic opportunities and to prevent community deterioration. No significant purpose of the loan involves the production of income or the appreciation of property. The investment significantly furthers the accomplishment of Y's exempt activities and would not have been made but for such relationship between the loan and Y's exempt activities. Accordingly, the loan is a program-related investment.

Example 5. X is a business enterprise which is financially secure and the stock of which is listed and traded on a national exchange. Y, a private foundation, makes a loan to X at an interest rate below the market rate in order to induce X to establish a new plant in a deteriorated urban area which, because of the high risks involved, X would be unwilling to establish absent such inducement. The loan is made pursuant to a program run by Y to enhance the economic development of the area by, for example, providing employment opportunities for low-income persons at the new plant, and no significant purpose involves the production of income or the appreciation of property. The loan significantly furthers the accomplishment of Y's exempt activities and would not have been made but for such relationship between the

loan and Y's exempt activities. Accordingly, even though X is large and established, the investment is program-related.

Example 6. X is a business enterprise which is owned by a nonprofit community development corporation. When fully operational, X will market agricultural products, thereby providing a marketing outlet for low-income farmers in a depressed rural area. Y, a private foundation, makes a loan to X bearing interest at a rate less than the rate charged by financial institutions which have agreed to lend funds to X if Y makes the loan. The loan is made pursuant to a program run by Y to encourage economic redevelopment of depressed areas, and no significant purpose involves the production of income or the appreciation of property. The loan significantly furthers the accomplishment of Y's exempt activities and would not have been made but for such relationship between the loan and Y's exempt activities. Accordingly, the loan is a program-related investment.

Example 7. X, a private foundation, invests $100,000 in the common stock of corporation M. The dividends received from such investment are later applied by X in furtherance of its exempt purposes. Although there is a relationship between the return on the investment and the accomplishment of X's exempt activities, there is no relationship between the investment per se and such accomplishment. Therefore, the investment cannot be considered as made primarily to accomplish one or more of the purposes described in section 170(c)(2)(B) and cannot qualify as program-related.

Example 8. S, a private foundation, makes an investment in T, a business corporation, which qualifies as a program-related investment under section 4944(c) at the time that it is made. All of T's voting stock is owned by S. T experiences financial and management problems which, in the judgment of the foundation, require changes in management, in financial structure or in the form of the investment. The following three methods of resolving the problems appear feasible to S, but each of the three methods would result in reduction of the exempt purposes for which the program-related investment was initially made:

(*a*) *Sale of stock or assets.* The foundation sells its stock to an unrelated person. Payment is made in part at the time of sale; the balance is payable over an extended term of years with interest on the amount outstanding. The foundation receives a purchase-money mortgage.

(*b*) *Lease.* The corporation leases its assets for a term of years to an unrelated person, with an option in the lessee to buy the assets. If the option is exercised, the terms of payment are to be similar to those described in (*a*) of this example.

(*c*) *Management contract.* The corporation enters into a management contract which gives broad operating authority to one or more unrelated persons for a term of years. The foundation and the unrelated persons are obligated to contribute toward working capital requirements. The unrelated persons will be compensated by a fixed fee or a share of profits, and they will receive an option to buy the stock held by S or the assets of the corporation. If the option is exercised, the terms of payment are to be similar to those described in (*a*) of this example.

Each of the three methods involves a change in the form or terms of a program-related investment for the prudent protection of the foundation's investment. Thus, under § 53.4944–3(a)(3)(i), none of the three transactions (nor any debt instruments or other obligations held by S as a result of engaging in one of these transactions) would cause the investment to cease to qualify as program-related.

Example 9. X is a socially and economically disadvantaged individual. Y, a private foundation, makes an interest-free loan to X for the primary purpose of enabling X to attend college. The loan has no significant purpose involving the production of income or the appreciation of property. The loan significantly furthers the accomplishment of Y's exempt activities and would not have been made but for such relationship between the loan and Y's exempt activities. Accordingly, the loan is a program-related investment.

Example 10. Y, a private foundation, makes a high-risk investment in low-income housing, the indebtedness with respect to which is insured by the Federal Housing Administration. Y's primary purpose in making the investment is to finance the purchase, rehabilitation, and construction of housing for low-income persons. The investment has no significant purpose involving the production of income or the appreciation of property. The investment significantly furthers the accomplishment of Y's exempt activities and would not have been made but for such relationship between the investment and Y's exempt activities. Accordingly, the investment is program-related.

Example 11. X is a business enterprise that researches and develops new drugs. X's research demonstrates that a vaccine can be developed within ten years to prevent a disease that predominantly affects poor individuals in developing countries. However, neither X nor other commercial enterprises like X will devote their resources to develop the vaccine because the potential return on investment is significantly less than required by X or other commercial enterprises to undertake a project to develop new drugs. Y, a private foundation, enters into an investment agreement with X in order to induce X to develop the vaccine. Pursuant to the investment agreement, Y purchases shares of

the common stock of S, a subsidiary corporation that X establishes to research and develop the vaccine. The agreement requires S to distribute the vaccine to poor individuals in developing countries at a price that is affordable to the affected population, although, the agreement does not preclude S from selling the vaccine to other individuals at a market rate. The agreement also requires S to publish the research results, disclosing substantially all information about the results that would be useful to the interested public. S agrees that the publication of its research results will be made as promptly after the completion of the research as is reasonably possible without jeopardizing S's right to secure patents necessary to protect its ownership or control of the results of the research. The expected rate of return on Y's investment in S is less than the expected market rate of return for an investment of similar risk. Y's primary purpose in making the investment is to fund scientific research in the public interest. No significant purpose of the investment involves the production of income or the appreciation of property. The investment significantly furthers the accomplishment of Y's exempt activities and would not have been made but for such relationship between the investment and Y's exempt activities. Accordingly, Y's purchase of the common stock of S is a program-related investment.

Example 12. Q, a developing country, produces a substantial amount of recyclable solid waste materials that are currently disposed of in landfills and by incineration, contributing significantly to environmental deterioration in Q. X is a new business enterprise located in Q. X's only activity will be collecting recyclable solid waste materials in Q and delivering those materials to recycling centers that are inaccessible to a majority of the population. If successful, the recycling collection business would prevent pollution in Q caused by the usual disposition of solid waste materials. X has obtained funding from only a few commercial investors who are concerned about the environmental impact of solid waste disposal. Although X made substantial efforts to procure additional funding, X has not been able to obtain sufficient funding because the expected rate of return is significantly less than the acceptable rate of return on an investment of this type. Because X has been unable to attract additional investors on the same terms as the initial investors, Y, a private foundation, enters into an investment agreement with X to purchase shares of X's common stock on the same terms as X's initial investors. Although there is a high risk associated with the investment in X, there is also the potential for a high rate of return if X is successful in the recycling business in Q. Y's primary purpose in making the investment is to combat environmental deterioration. No significant purpose of the investment involves the production of income or the appreciation of property. The investment significantly furthers the accomplishment of Y's exempt activities and would not have been made but for such relationship between the investment and Y's exempt activities. Accordingly, Y's purchase of the X common stock is a program-related investment.

Example 13. Assume the facts as stated in *Example 12*, except that X offers Y shares of X's common stock in order to induce Y to make a below-market rate loan to X. X previously made the same offer to a number of commercial investors. These investors were unwilling to provide loans to X on such terms because the expected return on the combined package of stock and debt was below the expected market return for such a package based on the level of risk involved, and they were also unwilling to provide loans on other terms X considers economically feasible. Y accepts the stock and makes the loan on the same terms that X offered to the commercial investors. Y's primary purpose in making the investment is to combat environmental deterioration. No significant purpose of the investment involves the production of income or the appreciation of property. The investment significantly furthers the accomplishment of Y's exempt activities and would not have been made but for such relationship between the investment and Y's exempt activities. Accordingly, the loan accompanied by the acceptance of common stock is a program-related investment.

Example 14. X is a business enterprise located in V, a rural area in State Z. X employs a large number of poor individuals in V. A natural disaster occurs in V, causing significant damage to the area. The business operations of X are harmed because of damage to X's equipment and buildings. X has insufficient funds to continue its business operations and conventional sources of funds are unwilling or unable to provide loans to X on terms it considers economically feasible. In order to enable X to continue its business operations, Y, a private foundation, makes a loan to X bearing interest below the market rate for commercial loans of comparable risk. Y's primary purpose in making the loan is to provide relief to the poor and distressed. No significant purpose of the loan involves the production of income or the appreciation of property. The loan significantly furthers the accomplishment of Y's exempt activities and would not have been made but for such relationship between the loan and Y's exempt activities. Accordingly, the loan is a program-related investment.

Example 15. Y, a private foundation, makes loans bearing interest below the market rate for commercial loans of comparable risk to poor individuals who live in W, a developing

country, to enable them to start small businesses such as a roadside fruit stand. Conventional sources of funds were unwilling or unable to provide such loans on terms they consider economically feasible. Y's primary purpose in making the loans is to provide relief to the poor and distressed. No significant purpose of the loans involves the production of income or the appreciation of property. The loans significantly further the accomplishment of Y's exempt activities and would not have been made but for such relationship between the loans and Y's exempt activities. Accordingly, the loans to the poor individuals who live in W are program-related investments.

Example 16. X is a limited liability company treated as a partnership for federal income tax purposes. X purchases coffee from poor farmers residing in a developing country, either directly or through farmer-owned cooperatives. To fund the provision of efficient water management, crop cultivation, pest management, and farm management training to the poor farmers by X, Y, a private foundation, makes a loan to X bearing interest below the market rate for commercial loans of comparable risk. The loan agreement requires X to use the proceeds from the loan to provide the training to the poor farmers. X would not provide such training to the poor farmers absent the loan. Y's primary purpose in making the loan is to educate poor farmers about advanced agricultural methods. No significant purpose of the loan involves the production of income or the appreciation of property. The loan significantly furthers the accomplishment of Y's exempt activities and would not have been made but for such relationship between the loan and Y's exempt activities. Accordingly, the loan is a program-related investment.

Example 17. X is a social welfare organization that is recognized as an organization described in section 501(c)(4). X was formed to develop and encourage interest in painting, sculpture, and other art forms by, among other things, conducting weekly community art exhibits. X needs to purchase a large exhibition space to accommodate the demand for exhibition space within the community. Conventional sources of funds are unwilling or unable to provide funds to X on terms it considers economically feasible. Y, a private foundation, makes a loan to X at an interest rate below the market rate for commercial loans of comparable risk to fund the purchase of the new space. Y's primary purpose in making the loan is to promote the arts. No significant purpose of the loan involves the production of income or the appreciation of property. The loan significantly furthers the accomplishment of Y's exempt activities and would not have been made but for such relationship between the loan and Y's exempt activities. Accordingly, the loan is a program-related investment.

Example 18. X is a non-profit corporation that provides child care services in a low-income neighborhood, enabling many residents of the neighborhood to be gainfully employed. X meets the requirements of section 501(k) and is recognized as an organization described in section 501(c)(3). X's current child care facility has reached capacity and has a long waiting list. X has determined that the demand for its services warrants the construction of a new child care facility in the same neighborhood. X is unable to obtain a loan from conventional sources of funds including B, a commercial bank because of X's credit record. Pursuant to a deposit agreement, Y, a private foundation, deposits $h in B, and B lends an identical amount to X to construct the new child care facility. The deposit agreement requires Y to keep $h on deposit with B during the term of X's loan and provides that if X defaults on the loan, B may deduct the amount of the default from the deposit. To facilitate B's access to the funds in the event of default, the agreement requires that the funds be invested in instruments that allow B to access them readily. The deposit agreement also provides that Y will earn interest at a rate of t% on the deposit. The t% rate is substantially less than Y could otherwise earn on this sum of money, if Y invested it elsewhere. The loan agreement between B and X requires X to use the proceeds from the loan to construct the new child care facility. Y's primary purpose in making the deposit is to further its educational purposes by enabling X to provide child care services within the meaning of section 501(k). No significant purpose of the deposit involves the production of income or the appreciation of property. The deposit significantly furthers the accomplishment of Y's exempt activities and would not have been made but for such relationship between the deposit and Y's exempt activities. Accordingly, the deposit is a program-related investment.

Example 19. Assume the same facts as stated in *Example 18*, except that instead of making a deposit of $h into B, Y enters into a guarantee agreement with B. The guarantee agreement provides that if X defaults on the loan, Y will repay the balance due on the loan to B. B was unwilling to make the loan to X in the absence of Y's guarantee. X must use the proceeds from the loan to construct the new child care facility. At the same time, X and Y enter into a reimbursement agreement whereby X agrees to reimburse Y for any and all amounts paid to B under the guarantee agreement. The signed guarantee and reimbursement agreements together constitute a ''guarantee and reimbursement arrangement.'' Y's primary purpose in entering into the guarantee and reimbursement arrangement is to further Y's educational

purposes. No significant purpose of the guarantee and reimbursement arrangement involves the production of income or the appreciation of property. The guarantee and reimbursement arrangement significantly furthers the accomplishment of Y's exempt activities and would not have been made but for such relationship between the guarantee and reimbursement arrangement and Y's exempt activities. Accordingly, the guarantee and reimbursement arrangement is a program-related investment.

(c) *Effective/applicability date*. Paragraphs (a)(2)(ii) and (b), *Examples 11* through *19* of this section, apply on or after April 25, 2016.

[T.D. 7240, 37 FR 28747, Dec. 27, 1972, as amended by T.D. 9762, 81 FR 24017, Apr. 25, 2016]

§ 53.4944–4 Special rules.

(a) *Joint and several liability*. In any case where more than one foundation manager is liable for the tax imposed under section 4944 (a)(2) or (b)(2) with respect to any one jeopardizing investment, all such foundation managers shall be jointly and severally liable for the tax imposed under each such paragraph with respect to such investment.

(b) *Limits on liability for management*. With respect to anyone jeopardizing investment, the maximum aggregate amount of tax collectible under section 4944(a)(2) from all foundation managers shall not exceed $5,000, and the maximum aggregate amount of tax collectible under section 4944(b)(2) from all foundation managers shall not exceed $10,000.

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

Example 1. A, B, and C are foundation managers of X, a private foundation. Assume that A, B, and C are liable for both initial and additional taxes under sections 4944(a)(2) and 4944(b)(2), respectively, for the following investments by X: an investment of $5,000 in the common stock of corporation M, and an investment of $10,000 in the common stock of corporation N. A, B, and C will be jointly and severally liable for the following initial taxes under section 4944(a)(2): a tax of $250 (*i.e.*, 5 percent of $5,000) for each year (or part thereof) in the taxable period (as defined in section 4944(e)(1)) for the investment in M, and a tax of $500 (*i.e.*, 5 percent of $10,000) for each year (or part thereof) in the taxable period for the investment in N. Further, A, B, and C will be jointly and severally liable for the following additional taxes under section 4944(b)(2): a tax of $250 (*i.e.*, 5 percent of $5,000) for the investment in M, and a tax of $500 (*i.e.*, 5 percent of $10,000) for the investment in N.

Example 2. Assume the facts as stated in Example (1), except that X has invested $500,000 in the common stock of M, and $1 million in the common stock of N. A, B, and C will be jointly and severally liable for the following initial taxes under section 4944(a)(2): a tax of $5,000 for the investment in M, and a tax of $5,000 for the investment in N. Further, A, B, and C will be jointly and severally liable for the following additional taxes under section 4944(b) (2): a tax of $10,000 for the investment in M, and a tax of $10,000 for the investment in N.

§ 53.4944–5 Definitions.

(a) *Taxable period*—(1) *In general*. For purposes of section 4944, the term ''taxable period'' means, with respect to any investment which jeopardizes the carrying out of a private foundation's exempt purposes, the period beginning with the date on which the amount is invested and ending on the earliest of:

(i) The date of mailing of a notice of deficiency under section 6212 with respect to the tax imposed on the making of the investment by section 4944(a)(1);

(ii) The date on which the amount invested is removed from jeopardy; or

(iii) The date on which the tax imposed by section 4944(a)(1) is assessed.

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

(b) *Removal from jeopardy*. An investment which jeopardizes the carrying out of a private foundation's exempt purposes shall be considered to be removed from jeopardy when:

(1) The foundation sells or otherwise disposes of the investment, and

(2) The proceeds of such sale or other disposition are not themselves investments which jeopardize the carrying out of such foundation's exempt purposes.

A change by a private foundation in the form or terms of a jeopardizing investment shall result in the removal of the investment from jeopardy if, after such change, the investment no longer jeopardizes the carrying out of such foundation's exempt purposes. For purposes of section 4944, the making by a private foundation of one jeopardizing investment and a subsequent exchange by the foundation of such investment for another jeopardizing investment will be treated as only one jeopardizing investment, except as provided in § 53.4944–6 (b) and (c). For the treatment of a jeopardizing investment which is removed from jeopardy or otherwise transferred by a private foundation by the making of a grant or by bargain-sale, see sections 4941 and 4945 and the regulations thereunder. A jeopardizing investment cannot be removed from jeopardy by a transfer from a private foundation to another private foundation which is related to the transferor foundation within the meaning of section 4946(a) (1)(H) (i) or (ii), unless the investment is a program-related investment in the hands of the transferee foundation.

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

Example 1. X, a private foundation on the calendar year basis, makes a $1,000 jeopardizing investment on January 1, 1970. X thereafter sells the investment for $1,000 on January 3, 1971. The taxable period is from January 1, 1970, to January 3, 1971. X will be liable for an initial tax of $100, that is, a tax of 5 percent of the amount of the investment for each year (or part thereof) in the taxable period.

Example 2. Assume that both C and D are investments which jeopardize exempt purposes. X, a private foundation, purchases C in 1971 and later exchanges C for D. Such exchange does not constitute a removal of C from jeopardy. In addition, no new taxable period will arise with respect to D, since, for purposes of section 4944, only one jeopardizing investment has been made.

Example 3. Assume the facts as stated in Example (2), except that X sells C for cash and later reinvests such cash in D. Two separate investments jeopardizing exempt purposes have resulted. Since the cash received in the interim is not of a jeopardizing nature, the amount invested in C has been removed from jeopardy and, thus, the taxable period with respect to C has been terminated. The subsequent reinvestment of such cash in D gives rise to a new taxable period with respect to D.

(d) *Cross reference*. For rules relating to taxable events that are corrected within the correction period, defined in section 4963(e), see section 4961(a) and the regulations thereunder.

[T.D. 7240, 37 FR 28747, Dec. 27, 1972, as amended by T.D. 8084, 51 FR 16303, May 2, 1986]

§ 53.4944–6 Special rules for investments made prior to January 1, 1970.

(a) Except as provided in paragraph (b) or (c) of this section, an investment made by a private foundation prior to January 1, 1970, shall not be subject to the provisions of section 4944.

(b) If the form or terms of an investment made by a private foundation prior to January 1, 1970, are changed (other than as described in paragraph (c) of this section) on or after such date, the provisions of § 53.4944–1(a)(2)(iii) shall apply with respect to such investment.

(c) In the case of an investment made by a private foundation prior to January 1, 1970, which is exchanged on or after such date for another investment, for purposes of section 4944 the foundation will be considered to have made a new investment on the date of such exchange, unless the post-1969 investment is described in § 53.4944–1(a)(2)(ii)(*b*). Accordingly, a determination, under § 53.4944–1(a) (2)(i), whether the investment jeopardizes the carrying out of the foundation's exempt purposes shall be made at such time.

Subpart F—Taxes on Taxable Expenditures

SOURCE: T.D. 7215, 37 FR 23161, Oct. 31, 1972, unless otherwise noted.

§ 53.4945–1 Taxes on taxable expenditures.

(a) *Imposition of initial taxes*—(1) *Tax on private foundation*. Section 4945(a)(1) of the Code imposes an excise tax on each taxable expenditure (as defined in section 4945(d)) of a private foundation. This tax is to be paid by the private

foundation and is at the rate of 10 percent of the amount of each taxable expenditure.

(2) *Tax on foundation manager*—(i) *In general*. Section 4945(a)(2) of the Code imposes, under certain circumstances, an excise tax on the agreement of any foundation manager to the making of a taxable expenditure by a private foundation. This tax is imposed only in cases in which the following circumstances are present:

(*a*) A tax is imposed by section 4945(a)(1);

(*b*) Such foundation manager knows that the expenditure to which he agrees is a taxable expenditure, and

(*c*) Such agreement is willfull and is not due to reasonable cause.

However, the tax with respect to any particular expenditure applies only to the agreement of those foundation managers who are authorized to approve, or to exercise discretion in recommending approval of, the making of the expenditure by the foundation and to those foundation managers who are members of a group (such as the foundation's board of directors or trustees) which is so authorized. For the definition of the term *foundation manager*, see section 4946(b) and the regulations thereunder.

(ii) *Agreement*. The agreement of any foundation manager to the making of a taxable expenditure shall consist of any manifestation of approval of the expenditure which is sufficient to constitute an exercise of the foundation manager's authority to approve, or to exercise discretion in recommending approval of, the making of the expenditure by the foundation, whether or not such manifestation of approval is the final or decisive approval on behalf of the foundation.

(iii) *Knowing*. For purposes of section 4945, a foundation manager shall be considered to have agreed to an expenditure ''knowing'' that it is a taxable expenditure only if:

(*a*) He has actual knowledge of sufficient facts so that, based solely upon such facts, such expenditure would be a taxable expenditure,

(*b*) He is aware that such an expenditure under these circumstances may violate the provisions of federal tax law governing taxable expenditures, and

(*c*) He negligently fails to make reasonable attempts to ascertain whether the expenditure is a taxable expenditure, or he is in fact aware that it is such an expenditure.

For purposes of this part and Chapter 42, the term *knowing* does not mean ''having reason to know''. However, evidence tending to show that a foundation manager has reason to know of a particular fact or particular rule is relevant in determining whether he had actual knowledge of such fact or rule. Thus, for example, evidence tending to show that a foundation manager has reason to know of sufficient facts so that, based solely upon such facts, an expenditure would be a taxable expenditure is relevant in determining whether he has actual knowledge of such facts.

(iv) *Willful*. A foundation manager's agreement to a taxable expenditure is willful if it is voluntary, conscious, and intentional. No motive to avoid the restrictions of the law or the incurrence of any tax is necessary to make an agreement willful. However, a foundation manager's agreement to a taxable expenditure is not willful if he does not know that it is a taxable expenditure.

(v) *Due to reasonable cause*. A foundation manager's actions are due to reasonable cause if he has exercised his responsibility on behalf of the foundation with ordinary business care and prudence.

(vi) *Advice of counsel*. If a foundation manager, after full disclosure of the factual situation to legal counsel (including house counsel), relies on the advice of such counsel expressed in a reasoned written legal opinion that an expenditure is not a taxable expenditure under section 4945 (or that expenditures conforming to certain guidelines are not taxable expenditures), although such expenditure is subsequently held to be a taxable expenditure (or that certain proposed reporting procedures with respect to an expenditure will satisfy the tests of section 4945(h), although such procedures are subsequently held not to satisfy such section), the foundation manager's agreement to such expenditure (or to grants made with provision for such reporting

procedures which are taxable solely because of such inadequate reporting procedures) will ordinarily not be considered ''knowing'' or ''willful'' and will ordinarily be considered ''due to reasonable cause'' within the meaning of section 4945(a)(2). For purposes of the subdivision, a written legal opinion will be considered ''reasoned'' even if it reaches a conclusion which is subsequently determined to be incorrect so long as such opinion addresses itself to the facts and applicable law. However, a written legal opinion will not be considered ''reasoned'' if it does nothing more than recite the facts and express a conclusion. However, the absence of advice of counsel with respect to an expenditure shall not, by itself, give rise to any inference that a foundation manager agreed to the making of the expenditure knowingly, willfully, or without reasonable cause.

(vii) *Rate and incidence of tax*. The tax imposed under section 4945(a)(2) is at the rate of 2½ percent of the amount of each taxable expenditure to which the foundation manager has agreed. This tax shall be paid by the foundation manager.

(viii) *Cross reference*. For provisions relating to the burden of proof in cases involving the issue whether a foundation manager has knowingly agreed to the making of a taxable expenditure, see section 7454(b).

(b) *Imposition of additional taxes*—(1) *Tax on private foundation*. Section 4945(b)(1) of the Code imposes an excise tax in any case in which an initial tax is imposed under section 4945(a)(1) on a taxable expenditure of a private foundation and the expenditure is not corrected within the taxable period (as defined in section 4945(i)(2)). The tax imposed under section 4945(b)(1) is to be paid by the private foundation and is at the rate of 100 percent of the amount of each taxable expenditure.

(2) *Tax on foundation manager*. Section 4945(b)(2) of the Code imposes an excise tax in any case in which a tax is imposed under section 4945(b)(1) and a foundation manager has refused to agree to part or all of the correction of the taxable expenditure. The tax imposed under section 4945(b)(2) is at the rate of 50 percent of the amount of the taxable expenditure. This tax is to be paid by any foundation manager who has refused to agree to part or all of the correction of the taxable expenditure.

(c) *Special rules*—(1) *Joint and several liability*. In any case where more than one foundation manager is liable for tax imposed under section 4945 (a) (2) or (b)(2) with respect to the making of a taxable expenditure, all such foundation managers shall be jointly and severally liable for the tax imposed under such paragraph with respect to such taxable expenditure.

(2) *Limits on liability for management*. The maximum aggregate amount of tax collectible under section 4945(a)(2) from all foundation managers with respect to any one taxable expenditure shall be $5,000, and the maximum aggregate amount of tax collectible under section 4945(b) (2) from all foundation managers with respect to any one taxable expenditure shall be $10,000.

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

Example 1. A, B, and C comprise the board of directors of Foundation M. They vote unanimously in favor of a grant of $100,000 to D, a business associate of each of the directors. The grant is to be used by D for travel and educational purposes and is not made in accordance with the requirements of section 4945(g). Each director knows that D was selected as the recipient of the grant solely because of his friendship with the directors and is aware that some grants made for travel, study, or other similar purposes may be taxable expenditures. Also, none of the directors makes any attempt to consult counsel, or to otherwise determine, whether this grant is a taxable expenditure. Initial taxes are imposed under paragraphs (1) and (2) of section 4945(a). The tax to be paid by the foundation is $10,000 (10 percent of $100,000). The tax to be paid by the board of directors is $2,500 (2½ percent of $100,000). A, B, and C are jointly and severally liable for this $2,500 and this sum may be collected by the Service from any one of them.

Example 2. Assume the same facts as in example (1). Further assume that within the taxable period A makes a motion to correct the taxable expenditure at a meeting of the board of directors. The motion is defeated by a two-to-one vote, A voting for the motion and B and C voting against it. In these circumstances an additional tax is imposed on the private foundation in the amount of $100,000 (100 percent of $100,000). The additional tax imposed on B and C is $10,000 (50 percent of $100,000 subject to a maximum of

$10,000). B and C are jointly and severally liable for the $10,000, and this sum may be collected by the Service from either of them.

(d) *Correction*—(1) *In general.* Except as provided in paragraph (d) (2) or (3) of this paragraph, correction of a taxable expenditure shall be accomplished by recovering part or all of the expenditure to the extent recovery is possible, and, where full recovery cannot be accomplished, by any additional corrective action which the Commissioner may prescribe. Such additional corrective action is to be determined by the circumstances of each particular case and may include the following:

(i) Requiring that any unpaid funds due the grantee be withheld;

(ii) Requiring that no further grants be made to the particular grantee;

(iii) In addition to other reports that are required, requiring periodic (e.g., quarterly) reports from the foundation with respect to all expenditures of the foundation (such reports shall be equivalent in detail to the reports required by section 4945(h)(3) and § 53.4945–5(d));

(iv) Requiring improved methods of exercising expenditure responsibility;

(v) Requiring improved methods of selecting recipients of individual grants; and

(vi) Requiring such other measures as the Commissioner may prescribe in a particular case.

The foundation making the expenditure shall not be under any obligation to attempt to recover the expenditure by legal action if such action would in all probability not result in the satisfaction of execution on a judgment.

(2) *Correction for inadequate reporting.* If the expenditure is taxable only because of a failure to obtain a full and complete report as required by section 4945(h)(2) or because of a failure to make a full and detailed report as required by section 4945(h)(3), correction may be accomplished by obtaining or making the report in question. In addition, if the expenditure is taxable only because of a failure to obtain a full and complete report as required by section 4945(h)(2) and an investigation indicates that no grant funds have been diverted to any use not in furtherance of a purpose specified in the grant, correction may be accomplished by exerting all reasonable efforts to obtain the report in question and reporting the failure to the Internal Revenue Service, even though the report is not finally obtained.

(3) *Correction for failure to obtain advance approval.* Where an expenditure is taxable under section 4945(d)(3) only because of a failure to obtain advance approval of procedures with respect to grants as required by section 4945(g), correction may be accomplished by obtaining approval of the grant making procedures and establishing to the satisfaction of the Commissioner that:

(i) No grant funds have been diverted to any use not in furtherance of a purpose specified in the grant;

(ii) The grant making procedures instituted would have been approved if advance approval of such procedures had been properly requested; and

(iii) Where advance approval of grant making procedures is subsequently required, such approval will be properly requested.

(e) *Certain periods*—(1) *Taxable period.* For purposes of section 4945, the term ''taxable period'' means, with respect to any taxable expenditure, the period beginning with the date on which the taxable expenditure occurs and ending on the earlier of:

(i) The date of mailing of a notice of deficiency under section 6212 with respect to the tax imposed on taxable expenditures by section 4945(a)(1); or

(ii) The date on which the tax imposed by section 4945(a)(1) is assessed.

(2) *Cross reference.* For rules relating to taxable events that are corrected within the correction period, defined in section 4963(e), see section 4961(a) and the regulations thereunder.

[T.D. 7215, 37 FR 23161, Oct. 31, 1972, as amended by T.D. 7299, 38 FR 35305, Dec. 27, 1973; T.D. 7527, 42 FR 64625, Dec. 27, 1977; T.D. 8084, 51 FR 16303, May 2, 1986]

§ 53.4945–2 Propaganda influencing legislation.

(a) *Propaganda influencing legislation, etc.*—(1) *In general.* Under section 4945(d)(1) the term ''taxable expenditure'' includes any amount paid or incurred by a private foundation to carry on propaganda, or otherwise to attempt, to influence legislation. An expenditure is an attempt to influence legislation if it is for a direct or grass

roots lobbying communication, as defined in § 56.4911–2 (without reference to §§ 56.4911–2(b)(3) and 56.4911–2(c)) and § 56.4911–3. See, however, paragraph (d) of this section for exceptions to the general rule of this paragraph (a)(1).

(2) *Expenditures for membership communications.* Section 56.4911–5, which provides special rules for electing public charities' communications with their members, does not apply to private foundations. Thus, whether a private foundation's communications with its members (assuming it has any) are lobbying communications is determined solely under § 56.4911–2 and without reference to § 56.4911–5. However, where a private foundation makes a grant to an electing public charity, § 56.4911–5 applies to the electing public charity's communications with its own members. Therefore, in the limited context of determining whether a private foundation's grant to an electing public charity is a taxable expenditure under section 4945, the § 56.4911–5 membership rules apply. For example, if the grant is specifically earmarked for a communication from the electing public charity to its members and the communication is, because of § 56.4911–5, a nonlobbying communication, the grant is not a taxable expenditure under section 4945.

(3) *Jointly funded projects.* A private foundation will not be treated as having paid or incurred any amount to attempt to influence legislation merely because it makes a grant to another organization upon the condition that the recipient obtain a matching support appropriation from a governmental body. In addition, a private foundation will not be treated as having made taxable expenditures of amounts paid or incurred in carrying on discussions with officials of governmental bodies provided that:

(i) The subject of such discussions is a program which is jointly funded by the foundation and the Government or is a new program which may be jointly funded by the foundation and the Government,

(ii) The discussions are undertaken for the purpose of exchanging data and information on the subject matter of the programs, and

(iii) Such discussions are not undertaken by foundation managers in order to make any direct attempt to persuade governmental officials or employees to take particular positions on specific legislative issues other than such program.

(4) *Certain expenditures by recipients of program-related investments.* Any amount paid or incurred by a recipient of a program-related investment (as defined in § 53.4944–3) in connection with an appearance before, or communication with, any legislative body with respect to legislation or proposed legislation of direct interest to such recipient shall not be attributed to the investing foundation, if:

(i) The foundation does not earmark its funds to be used for any activities described in section 4945(d) (1) and

(ii) A deduction under section 162 is allowable to the recipient for such amount.

(5) *Grants to public organizations*—(i) *In general.* A grant by a private foundation to an organization described in section 509(a) (1), (2) or (3) does not constitute a taxable expenditure by the foundation under section 4945(d), other than under section 4945(d)(1), if the grant by the private foundation is not earmarked to be used for any activity described in section 4945(d) (2) or (5), is not earmarked to be used in a manner which would violate section 4945(d) (3) or (4), and there does not exist an agreement, oral or written, whereby the grantor foundation may cause the grantee to engage in any such prohibited activity or to select the recipient to which the grant is to be devoted. For purposes of this paragraph (a)(5)(i), a grant by a private foundation is earmarked if the grant is given pursuant to an agreement, oral or written, that the grant will be used for specific purposes. For the expenditure responsibility requirements with respect to organizations other than those described in section 509(a) (1), (2), or (3), see § 53.4945–5. For rules for determining whether grants to public charities are taxable expenditures under section 4945(d)(1), see paragraphs (a)(2), (a)(6) and (a)(7) of this section.

(ii) *Certain ''public'' organizations.* For purposes of this section, an organization shall be considered a section

509(a)(1) organization if it is treated as such under subparagraph (4) of § 53.4945–5(a).

(6) *Grants to public organizations that attempt to influence legislation*—(i) *General support grant.* A general support grant by a private foundation to the organization described in section 509(a)(1), (2), or (3) (a ''public charity'' for purposes of paragraphs (a)(6) and (7) of this section) does not constitute a taxable expenditure under section 4945(d)(1) to the extent that the grant is not earmarked, within the meaning of § 53.4945–2(a)(5)(i), to be used in an attempt to influence legislation. The preceding sentence applies without regard to whether the public charity has made the election under section 501(h).

(ii) *Specific project grant.* A grant, by a private foundation to fund a specific project of a public charity is not a taxable expenditure by the foundation under section 4945(d)(1) to the extent that—

(A) The grant is not earmarked, within the meaning of § 53.4945–2(a)(5)(i), to be used in an attempt to influence legislation, and

(B) The amount of the grant, together with other grants by the same private foundation for the same project for the same year, does not exceed the amount budgeted, for the year of the grant, by the grantee organization for activities of the project that are not attempts to influence legislation. If the grant is for more than one year, the preceding sentence applies to each year of the grant with the amount of the grant measured by the amount actually disbursed by the private foundation in each year or divided equally between years, at the option of the private foundation. The same method of measuring the annual amount must be used in all years of a grant. This paragraph (a)(6)(ii) applies without regard to whether the public charity has made the election under section 501(h).

(iii) *Reliance upon grantee's budget.* For purposes of determining the amount budgeted by a prospective grantee for specific project activities that are not attempts to influence legislation under paragraph (a)(6)(ii) of this section, a private foundation may rely on budget documents or other sufficient evidence supplied by the grantee organization (such as a signed statement by an authorized officer, director or trustee of such grantee organization) showing the proposed budget of the specific project, unless the private foundation doubts or, in light of all the facts and circumstances, reasonably should doubt the accuracy or reliability of the documents.

(7) *Grants to organizations that cease to be described in 501(c)(3)*—(i) *Not taxable expenditure; conditions.* A grant to a public charity (as defined in paragraph (a)(6)(i) of this section) that thereafter ceases to be an organization described in section 501(c)(3) by reason of its attempts to influence legislation is not a taxable expenditure if—

(A) The grant meets the requirements of paragraph (a)(6) of this section,

(B) The recipient organization had received a ruling or determination letter, or an advance ruling or determination letter, that it is described in sections 501(c)(3) and 509(a),

(C) Notice of a change in the recipient organization's status has not been made to the public (such as by publication in the Internal Revenue Bulletin), and the private foundation has not acquired knowledge that the Internal Revenue Service has given notice to the recipient organization that it will be deleted from such status; and

(D) The recipient organization is not controlled directly or indirectly by the private foundation. A recipient organization is controlled by a private foundation for this purpose if the private foundation and disqualified persons (defined in section 4946(a)(1) (A) through (H) with reference to the private foundation, by aggregating their votes or positions of authority, can cause or prevent action on legislative issues by the recipient.

(ii) *Examples.* The provisions of paragraphs (a)(6) and (a)(7) of this section are illustrated by the following examples:

Example 1. W, a private foundation, makes a general support grant to Z, a public charity described in section 509(a)(1). Z informs W that, as an insubstantial portion of its activities, Z attempts to influence the State legislature with regard to changes in the mental health laws. The use of the grant is not earmarked by W to be used in a manner that would violate section 4945(d)(1). Even if

the grant is subsequently devoted by Z to its legislative activities, the grant by W is not a taxable expenditure under section 4945(d).

Example 2. X, a private foundation, makes a specific project grant to Y University for the purpose of conducting research on the potential environmental effects of certain pesticides. X does not earmark the grant for any purpose that would violate section 4945(d)(1) and there is no oral or written agreement or understanding whereby X may cause Y to engage in any activity described in section 4945(d) (1), (2), or (5), or to select any recipient to which the grant may be devoted. Further, X determines, based on budget information supplied by Y, that Y's budget for the project does not contain any amount for attempts to influence legislation. X has no reason to doubt the accuracy or reliability of the budget information. Y uses most of the funds for the research project; however, Y expends a portion of the grant funds to send a representative to testify at Congressional hearings on a specific bill proposing certain pesticide control measures. The portion of the grant funds expended with respect to the Congressional hearings is not treated as a taxable expenditure by X under section 4945(d)(1).

Example 3. M, a private foundation, makes a specific project grant of $150,000 to P, a public charity described in section 509(a)(1). In requesting the grant from M, P stated that the total budgeted cost of the project is $200,000, and that of this amount $20,000 is allocated to attempts to influence legislation related to the project. M relies on the budget figures provided by P in determining the amount P will spend on influencing legislation and M has no reason to doubt the accuracy or reliability of P's budget figures. In making the grant, M did not earmark any of the funds from the grant to be used for attempts to influence legislation. M's grant of $150,000 to P will not constitute a taxable expenditure under section 4945(d)(1) because M did not earmark any of the funds for attempts to influence legislation and because the amount of its grant ($150,000) does not exceed the amount allocated to specific project activities that are not attempts to influence legislation ($200,000 − $20,000 = $180,000).

Example 4. Assume the same facts as in example (3), except that M's grant letter to P provides that M has the right to renegotiate the terms of the grant if there is a substantial deviation from those terms. This additional fact does not make M's grant a taxable expenditure under section 4945(d)(1).

Example 5. Assume the same facts as in example (3), except that M made a specific project grant of $200,000 to P. Part of M's grant of $200,000 will constitute a taxable expenditure under section 4945(d)(1). The amount of the grant ($200,000) exceeds by $20,000 the amount P allocated to specific project activities that are not attempts to influence legislation ($180,000). M has made a taxable expenditure of $20,000.

Example 6. Assume the same facts as example (3), except that M made a specific project grant of $180,000, and received from P an enforceable commitment that grant funds would not be used in connection with attempts to influence legislation. M's grant is not a taxable expenditure under section 4945(d)(1).

Example 7. Assume the same facts as in example (3) except that M directed P to hire A, an individual, to expend $20,000 from the grant to engage in direct lobbying (within the meaning of § 56.4911–2(b)) and grass roots lobbying (within the meaning of § 56.4911–2(c)). P does not expend any other grant funds for lobbying activities. The $20,000 that is earmarked for direct lobbying and grass roots lobbying is a taxable expenditure under section 4945(d)(1).

Example 8. R, a public charity described in section 509(a)(1), requested N, a private foundation, to make a general purpose grant to it to aid R in carrying out its exempt purpose. In making this request, R notified N that it had elected the expenditure test under section 501(h) and that it expected to attempt to influence legislation in areas related to its exempt purpose. Since its formation, R generally has had exempt purpose expenditures (as defined in § 56.4911–4) in excess of $7,000,000 in each of its taxable years, and has budgeted in excess of $7,000,000 of exempt purpose expenditures for the year of the grant. N made a grant of $200,000 to R. N did not earmark the funds for R's attempt to influence legislation. The general purpose grant by N does not constitute a taxable expenditure under section 4945(d)(1).

Example 9. Assume the same facts as in example (8), except that N learns that R has had excess lobbying expenditures (within the meaning of § 56.4911–1(b)) in some prior years. N also learns that in no year has R's lobbying or grass roots expenditures (within the meaning of § 56.4911–2 (a) and (c)) exceeded the corresponding ceiling amount (within the meaning of § 1.501(h)–3(c) (3) and (6)). N then makes the grant to R. After receiving the grant, R spends a large portion of its funds on influencing legislation and, as a consequence, is denied exemption from tax, as an organization described in section 501(c)(3), under section 501(h) and § 1.501(h)–3. No disqualified person with respect to N controlled, in whole or in part, R's attempts to influence legislation. The general purpose grant will not constitute a taxable expenditure under section 4945(d)(1).

Example 10. X, a private foundation, makes a specific project grant to Y, a public charity described in section 509(a). In requesting the grant, Y stated that it planned to use the funds to purchase a computer for purpose of computerizing its research files and that the

grant will not be used to influence legislation. Two years after X makes the grant, X discovers that Y has also used the computer for purposes of maintaining and updating the mailing list for Y's lobbying newsletter. Because X did not earmark any of the grant funds to be used for attempts to influence legislation and because X had no reason to doubt the accuracy or reliability of Y's documents representing that the grant would not be used to influence legislation, X's grant is not treated as a taxable expenditure.

Example 11. G, a private foundation, makes a specific project grant of $300,000 to L, a public charity described in section 509(a)(1) for a three-year specific project studying child care problems. L provides budget material indicating that the specific project will expend $200,000 in each of three years. L's budget materials indicate that attempts to influence legislation will amount to $10,000 in the first year, $20,000 in the second year and $100,000 in the third year. G intends to pay its $300,000 grant over three years as follows: $200,000 in the first year, $50,000 in the second year and $50,000 in the third year. The amount of the grant actually disbursed by G in the first year of the grant exceeds the nonlobbying expenditures of L in that year. However, because the amount of the grant in each of the three years, when divided equally among the three years ($100,000 for each year), is not more than the nonlobbying expenditures of L on the specific project for any of the three years, none of the grant is treated as a taxable expenditure under section 4945(d)(1).

Example 12. P, a private foundation, makes a $120,000 specific project grant to C, a public charity described in section 509(a) for a three-year project. P intends to pay its grant to C in three equal annual installments of $40,000. C provides budget material indicating that the specific project will expend $100,000 in each of three years. C's budget materials, which P reasonably does not doubt, indicate that the project's attempts to influence legislation will amount to $50,000 in each of the three years. After P pays the first annual installment to C, but before P pays the second installment to C, reliable information comes to P's attention that C has spent $90,000 of the project's $100,000 first-year budget on attempts to influence legislation. This information causes P to doubt the accuracy and reliability of C's budget materials. Because of the information, P does not pay the second-year installment to C. P's payment of the first installment of $40,000 is not a taxable expenditure under section 4945(d)(1) because the grant in the first year is not more than the nonlobbying expenditures C projected in its budget materials that P reasonably did not doubt.

Example 13. Assume the same facts as in Example (12), except that P pays the second-year installment of $40,000 to C. In the project's second year, C once again spends $90,000 of the project's $100,000 annual budget in attempts to influence legislation. Because P doubts or reasonably should doubt the accuracy or reliability of C's budget materials when P makes the second-year grant payment, P may not rely upon C's budget documents at that time. Accordingly, although none of the $40,000 paid in the first installment is a taxable expenditure, only $10,000 ($100,000 minus $90,000) of the second-year grant payment is not a taxable expenditure. The remaining $30,000 of the second installment is a taxable expenditure within the meaning of section 4945(d)(1).

Example 14. B, a private foundation, makes a specific project grant to C, a public charity described in section 509(a), of $40,000 for the purpose of conducting a study on the effectiveness of seat belts in preventing traffic deaths. B did not earmark any of the grant for attempts to influence legislation. In requesting the grant from B, C submitted a budget of $100,000 for the project. The budget contained expenses for postage and mailing, computer time, advertising, consulting services, salaries, printing, advertising, and similar categories of expenses. C also submitted to B a statement, signed by an officer of C, that 30% of the budgeted funds would be devoted to attempts to influence legislation within the meaning of section 4945. B has no reason to doubt the accuracy of the budget figures or the statement. B may rely on the budget figures and signed statement provided by C in determining the amount C will spend on influencing legislation. B's grant to C will not constitute a taxable expenditure under section 4945(d)(1), because the amount of the grant does not exceed the amount allocated to specific project activities that are not attempts to influence legislation.

(b)–(c) [Reserved]

(d) *Exceptions*—(1) *Nonpartisan analysis, study, or research*—(i) *In general.* A communication is not a lobbying communication, for purposes of § 53.4945–2(a)(1), if the communication constitutes engaging in nonpartisan analysis, study or research and making available to the general public or a segment or members thereof or to governmental bodies, officials, or employees the results of such work. Accordingly, an expenditure for such a communication does not constitute a taxable expenditure under section 4945(d)(1) and § 53.4945–2(a)(1).

(ii) *Nonpartisan analysis, study, or research.* For purposes of section 4945(e),

''nonpartisan analysis, study, or research'' means an independent and objective exposition of a particular subject matter, including any activity that is ''educational'' within the meaning of § 1.501(c)(3)–1(d)(3). Thus, ''nonpartisan analysis, study, or research'' may advocate a particular position or viewpoint so long as there is a sufficiently full and fair exposition of the pertinent facts to enable the public or an individual to form an independent opinion or conclusion. On the other hand, the mere presentation of unsupported opinion does not qualify as ''nonpartisan analysis, study, or research''.

(iii) *Presentation as part of a series.* Normally, whether a publication or broadcast qualifies as ''nonpartisan analysis, study, or research'' will be determined on a presentation-by-presentation basis. However, if a publication or broadcast is one of a series prepared or supported by a private foundation and the series as a whole meets the standards of subdivision (ii) of this subparagraph, then any individual publication or broadcast within the series will not result in a taxable expenditure even though such individual broadcast or publication does not, by itself, meet the standards of subdivision (ii) of this subparagraph. Whether a broadcast or publication is considered part of a series will ordinarily depend on all the facts and circumstances of each particular situation. However, with respect to broadcast activities, all broadcasts within any period of 6 consecutive months will ordinarily be eligible to be considered as part of a series. If a private foundation times or channels a part of a series which is described in this subdivision in a manner designed to influence the general public or the action of a legislative body with respect to a specific legislative proposal in violation of section 4945(d)(1), the expenses of preparing and distributing such part of the analysis, study, or research will be a taxable expenditure under this section.

(iv) *Making available results of analysis, study, or research.* A private foundation may choose any suitable means, including oral or written presentations, to distribute the results of its nonpartisan analysis, study, or research, with or without charge. Such means include distribution of reprints of speeches, articles, and reports (including the report required under section 6056); presentation of information through conferences, meetings, and discussions; and dissemination to the news media, including radio, television, and newspapers, and to other public forums. For purposes of this paragraph (d)(1)(iv), such communications may not be limited to, or be directed toward, persons who are interested solely in one side of a particular issue.

(v) *Subsequent lobbying use of certain analysis, study, or research*—(A) *In general.* Even though certain analysis, study or research is initially within the exception for nonpartisan analysis, study, or research, subsequent use of that analysis, study or research for grass roots lobbying may cause that analysis, study or research to be treated as a grass roots lobbying communication that is not within the exception for nonpartisan analysis, study, or research. This paragraph (d)(1)(v) of this section does not cause any analysis, study, or research to be considered a direct lobbying communication. For rules regarding when analysis, study, or research is treated as a grass roots lobbying communication that is not within the scope of the exception for nonpartisan analysis, study, or research, see § 56.4911–2(b)(2)(v).

(B) *Special rule for grants to public charities.* This paragraph (d)(1)(v)(B) of this section applies where a public charity uses a private foundation grant to finance, in whole or in part, a nonlobbying communication that is subsequently used in lobbying, causing the public charity's expenditures for the communication to be treated as lobbying expenditures under the subsequent use. In such a case, the private foundation's grant will ordinarily not be characterized as a lobbying expenditure by virtue of the subsequent use rule. The only situations where the private foundation's grant will be treated as a lobbying expenditure under the subsequent use rule are where the private foundation's primary purpose in making the grant to the public charity was for lobbying or where, at the time

of making the grant, the private foundation knows (or in light of all the facts and circumstances reasonably should know) that the public charity's primary purpose in preparing the communication to be funded by the grant is for use in lobbying.

(vi) *Directly encouraging action by recipients of a communication.* A communication that reflects a view on specific legislation is not within the nonpartisan analysis, study, or research exception of this § 53.4945–2(d)(1) if the communication directly encourages the recipient to take action with respect to such legislation. For purposes of this section, a communication directly encourages the recipient to take action with respect to legislation if the communication is described in one or more of § 56.4911–2(b)(2)(iii)(A) through (C). As described in § 56.4911–2(b)(2)(iv), a communication would encourage the recipient to take action with respect to legislation, but not *directly* encourage such action, if the communication does no more than specifically identify one or more legislators who will vote on the legislation as: opposing the communication's view with respect to the legislation; being undecided with respect to the legislation; being the recipient's representative in the legislature; or being a member of the legislative committee or subcommittee that will consider the legislation.

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

Example 1. M, a private foundation, establishes a research project to collect information for the purpose of showing the dangers of the use of pesticides in raising crops. The information collected includes data with respect to proposed legislation, pending before several State legislatures, which would ban the use of pesticides. The project takes favorable positions on such legislation without producing a sufficiently full and fair exposition of the pertinent facts to enable the public or an individual to form an independent opinion or conclusion on the pros and cons of the use of pesticides. This project is not within the exception for nonpartisan analysis, study, or research because it is designed to present information merely on one side of the legislative controversy.

Example 2. N, a private foundation, establishes a research project to collect information concerning the dangers of the use of pesticides in raising crops for the ostensible purpose of examining and reporting information as to the pros and cons of the use of pesticides in raising crops. The information is collected and distributed in the form of a published report which analyzes the effects and costs of the use and nonuse of various pesticides under various conditions on humans, animals, and crops. The report also presents the advantages, disadvantages, and economic cost of allowing the continued use of pesticides unabated, of controlling the use of pesticides, and of developing alternatives to pesticides. Even if the report sets forth conclusions that the disadvantages as a result of using pesticides are greater than the advantages of using pesticides and that prompt legislative regulation of the use of pesticides is needed, the project is within the exception for nonpartisan analysis, study or research since it is designed to present information on both sides of the legislative controversy and presents a sufficiently full and fair exposition of the pertinent facts to enable the public or an individual to form an independent opinion or conclusion.

Example 3. O, a private foundation, establishes a research project to collect information on the presence or absence of disease in humans from eating food grown with pesticides and the presence or absence of disease in humans from eating food not grown with pesticides. As part of the research project, O hires a consultant who prepares a ''fact sheet'' which calls for the curtailment of the use of pesticides and which addresses itself to the merits of several specific legislative proposals to curtail the use of pesticides in raising crops which are currently pending before State legislatures. The ''fact sheet'' presents reports of experimental evidence tending to support its conclusions but omits any reference to reports of experimental evidence tending to dispute its conclusions. O distributes 10,000 copies to citizens' groups. Expenditures by O in connection with this work of the consultant are not within the exception for nonpartisan analysis, study, or research.

Example 4. P publishes a bi-monthly newsletter to collect and report all published materials, ongoing research, and new developments with regard to the use of pesticides in raising crops. The newsletter also includes notices of proposed pesticide legislation with impartial summaries of the provisions and debates on such legislation. The newsletter does not encourage recipients to take action with respect to such legislation, but is designed to present information on both sides of the legislative controversy and does present information fully and fairly. It is within the exception for nonpartisan analysis, study, or research.

Example 5. X is satisfied that A, a member of the faculty of Y University, is exceptionally well qualified to undertake a project involving a comprehensive study of the effects of pesticides on crop yields. Consequently, X

makes a grant to A to underwrite the cost of the study and of the preparation of a book on the effect of pesticides on crop yields. X does not take any position on the issues or control the content of A's output. A produces a book which concludes that the use of pesticides often has a favorable effect on crop yields, and on that basis argues against pending bills which would ban the use of pesticides. A's book contains a sufficiently full and fair exposition of the pertinent facts, including known or potential disadvantages of the use of pesticides, to enable the public or an individual to form an independent opinion or conclusion as to whether pesticides should be banned as provided in the pending bills. The book does not directly encourage readers to take action with respect to the pending bills. Consequently, the book is within the exception for nonpartisan analysis, study, or research.

Example 6. Assume the same facts as Example (2), except that, instead of issuing a report, X presents within a period of 6 consecutive months a two-program television series relating to the pesticide issue. The first program contains information, arguments, and conclusions favoring legislation to restrict the use of pesticides. The second program contains information, arguments, and conclusions opposing legislation to restrict the use of pesticides. The programs are broadcast within 6 months of each other during commensurate periods of prime time. X's programs are within the exception for nonpartisan analysis, study, or research. Although neither program individually could be regarded as nonpartisan, the series of two programs constitutes a balanced presentation.

Example 7. Assume the same facts as Example (6), except that X arranged for televising the program favoring legislation to restrict the use of pesticides at 8 p.m. on a Thursday evening and for televising the program opposing such legislation at 7 a.m. on a Sunday morning. X's presentation is not within the exception for nonpartisan analysis, study, or research, since X disseminated its information in a manner prejudicial to one side of the legislative controversy.

Example 8. Organization Z researches, writes, prints and distributes a study on the use and effects of pesticide X. A bill is pending in the U.S. Senate to ban the use of pesticide X. Z's study leads to the conclusion that pesticide X is extremely harmful and that the bill pending in the U.S. Senate is an appropriate and much needed remedy to solve the problems caused by pesticide X. The study contains a sufficiently full and fair exposition of the pertinent facts, including known or potential advantages of the use of pesticide X, to enable the public or an individual to form an independent opinion or conclusion as to whether pesticides should be banned as provided in the pending bills. In its analysis of the pending bill, the study names certain undecided Senators on the Senate committee considering the bill. Although the study meets the three part test for determining whether a communication is a grass roots lobbying communication, the study is within the exception for nonpartisan analysis, study or research, because it does not directly encourage recipients of the communication to urge a legislator to oppose the bill.

Example 9. Assume the same facts as in Example (8), except that, after stating support for the pending bill, the study concludes: ''You should write to the undecided committee members to support this crucial bill.'' The study is not within the exception for nonpartisan analysis, study or research because it directly encourages the recipients to urge a legislator to support a specific piece of legislation.

Example 10. Organization X plans to conduct a lobbying campaign with respect to illegal drug use in the United States. It incurs $5,000 in expenses to conduct research and prepare an extensive report primarily for use in the lobbying campaign. Although the detailed report discusses specific pending legislation and reaches the conclusion that the legislation would reduce illegal drug use, the report contains a sufficiently full and fair exposition of the pertinent facts to enable the public or an individual to form an independent conclusion regarding the effect of the legislation. The report does not encourage readers to contact legislators regarding the legislation. Accordingly, the report does not, in and of itself, constitute a lobbying communication.

Copies of the report are available to the public at X's office, but X does not actively distribute the report or otherwise seek to make the contents of the report available to the general public. Whether or not X's distribution is sufficient to meet the requirement in § 53.4945–2(d)(1)(iv) that a nonpartisan communication be made available, X's distribution is not substantial (for purposes of §§ 53.4945–2(D)(1)(v) and 56.4911–2(b)(2)(v)) in light of all of the facts and circumstances, including the normal distribution pattern of similar nonpartisan reports. X then mails copies of the report, along with a letter, to 10,000 individuals on X's mailing list. In the letter, X requests that individuals contact legislators urging passage of the legislation discussed in the report. Because X's research and report were primarily undertaken by X for lobbying purposes and X did not make a substantial distribution of the report (without an accompanying lobbying message) prior to or contemporaneously with the use of the report in lobbying, the report is a grass roots lobbying communication that is not within the exception for nonpartisan analysis, study or research. Thus, the expenditures for preparing

and mailing both the report and the letter are taxable expenditures under section 4945.

Example 11. Assume the same facts as in Example (10), except that before using the report in the lobbying campaign, X sends the research and report (without an accompanying lobbying message) to universities and newspapers. At the same time, X also advertises the availability of the report in its newsletter. This distribution is similar in scope to the normal distribution pattern of similar nonpartisan reports. In light of all of the facts and circumstances, X's distribution of the report is substantial. Because of X's substantial distribution of the report, X's primary purpose will be considered to be other than for use in lobbying and the report will not be considered a grass roots lobbying communication. Accordingly, only the expenditures for copying and mailing the report to the 10,000 individuals on X's mailing list, as well as for preparing and mailing the letter, are expenditures for grass roots lobbying communications, and are thus taxable expenditures under section 4945.

Example 12. Organization M pays for a bumper sticker that reads: ''STOP ABORTION: Vote *NO* on Prop. X!'' M also pays for a 30-second television advertisement and a billboard that similarly advocate opposition to Prop. X. In light of the limited scope of the communications, none of the communications is within the exception for nonpartisan analysis, study or research. First, none of the communications rises to the level of analysis, study or research. Second, none of the communications is nonpartisan because none contains a sufficiently full and fair exposition of the pertinent facts to enable the public or an individual to form an independent opinion or conclusion. Thus, each communication is a lobbying communication.

(2) *Technical advice or assistance*—(i) *In general.* Amounts paid or incurred in connection with providing technical advice or assistance to a governmental body, a governmental committee, or a subdivision of either of the foregoing, in response to a written request by such body, committee, or subdivision do not constitute taxable expenditures for purposes of this section. Under this exception, the request for assistance or advice must be made in the name of the requesting governmental body, committee or subdivision rather than an individual member thereof. Similarly, the response to such request must be available to every member of the requesting body, committee or subdivision. For example, in the case of a written response to a request for technical advice or assistance from a congressional committee, the response will be considered available to every member of the requesting committee if the response is submitted to the person making such request in the name of the committee and it is made clear that the response is for the use of all the members of the committee.

(ii) *Nature of technical advice or assistance.* ''Technical advice or assistance'' may be given as a result of knowledge or skill in a given area. Because such assistance or advice may be given only at the express request of a governmental body, committee or subdivision, the oral or written presentation of such assistance or advice need not qualify as nonpartisan analysis, study or research. The offering of opinions or recommendations will ordinarily qualify under this exception only if such opinions or recommendations are specifically requested by the governmental body, committee or subdivision or are directly related to the materials so requested.

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

Example 1. A congressional committee is studying the feasibility of legislation to provide funds for scholarships to U.S. students attending schools abroad. X, a private foundation which has engaged in a private scholarship program of this type, is asked, in writing, by the committee to describe the manner in which it selects candidates for its program. X's response disclosing its methods of selection constitutes technical advice or assistance.

Example 2. Assume the same facts as Example (1), except that X's response not only includes a description of its own grant-making procedures, but also its views regarding the wisdom of adopting such a program. Since such views are directly related to the subject matter of the request for technical advice or assistance, expenditures paid or incurred with respect to the presentation of such views would not constitute taxable expenditures. However, expenditures paid or incurred with respect to a response which is not directly related to the subject matter of the request for technical advice or assistance would constitute taxable expenditures unless the presentation can qualify as the making available of nonpartisan analysis, study or research.

Example 3. Assume the same facts as Example (1), except that X is requested, in addition, to give any views it considers relevant. A response to this request giving opinions

which are relevant to the committee's consideration of the scholarship program but which are not necessarily directly related to X's scholarship program, such as discussions of alternative scholarships programs and their relative merits, would qualify as ''technical advice or assistance'', and expenditures paid or incurred with respect to such response would not constitute taxable expenditures.

Example 4. A, an official of the State Department, makes a written request in his official capacity for information from foundation Y relating to the economic development of country M and for the opinions of Y as to the proper position of the United States in pending negotiations with M concerning a proposed treaty involving a program of economic and technical aid to M. Y's furnishing of such information and opinions constitutes technical advice or assistance.

Example 5. In response to a telephone inquiry from Senator X's staff, organization B sends Senator X a report concluding that the Senate should not advise and consent to the nomination of Z to serve as a Supreme Court Justice. Because the request was not in writing, and also because the request was not from the Senate itself or from a committee or subcommittee, B's report is not within the scope of the exception for responses to requests for technical advice. Accordingly, B's report is a lobbying communication unless the report is within the scope of the exception for nonpartisan analysis, study or research.

Example 6. Assume the same facts as in Example (5), except that B's report is sent in response to a written request that Senator X sends to B. The request from Senator X is a request from the Senator as an individual member of the Senate rather than from the Senate itself or from a committee or subcommittee. Accordingly, B's report is not within the scope of the exception for responses to requests for technical advice and is a lobbying conmmunication unless the report is within the scope of the exception for nonpartisan analysis, study or research.

Example 7. Assume the same facts as in Example (6), except that B's report is sent in response to a written request from the Senate committee that is considering the nomination for an evaluation of the nominee's legal writings and a recommendation as to whether the candidate is or is not qualified to serve on the Supreme Court. The report is within the scope of the exception for responses to requests for technical advice and is not a lobbying communication.

(3) *Decisions affecting the powers, duties, etc., of a private foundation*—(i) *In general.* Paragraph (c) of this section does not apply to any amount paid or incurred in connection with an appearance before, or communication with, any legislative body with respect to a possible decision of such body which might affect the existence of the private foundation, its powers and duties, its tax-exempt status, or the deductibility of contributions to such foundation. Under this exception, a foundation may communicate with the entire legislative body, committees or subcommittees of such legislative body, individual congressmen or legislators, members of their staffs, or representatives of the executive branch, who are involved in the legislative process, if such communication is limited to the prescribed subjects. Similarly, the foundation may make expenditures in order to initiate legislation if such legislation concerns only matters which might affect the existence of the private foundation, its powers and duties, its tax-exempt status, or the deductibility of contributions to such foundation.

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

Example 1. A bill is being considered by Congress which would, if enacted, restrict the power of a private foundation to engage in transactions with certain related persons. Under the proposed bill a private foundation would lose its exemption from taxation if it engages in such transactions. W, a private foundation, writes to the congressional committee considering the bill, arguing that the enactment of such a bill would not be advisable, and subsequently appears before such committee to make its arguments. In addition, W requests that the congressional committee consider modification of the 2 percent de minimis rule of section 4943(c) (2) (C). Expenditures paid or incurred with respect to such submissions do not constitute taxable expenditures since they are made with respect to a possible decision of Congress which might affect the existence of the private foundation, its powers and duties, its tax-exempt status, or the deduction of contributions to such foundation.

Example 2. A bill being considered in a State legislature is designed to implement the requirements of section 508(e) of the Internal Revenue Code of 1954. Under such section, a private foundation is required to make certain amendments to its governing instrument. X, a private foundation, makes a submission to the legislature which proposes alternative measures which might be taken in lieu of the proposed bill. X also arranges to have its president contact certain State

legislators with regard to this bill. Expenditures paid or incurred in making such submission and in contacting the State legislators do not constitute taxable expenditures since they are made with respect to a possible decision of such State legislature which might affect the existence of the private foundation, its powers and duties, its tax-exempt status, or the deduction of contributions to such foundation.

Example 3. A bill is being considered by a State legislature under which the State would assume certain responsibilities for nursing care of the aged. Y, a private foundation which hitherto has engaged in such activities, appears before the State legislature and contends that such activities can be better performed by privately supported organizations. Expenditures paid or incurred with respect to such appearance are not made with respect to possible decisions of the State legislature which might affect the existence of the private foundation, its powers and duties, its tax-exempt status, or the deduction of contributions to such foundation, but rather merely affect the scope of the private foundation's future activities.

Example 4. A State legislature is considering the annual appropriations bill. Z, a private foundation which had hitherto performed contract research for the State, appears before the appropriations committee in order to attempt to persuade the committee of the advisability of continuing the program. Expenditures paid or incurred with respect to such appearance are not made with respect to possible decisions of the State legislature which might affect the existence of the private foundation, its powers and duties, its tax-exempt status, or the deduction of contributions to such foundation, but rather merely affect the scope of the private foundation's future activities.

(4) *Examination and discussions of broad social, economic, and similar problems.* Examinations and discussions of broad social, economic, and similar problems are neither direct lobbying communications under § 56.4911–2(b)(1) nor grass roots lobbying communications under § 56.4911–2(b)(2) even if the problems are of the type with which government would be expected to deal ultimately. Thus, under §§ 56.4911–2(b)(1) and (2), lobbying communications do not include public discussion, or communications with members of legislative bodies or governmental employees, the general subject of which is also the subject of legislation before a legislative body, so long as such discussion does not address itself to the merits of a specific legislative proposal and so long as such discussion does not directly encourage recipients to take action with respect to legislation. For example, this paragraph (d)(4) excludes from grass roots lobbying under § 56.4911(b)(2) an organization's discussions of problems such as environmental pollution or population growth that are being considered by Congress and various State legislatures, but only where the discussions are not directly addressed to specific legislation being considered, and only where the discussions do not directly encourage recipients of the communication to contact a legislator, an employee of a legislative body, or a government official or employee who may participate in the formulation of legislation.

[T.D. 7215, 37 FR 23161, Oct. 31, 1972; 37 FR 23918, Nov. 11, 1972, as amended by T.D. 8308, 55 FR 35594, Aug. 31, 1990]

§ 53.4945–3 Influencing elections and carrying on voter registration drives.

(a) *Expenditures to influence elections or carry on voter registration drives*—(1) *In general.* Under section 4945(d) (2), the term ''taxable expenditure'' includes any amount paid or incurred by a private foundation to influence the outcome of any specific public election or to carry on, directly or indirectly, any voter registration drive, unless such amount is paid or incurred by an organization described in section 4945(f). However, for treatment of nonearmarked grants to public organizations, see § 53.4945–2(a) (5) and for treatment of certain earmarked grants to organizations described in section 4945(f), see paragraph (b) (2) of this section.

(2) *Influencing the outcome of a specific public election.* For purposes of this section, an organization shall be considered to be influencing the outcome of any specific public election if it participates or intervenes, directly or indirectly, in any political campaign on behalf of or in opposition to any candidate for public office. The term *candidate for public office* means an individual who offers himself, or is proposed by others, as a contestant for an elective public office, whether such office be national, State or local. Activities which constitute participation or intervention in a political campaign on

behalf of or in opposition to a candidate include, but are not limited to:

(i) Publishing or distributing written or printed statements or making oral statements on behalf of or in opposition to such a candidate;

(ii) Paying salaries or expenses of campaign workers; and

(iii) Conducting or paying the expenses of conducting a voter-registration drive limited to the geographic area covered by the campaign.

(b) *Nonpartisan activities carried on by certain organizations*—(1) *In general.* If an organization meets the requirements described in section 4945(f), an amount paid or incurred by such organization shall not be considered a taxable expenditure even though the use of such amount is otherwise described in section 4945(d) (2). Such requirements are:

(i) The organization is described in section 501(c) (3) and exempt from taxation under section 501(a);

(ii) The activities of the organization are nonpartisan, are not confined to one specific election period, and are carried on in five or more States;

(iii) The organization expends at least 85 percent of its income directly for the active conduct (within the meaning of section 4942(j) (3) and the regulations thereunder) of the activities constituting the purpose or function for which it is organized and operated;

(iv) The organization receives at least 85 percent of its support (other than gross investment income as defined in section 509(e)) from exempt organizations, the general public, governmental units described in section 170(c) (1), or any combination of the foregoing; the organization does not receive more than 25 percent of its support (other than gross investment income) from any one exempt organization (for this purpose treating private foundations which are described in section 4946(a) (1) (H) with respect to each other as one exempt organization); and not more than half of the support of the organization is received from gross investment income; and

(v) Contributions to the organization for voter registration drives are not subject to conditions that they may be used only in specified States, possessions of the United States, or political subdivisions or other areas of any of the foregoing, or the District of Columbia, or that they may be used in only one specific election period.

(2) *Grants to section 4945(f) organizations.* If a private foundation makes a grant to an organization described in section 4945(f) (whether or not such grantee is a private foundation as defined in section 509(a)), such grant will not be treated as a taxable expenditure under section 4945(d) (2) or (4). Even if a grant to such an organization is earmarked for voter registration purposes generally, such a grant will not be treated as a taxable expenditure under section 4945(d) (2) or (4) as long as such earmarking does not violate section 4945(f) (5).

(3) *Period for determining support*—(i) *In general.* The determination whether an organization meets the support test in section 4945(f) (4) for any taxable year is to be made by aggregating all amounts of support received by the organization during the taxable year and the immediately preceding four taxable years. However, the support received in any taxable year which begins before January 1, 1970, shall be excluded.

(ii) *New organizations and organizations with no preceding taxable years beginning after December 31, 1969.* Except as provided in subparagraph (4) of this paragraph, in the case of a new organization or an organization with no taxable years that begin after December 31, 1969, and immediately precede the taxable year in question, the requirements of the support test in section 4945(f)(4) will be considered as met for the taxable year if such requirements are met by the end of the taxable year.

(iii) *Organization with three or fewer preceding taxable years.* In the case of an organization which has been in existence for at least 1 but fewer than 4 preceding taxable years beginning after December 31, 1969, the determination whether such organization meets the requirements of the support test in section 4945(f)(4) for the taxable year is to be made by taking into account all the support received by such organization during the taxable year and during each preceding taxable year beginning after December 31, 1969.

(4) *Advance rulings.* An organization will be given an advance ruling that it is an organization described in section 4945(f) for its first taxable year of operation beginning after October 30, 1972, or for its first taxable year of operation beginning after December 31, 1969, if it submits evidence establishing that it can reasonably be expected to meet the tests under section 4945(f) for such taxable year. An organization which, pursuant to this subparagraph, has been treated as an organization described in section 4945(f) for a taxable year (without withdrawal of such treatment by notification from the Internal Revenue Service during such year), but which actually fails to meet the requirements of section 4945(f) for such taxable year, will not be treated as an organization described in section 4945(f) as of the first day of its next taxable year (for purposes of making any determination under the internal revenue laws with respect to such organization) and until such time as the organization does meet the requirements of section 4945(f). For purposes of section 4945, the status of grants or contributions with respect to grantors or contributors to such organization will not be affected until notice of change of status of such organization is made to the public (such as by publication in the Internal Revenue Bulletin). The preceding sentence shall not apply, however, if the grantor or contributor was responsible for, or was aware of, the fact that the organization did not satisfy section 4945(f) at the end of the taxable year with respect to which the organization had obtained an advance ruling or a determination letter that it was a section 4945(f) organization, or acquired knowledge that the Internal Revenue Service had given notice to such organization that it would be deleted from classification as a section 4945(f) organization.

[T.D. 7215, 37 FR 23161, Oct. 31, 1972; 37 FR 23918, Nov. 11, 1972]

§ 53.4945–4 Grants to individuals.

(a) *Grants to individuals*—(1) *In general.* Under section 4945(d) (3) the term ''taxable expenditure'' includes any amount paid or incurred by a private foundation as a grant to an individual for travel, study, or other similar purposes by such individual unless the grant satisfies the requirements of section 4945(g). Grants to individuals which are not taxable expenditures because made in accordance with the requirements of section 4945(g) may result in the imposition of excise taxes under other provisions of chapter 42.

(2) *''Grants'' defined.* For purposes of section 4945, the term ''grants'' shall include, but is not limited to, such expenditures as scholarships, fellowships, internships, prizes, and awards. Grants shall also include loans for purposes described in section 170(c) (2) (B) and ''program related investments'' (such as investments in small businesses in central cities or in businesses which assist in neighborhood renovation). Similarly, ''grants'' include such expenditures as payments to exempt organizations to be used in furtherance of such recipient organizations' exempt purposes whether or not such payments are solicited by such recipient organizations. Conversely, ''grants'' do not ordinarily include salaries or other compensation to employees. For example, ''grants'' do not ordinarily include educational payments to employees which are includible in the employees' incomes pursuant to section 61. In addition, ''grants'' do not ordinarily include payments (including salaries, consultants' fees and reimbursement for travel expenses such as transportation, board, and lodging) to persons (regardless of whether such persons are individuals) for personal services in assisting a foundation in planning, evaluating or developing projects or areas of program activity by consulting, advising, or participating in conferences organized by the foundation.

(3) *Requirements for individual grants*—(i) *Grants for other than section 4945(d)(3) purposes.* A grant to an individual for purposes other than those described in section 4945(d) (3) is not a taxable expenditure within the meaning of section 4945(d) (3). For example, if a foundation makes grants to indigent individuals to enable them to purchase furniture, such grants are not taxable expenditures within the meaning of section 4945(d) (3) even if the requirements of section 4945(g) are not met.

(ii) *Grants for section 4945(d) (3) purposes.* Under section 4945(g), a grant to

an individual for travel, study, or other similar purposes is not a ''taxable expenditure'' only if:

(*a*) The grant is awarded on an objective and nondiscriminatory basis (within the meaning of paragraph (b) of this section);

(*b*) The grant is made pursuant to a procedure approved in advance by the Commissioner; and

(*c*) It is demonstrated to the satisfaction of the Commissioner that:

(*1*) The grant constitutes a scholarship or fellowship grant which is excluded from gross income under section 117(a) and is to be utilized for study at an educational institution described in section 151(e) (4);

(*2*) The grant constitutes a prize or award which is excluded from gross income under section 74(b), and the recipient of such prize or award is selected from the general public (within the meaning of section 4941(d) (2) (G) (i) and the regulations thereunder); or

(*3*) The purpose of the grant is to achieve a specific objective, produce a report or other similar product, or improve or enhance a literary, artistic, musical, scientific, teaching, or other similar capacity, skill, or talent of the grantee.

If a grant is made to an individual for a purpose described in section 4945(g) (3) and such grant otherwise meets the requirements of section 4945(g), such grant shall not be treated as a taxable expenditure even if it is a scholarship or a fellowship grant which is not excludable from income under section 117 or if it is a prize or award which is includible in income under section 74.

(iii) *Renewals*. A renewal of a grant which satisfied the requirements of subdivision (ii) of this subparagraph shall not be treated as a grant to an individual which is subject to the requirements of this section, if:

(*a*) The grantor has no information indicating that the original grant is being used for any purpose other than that for which it was made,

(*b*) Any reports due at the time of the renewal decision pursuant to the terms of the original grant have been furnished, and

(*c*) Any additional criteria and procedures for renewal are objective and nondiscriminatory.

For purposes of this section, an extension of the period over which a grant is to be paid shall not itself be regarded as a grant or a renewal of a grant.

(4) *Certain designated grants*—(i) *In general*. A grant by a private foundation to another organization, which the grantee organization uses to make payments to an individual for purposes described in section 4945(d)(3), shall not be regarded as a grant by the private foundation to the individual grantee if the foundation does not earmark the use of the grant for any named individual and there does not exist an agreement, oral or written, whereby such grantor foundation may cause the selection of the individual grantee by the grantee organization. For purposes of this subparagraph, a grant described herein shall not be regarded as a grant by the foundation to an individual grantee even though such foundation has reason to believe that certain individuals would derive benefits from such grant so long as the grantee organization exercises control, in fact, over the selection process and actually makes the selection completely independently of the private foundation.

(ii) *Certain grants to ''public charities''*. A grant by a private foundation to an organization described in section 509(a) (1), (2), or (3), which the grantee organization uses to make payments to an individual for purposes described in section 4945(d)(3), shall not be regarded as a grant by the private foundation to the individual grantee (regardless of the application of subdivision (i) of this subparagraph) if the grant is made for a project which is to be undertaken under the supervision of the section 509(a) (1), (2), or (3) organization and such grantee organization controls the selection of the individual grantee. This subdivision shall apply regardless of whether the name of the individual grantee was first proposed by the private foundation, but only if there is an objective manifestation of the section 509(a), (1), (2), or (3) organization's control over the selection process, although the selection need not be made completely independently of the private foundation. For purposes of this subdivision, an organization shall be

considered a section 509(a)(1) organization if it is treated as such under subparagraph (4) of § 53.4945–5(a).

(iii) *Grants to governmental agencies.* If a private foundation makes a grant to an organization described in section 170(c)(1) (regardless of whether it is described in section 501(c)(3)) and such grant is earmarked for use by an individual for purposes described in section 4945(d)(3), such grant is not subject to the requirements of section 4945(d)(3) and (g) and this section (regardless of the application of subdivision (i) of this subparagraph) if the section 170(c)(1) organization satisfies the Commissioner in advance that its grant-making program:

(*a*) Is in furtherance of a purpose described in section 170(c)(2)(B),

(*b*) Requires that the individual grantee submit reports to it which would satisfy paragraph (c)(3) of this section, and

(*c*) Requires that the organization investigate jeopardized grants in a manner substantially similar to that described in paragraph (c)(4) of this section.

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

Example 1. M, a university described in section 170(b)(1)(A)(ii), requests that P, a private foundation, grant it $100,000 to enable M to obtain the services of a particular scientist for a research project in a special field of biochemistry in which he has exceptional qualifications and competence. P, after determining that the project deserves support, makes the grant to M to enable it to obtain the services of this scientist. M is authorized to keep the funds even if it is unsuccessful in attempting to employ the scientist. Under these circumstances P will not be treated as having made a grant to the individual scientist for purposes of section 4945(d)(3) and (g), since the requirements of subdivision (i) of this subparagraph have been satisfied. Even if M were not authorized to keep the funds if it is unsuccessful in attempting to employ the scientist, P would not be treated as having made a grant to the individual scientist for purposes of section 4945(d)(3) and (g), since it is clear from the facts and circumstances that the selection of the particular scientist was made by M and thus the requirements of subdivision (ii) of this subparagraph would have been satisfied.

Example 2. Assume the same facts as Example (1), except that there are a number of scientists who are qualified to administer the research project, P suggests the name of the particular scientist to be employed by M, and M is not authorized to keep the funds if it is unsuccessful in attempting to employ the particular scientist. For purposes of section 4945(d)(3) and (g), P will be treated as having made a grant to the individual scientist whose name it suggested, since it is clear from the facts and circumstances that selection of the particular scientist was made by P.

Example 3. X, a private foundation, is aware of the exceptional research facilities at Y University, an organization described in section 170(b)(1)(A)(ii). Officials of X approach officials of Y with an offer to give Y a grant of $100,000 if Y will engage an adequately qualified physicist to conduct a specific research project. Y's officials accept this proposal, and it is agreed that Y will administer the funds. After examining the qualifications of several research physicists, the officials of Y agree that A, whose name was first suggested by officials of X and who first suggested the specific research project to X, is uniquely qualified to conduct the project. X's grant letter provides that X has the right to renegotiate the terms of the grant if there is a substantial deviation from such terms, such as breakdown of Y's research facilities or termination of the conduct of the project by an adequately qualified physicist. Under these circumstances, X will not be treated as having made a grant to A for purposes of section 4945(d)(3) and (g), since the requirements of subdivision (ii) of this subparagraph have been satisfied.

Example 4. Professor A, a scholar employed by University Y, an organization described in section 170(b)(1)(A)(ii), approaches Foundation X to determine the availability of grant funds for a particular research project supervised or conducted by Professor A relevant to the program interests of Foundation X. After learning that Foundation X would be willing to consider the project if University Y were to submit the project to X, Professor A submits his proposal to the appropriate administrator of University Y. After making a determination that it should assume responsibility for the project, that Professor A is qualified to conduct the project, and that his participation would be consistent with his other faculty duties, University Y formally adopts the grant proposal and submits it to Foundation X. The grant is made to University Y which, under the terms of the grant, is responsible for the expenditure of the grant funds and the grant project. In such a case, and even if Foundation X retains the right to renegotiate the terms of the grant if the project ceases to be conducted by Professor A, the grant shall not be regarded as a grant by Foundation X to Professor A since University Y has retained control over the selection process within the

meaning of subdivision (ii) of this subparagraph.

(5) *Earmarked grants to individuals.* A grant by a private foundation to an individual, which meets the requirements of section 4945(d)(3) and (g), is a taxable expenditure by such foundation under section 4945(d) only if:

(i) The grant is earmarked to be used for any activity described in section 4945(d) (1), (2), or (5), or is earmarked to be used in a manner which would violate section 4945(d) (3) or (4),

(ii) There is an agreement, oral or written, whereby such grantor foundation may cause the grantee to engage in any such prohibited activity and such grant is in fact used in a manner which violates section 4945(d), or

(iii) The grant is made for a purpose other than a purpose described in section 170(c)(2)(B).

For purposes of this subparagraph, a grant by a private foundation is earmarked if such grant is given pursuant to an agreement, oral or written, that the grant will be used for specific purposes.

(b) *Selection of grantees on ''an objective and nondiscriminatory basis''*—(1) *In general.* For purposes of this section, in order for a foundation to establish that its grants to individuals are made on an objective and nondiscriminatory basis, the grants must be awarded in accordance with a program which, if it were a substantial part of the foundation's activities, would be consistent with:

(i) The existence of the foundation's exempt status under section 501(c)(3);

(ii) The allowance of deductions to individuals under section 170 for contributions to the granting foundation; and

(iii) The requirements of subparagraphs (2), (3), and (4) of this paragraph.

(2) *Candidates for grants.* Ordinarily, selection of grantees on an objective and nondiscriminatory basis requires that the group from which grantees are selected be chosen on the basis of criteria reasonably related to the purposes of the grant. Furthermore, the group must be sufficiently broad so that the giving of grants to members of such group would be considered to fulfill a purpose described in section 170(c)(2)(B). Thus, ordinarily the group must be sufficiently large to constitute a charitable class. However, selection from a group is not necessary where taking into account the purposes of the grant, one or several persons are selected because they are exceptionally qualified to carry out these purposes or it is otherwise evident that the selection is particularly calculated to effectuate the charitable purpose of the grant rather than to benefit particular persons or a particular class of persons. Therefore, consistent with the requirements of this subparagraph, the foundation may impose reasonable restrictions on the group of potential grantees. For example, selection of a qualified research scientist to work on a particular project does not violate the requirements of section 4945(d)(3) merely because the foundation selects him from a group of three scientists who are experts in that field.

(3) *Selection from within group of potential grantees.* The criteria used in selecting grant recipients from the potential grantees should be related to the purpose of the grant. Thus, for example, proper criteria for selecting scholarship recipients might include (but are not limited to) the following: Prior academic performance; performance on tests designed to measure ability and aptitude for college work; recommendations from instructors; financial need; and the conclusions which the selection committee might draw from a personal interview as to the individual's motivation, character, ability, and potential.

(4) *Persons making selections.* The person or group of persons who select recipients of grants should not be in a position to derive a private benefit, directly or indirectly, if certain potential grantees are selected over others.

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

Example 1. X company employs 100,000 people of whom 1,000 are classified by the company as executives. The company has organized the X company foundation which, as its sole activity, provides 100 4-year college scholarships per year for children of the company's employees. Children of all employees (other than disqualified persons with respect to the foundation) who have worked

for the X company for at least 2 years are eligible to apply for these scholarships. In previous years, the number of children eligible to apply for such scholarships has averaged 2,000 per year. Selection of scholarship recipients from among the applicants is made by three prominent educators, who have no connection (other than as members of the selection committee) with the company, the foundation or any of the employees of the company. The selections are made on the basis of the applicants' prior academic performance, performance on certain tests designed to measure ability and aptitude for college work, and financial need. No disproportionate number of scholarships has been granted to relatives of executives of X company. Under these circumstances, the operation of the scholarship program by the X company foundation: (1) Is consistent with the existence of the foundation's exempt status under section 501(c) (3) and with the allowance of deductions under section 170 for contributions to the foundation; (2) utilizes objective and nondiscriminatory criteria in selecting scholarship recipients from among the applicants; and (3) utilizes a selection committee which appears likely to make objective and nondiscriminatory selections of grant recipients.

Example 2. Assume the same facts as Example (1), except that the foundation establishes a program to provide 20 college scholarships per year for members of a certain ethnic minority. All members of this minority group (other than disqualified persons with respect to the foundation) living in State Z are eligible to apply for these scholarships. It is estimated that at least 400 persons will be eligible to apply for these scholarships each year. Under these circumstances, the operation of this scholarship program by the foundation: (1) Is consistent with the existence of the foundation's exempt status under section 501(c)(3) and with the allowance of deductions under section 170 for contributions to the foundation; (2) utilizes objective and nondiscriminatory criteria in selecting scholarship recipients from among the applicants; and (3) utilizes a selection committee which appears likely to make objective and nondiscriminatory selections of grant recipients.

(c) *Requirements of a proper procedure*—(1) *In general.* Section 4945(g) requires that grants to individuals must be made pursuant to a procedure approved in advance. To secure such approval, a private foundation must demonstrate to the satisfaction of the Commissioner that:

(i) Its grant procedure includes an objective and nondiscriminatory selection process (as described in paragraph (b) of this section);

(ii) Such procedure is reasonably calculated to result in performance by grantees of the activities that the grants are intended to finance; and

(iii) The foundation plans to obtain reports to determine whether the grantees have performed the activities that the grants are intended to finance.

No single procedure or set of procedures is required. Procedures may vary depending upon such factors as the size of the foundation, the amount and purpose of the grants and whether one or more recipients are involved.

(2) *Supervision of scholarship and fellowship grants.* Except as provided in subparagraph (5) of this paragraph, with respect to any scholarship or fellowship grants, a private foundation must make arrangements to receive a report of the grantee's courses taken (if any) and grades received (if any) in each academic period. Such a report must be verified by the educational institution attended by the grantee and must be obtained at least once a year. In cases of grantees whose study at an educational institution does not involve the taking of courses but only the preparation of research papers or projects, such as the writing of a doctoral thesis, the foundation must receive a brief report on the progress of the paper or project at least once a year. Such a report must be approved by the faculty member supervising the grantee or by another appropriate university official. Upon completion of a grantee's study at an educational institution, a final report must also be obtained.

(3) *Grants described in section 4945(g)(3).* With respect to a grant made under section 4945(g)(3), the private foundation shall require reports on the use of the funds and the progress made by the grantee toward achieving the purposes for which the grant was made. Such reports must be made at least once a year. Upon completion of the undertaking for which the grant was made, a final report must be made describing the grantee's accomplishments with respect to the grant and accounting for the funds received under such grant.

(4) *Investigation of jeopardized grants.* (i) Where the reports submitted under this paragraph or other information

(including the failure to submit such reports) indicates that all or any part of a grant is not being used in furtherance of the purposes of such grant, the foundation is under a duty to investigate. While conducting its investigation, the foundation must withhold further payments to the extent possible until any delinquent reports required by this paragraph have been submitted and where required by subdivision (ii) or (iii) of this subparagraph.

(ii) In cases in which the grantor foundation determines that any part of a grant has been used for improper purposes and the grantee has not previously diverted grant funds to any use not in furtherance of a purpose specified in the grant, the foundation will not be treated as having made a taxable expenditure solely because of the diversion so long as the foundation:

(*a*) Is taking all reasonable and appropriate steps either to recover the grant funds or to insure the restoration of the diverted funds and the dedication (consistent with the requirements of (*b*) (*1*) and (*2*) of this subdivision) of other grant funds held by the grantee to the purposes being financed by the grant, and

(*b*) Withholds any further payments to the grantee after the grantor becomes aware that a diversion may have taken place (hereinafter referred to as ''further payments'') until it has:

(*1*) Received the grantee's assurances that future diversions will not occur, and

(*2*) Required the grantee to take extraordinary precaution to prevent future diversions from occurring.

If a foundation is treated as having made a taxable expenditure under this subparagraph in a case to which this subdivision applies, then unless the foundation meets the requirements of (*a*) of this subdivision the amount of the taxable expenditure shall be the amount of the diversion plus the amount of any further payments to the same grantee. However, if the foundation complies with the requirements of (*a*) of this subdivision but not the requirements of (b) of this subdivision, the amount of the taxable expenditure shall be the amount of such further payments.

(iii) In cases where a grantee has previously diverted funds received from a grantor foundation, and the grantor foundation determines that any part of a grant has again been used for improper purposes, the foundation will not be treated as having made a taxable expenditure solely by reason of such diversion so long as the foundation:

(*a*) Is taking all reasonable and appropriate steps to recover the grant funds or to insure the restoration of the funds and the dedication (consistent with the requirements of (*b*) (*2*) and (*3*) of this subdivision) of other grant funds held by the grantee to the purposes being financed by the grant, and

(*b*) Withholds further payments until:

(*1*) Such funds are in fact so recovered or restored,

(*2*) It has received the grantee's assurances that future diversions will not occur, and

(*3*) It requires the grantee to take extraordinary precautions to prevent future diversions from occurring.

If a foundation is treated as having made a taxable expenditure under this subparagraph in a case to which this subdivision applies, then unless the foundation meets the requirements of (*a*) of this subdivision, the amount of the taxable expenditure shall be the amount of the diversion plus the amount of any further payments to the same grantee. However, if the foundation complies with the requirements of (*a*) of this subdivision, but fails to withhold further payments until the requirements of (*b*) of this subdivision are met, the amount of the taxable expenditure shall be the amount of such further payments.

(iv) The phrase ''all reasonable and appropriate steps'' in subdivisions (ii) and (iii) of this subparagraph includes legal action where appropriate but need not include legal action if such action would in all probability not result in the satisfaction of execution on a judgment.

(5) *Supervision of certain scholarship and fellowship grants.* Subparagraphs (2) and (4) of this paragraph shall be considered satisfied with respect to scholarship or fellowship grants under the following circumstances:

(i) The scholarship or fellowship grants are described in section 4945(g)(1);

(ii) The grantor foundation pays the scholarship or fellowship grants to an educational institution described in section 151(e)(4); and

(iii) Such educational institution agrees to use the grant funds to defray the recipient's expenses or to pay the funds (or a portion thereof) to the recipient only if the recipient is enrolled at such educational institution and his standing at such educational institution is consistent with the purposes and conditions of the grant.

(6) *Retention of records.* A private foundation shall retain records pertaining to all grants to individuals for purposes described in section 4945(d)(3). Such records shall include:

(i) All information the foundation secures to evaluate the qualification of potential grantees;

(ii) Identification of grantees (including any relationship of any grantee to the foundation sufficient to make such grantee a disqualified person of the private foundation within the meaning of section 4946(a)(1));

(iii) Specification of the amount and purpose of each grant; and

(iv) The follow-up information which the foundation obtains in complying with subparagraphs (2), (3), and (4) of this paragraph.

(7) *Example.* The provisions of paragraphs (b) and (c) of this section may be illustrated by the following example:

Example. The X foundation grants 10 scholarships each year to graduates of high schools in its area to permit the recipients to attend college. It makes the availability of its scholarships known by oral or written communications each year to the principals of three major high schools in the area. The foundation obtains information from each high school on the academic qualifications, background, and financial need of applicants. It requires that each applicant be recommended by two of his teachers or by the principal of his high school. All application forms are reviewed by the foundation officer responsible for making the awards and scholarships are granted on the basis of the academic qualifications and financial need of the grantees. The foundation obtains annual reports on the academic performance of the scholarship recipient from the college or university which he attends. It maintains a file on each scholarship awarded, including the original application, recommendations, a record of the action taken on the application, and the reports on the recipient from the institution which he attends. The described procedures of the X foundation for the making of grants to individuals qualify for Internal Revenue Service approval under section 4945(g). Furthermore, if the X foundation's scholarship program meets the requirements of subparagraph (5) of this paragraph, X foundation will not have to obtain reports on the academic performance of the scholarship recipients.

(d) *Submission of grant procedure*—(1) *Contents of request for approval of grant procedures.* A request for advance approval of a foundation's grant procedures must fully describe the foundation's procedures for awarding grants and for ascertaining that such grants are used for the proper purposes. The approval procedure does not contemplate specific approval of particular grant programs but instead one-time approval of a system of standards, procedures, and follow-up designed to result in grants which meet the requirements of section 4945(g). Thus, such approval shall apply to a subsequent grant program as long as the procedures under which it is conducted do not differ materially from those described in the request to the Commissioner. The request must contain the following items:

(i) A statement describing the selection process. Such statement shall be sufficiently detailed for the Commissioner to determine whether the grants are made on an objective and nondiscriminatory basis under paragraph (b) of this section.

(ii) A description of the terms and conditions under which the foundation ordinarily makes such grants, which is sufficient to enable the Commissioner to determine whether the grants awarded under such procedures would meet the requirements of paragraph (1), (2), or (3) of section 4945(g).

(iii) A detailed description of the private foundation's procedure for exercising supervision over grants, as described in paragraph (c)(2) and (3) of this section.

(iv) A description of the foundation's procedures for review of grantee reports, for investigation where diversion

of grant funds from their proper purposes is indicated, and for recovery of diverted grant funds, as described in paragraph (c) (4) of this section.

(2) *Place of submission*. Request for approval of grant procedures shall be submitted to the District Director.

(3) *Internal Revenue Service action on request for approval of grant procedures*. The 45th day after a request for approval of grant procedures has been properly submitted to the Internal Revenue Service, the organization has not been notified that such procedures are not acceptable, such procedures shall be considered as approved from the date of submission until receipt of actual notice from the Internal Revenue Service that such procedures do not meet the requirements of this section. If a grant to an individual for a purpose described in section 4945(d) (3) is made after notification to the organization by the Internal Revenue Service that the procedures under which the grant is made are not acceptable, such grant is a taxable expenditure under this section.

(e) *Effective dates*—(1) *In general*. This section shall apply to all grants to individuals for travel, study, or other similar purposes which are made by private foundations more than 90 days after October 30, 1972.

(2) *Transitional rules*—(i) *Grants committed prior to January 1, 1970*. Section 4945(d) (3) and (g) and this section shall not apply to a grant for section 170(c) (2) (B) purposes made on or after January 1, 1970, if the grant was made pursuant to a commitment entered into prior to such date, but only if such commitment was made in accordance with the foundation's usual practices and is reasonable in amount in light of the purposes of the grant. For purposes of this subdivision, a commitment will be considered entered into prior to January 1, 1970, if prior to such date, the amount and nature of the payments to be made and the name of the payee were entered on the records of the payor, or were otherwise adequately evidenced, or the notice of the payment to be received was communicated to the payee in writing.

(ii) *Grants awarded on or after January 1, 1970*. In the case of a grant awarded on or after January 1, 1970, but prior to the expiration of 90 days after October 30, 1972, and paid within 48 months after the award of such grant, the requirements of section 4945(g) that an individual grant be awarded on an objective and nondiscriminatory basis pursuant to a procedure approved in advance by the Commissioner will be deemed satisfied if the grantor utilizes any procedure in good faith in awarding a grant to an individual which, in fact, is reasonably calculated to provide objectivity and nondiscrimination in the awarding of such grant and to result in a grant which complies with the conditions of section 4945(g) (1), (2), or (3).

§ 53.4945–5 Grants to organizations.

(a) *Grants to nonpublic organizations*—(1) *In general*. Under section 4945(d)(4) the term ''taxable expenditure'' includes any amount paid or incurred by a private foundation as a grant to an organization (other than an organization described in section 509(a)(1), (a)(2), or (a)(3) (other than an organization described in section 4942(g)(4)(A)(i) or (ii)) or in section 4940(d)(2)), unless the private foundation exercises expenditure responsibility with respect to such grant in accordance with section 4945(h). However, the granting foundation does not have to exercise expenditure responsibility with respect to amounts granted to organizations described in section 4945(f).

(2) *''Grants'' described*. For a description of the term ''grants'', see § 53.4945–4(a)(2).

(3) *Section 509(a) (1), (2), and (3) organizations*. See section 508(b) and the regulations thereunder for rules relating to when a grantor may rely on a potential grantee's characterization of its status as set forth in the notice described in section 508(b).

(4) *Certain ''public'' organizations*. For purposes of this section, an organization will be treated as a section 509(a)(1) organization if:

(i) It qualifies as such under paragraph (a) of § 1.509(a)–2 of this chapter;

(ii) It is an organization described in section 170(c)(1) or 511(a)(2)(B), even if it is not described in section 501(c)(3); or

(iii) It is a foreign government, or any agency or instrumentality thereof,

or an international organization designated as such by Executive order under 22 U.S.C. 288, even if it is not described in section 501(c)(3).

However, any grant to an organization referred to in this subparagraph must be made exclusively for charitable purposes as described in section 170(c)(2)(B).

(5) *Certain foreign organizations*—(i) *In general*. If a private foundation makes a grant to a foreign organization, which does not have a ruling or determination letter that it is an organization described in section 509(a)(1), (a)(2), or (a)(3) or in section 4940(d)(2), the grant will nonetheless be treated as a grant made to an organization described in section 509(a)(1), (a)(2), or (a)(3) (other than an organization described in section 4942(g)(4)(A)(i) or (ii)) or in section 4940(d)(2) if the grantor private foundation has made a good faith determination that the grantee organization is an organization described in section 509(a)(1), (a)(2), or (a)(3) (other than an organization described in section 4942(g)(4)(A)(i) or (ii)) or in section 4940(d)(2). A determination ordinarily will be considered a good faith determination if the determination is based on current written advice received from a qualified tax practitioner concluding that the grantee is an organization described in section 509(a)(1), (a)(2), or (a)(3) (other than an organization described in section 4942(g)(4)(A)(i) or (ii)) or in section 4940(d)(2), and if the foundation reasonably relied in good faith on the written advice in accordance with the requirements of § 1.6664–4(c)(1) of this chapter. The written advice must set forth sufficient facts concerning the operations and support of the grantee organization for the Internal Revenue Service to determine that the grantee organization would be likely to qualify as an organization described in section 509(a)(1), (a)(2), or (a)(3) (other than an organization described in section 4942(g)(4)(A)(i) or (ii)) or in section 4940(d)(2) as of the date of the written advice. For purposes of these rules, except as provided in the next sentence, written advice will be considered current if, as of the date of the grant payment, the relevant law on which the advice is based has not changed since the date of the written advice and the factual information on which the advice is based is from the grantee's current or prior taxable year (or annual accounting period if the grantee does not have a taxable year for United States federal tax purposes). Written advice that a grantee met the public support test under section 170(b)(1)(A)(vi) or section 509(a)(2) for a test period of five years will be treated as current for purposes of grant payments to the grantee during the two taxable years (or, as applicable, annual accounting periods) of the grantee immediately following the end of the five-year test period. See paragraphs (b)(5) and (6) of this section for additional rules relating to foreign organizations.

(ii) *Definitions*. For purposes of this paragraph (a)(5)—

(*a*) The term ''foreign organization'' means any organization that is not described in section 170(c)(2)(A).

(*b*) The term ''qualified tax practitioner'' means an attorney, a certified public accountant, or an enrolled agent, within the meaning of 31 CFR 10.2 and 10.3, who is subject to the requirements in 31 CFR part 10.

(6) *Certain earmarked grants*—(i) *In general*. A grant by a private foundation to a grantee organization which the grantee organization uses to make payments to another organization (the secondary grantee) shall not be regarded as a grant by the private foundation to the secondary grantee if the foundation does not earmark the use of the grant for any named secondary grantee and there does not exist an agreement, oral or written, whereby such grantor foundation may cause the selection of the secondary grantee by the organization to which it has given the grant. For purposes of this subdivision, a grant described herein shall not be regarded as a grant by the foundation to the secondary grantee even though such foundation has reason to believe that certain organizations would derive benefits from such grant so long as the original grantee organization exercises control, in fact, over the selection process and actually makes the selection completely independently of the private foundation.

(ii) *To governmental agencies*. If a private foundation makes a grant to an

organization described in section 170(c)(1) and such grant is earmarked for use by another organization, the granting foundation need not exercise expenditure responsibility with respect to such grant if the section 170(c)(1) organization satisfies the Commissioner in advance that:

(*a*) Its grantmaking program is in furtherance of a purpose described in section 170(c)(2)(B), and

(*b*) The section 170(c)(1) organization exercises ''expenditure responsibility'' in a manner that would satisfy this section if it applied to such section 170(c)(1) organization. However, with respect to such grant, the granting foundation must make the reports required by section 4945(h)(3) and paragraph (d) of this section, unless such grant is earmarked for use by an organization described in section 509(a)(1), (a)(2), or (a)(3) (other than an organization described in section 4942(g)(4)(A)(i) or (ii)), or in section 4940(d)(2).

(b) *Expenditure responsibility*—(1) *In general*. A private foundation is not an insurer of the activity of the organization to which it makes a grant. Thus, satisfaction of the requirements of sections 4945(d)(4) and (h) and of subparagraph (3) or (4) of this paragraph, will ordinarily mean that the grantor foundation will not have violated section 4945(d) (1) or (2). A private foundation will be considered to be exercising ''expenditure responsibility'' under section 4945(h) as long as it exerts all reasonable efforts and establishes adequate procedures:

(i) To see that the grant is spent solely for the purpose for which made,

(ii) To obtain full and complete reports from the grantee on how the funds are spent, and

(iii) To make full and detailed reports with respect to such expenditures to the Commissioner.

In cases in which pursuant to paragraph (a)(6) of this section a grant is considered made to a secondary grantee rather than the primary grantee, the grantor foundation's obligation to obtain reports from the grantee pursuant to section 4945(h)(2) and this section will be satisfied if appropriate reports are obtained from the secondary grantee. For rules relating to expenditure responsibility with respect to transfers of assets described in section 507(b)(2), see section 507(b)(2) and the regulations thereunder.

(2) *Pre-grant inquiry*—(i) Before making a grant to an organization with respect to which expenditure responsibility must be exercised under this section, a private foundation should conduct a limited inquiry concerning the potential grantee. Such inquiry should be complete enough to give a reasonable man assurance that the grantee will use the grant for the proper purposes. The inquiry should concern itself with matters such as: (*a*) The identity, prior history and experience (if any) of the grantee organization and its managers; and (*b*) any knowledge which the private foundation has (based on prior experience or otherwise) of, or other information which is readily available concerning, the management, activities, and practices of the grantee organization. The scope of the inquiry might be expected to vary from case to case depending upon the size and purpose of the grant, the period over which it is to be paid, and the prior experience which the grantor has had with respect to the capacity of the grantee to use the grant for the proper purposes. For example, if the grantee has made proper use of all prior grants to it by the grantor and filed the required reports substantiating such use, no further pregrant inquiry will ordinarily be necessary. Similarly, in the case of an organization, such as a trust described in section 4947(a)(2), which is required by the terms of its governing instrument to make payments to a specified organization exempt from taxation under section 501(a), a less extensive pregrant inquiry is required than in the case of a private foundation possessing discretion with respect to the distribution of funds.

(ii) The provisions of this subparagraph may be illustrated by the following examples:

Example 1. Officials of M, a newly established organization which is described in section 501(c)(4), request a grant from X foundation to be used for a proposed program to combat drug abuse by establishing neighborhood clinics in certain ghetto areas of a city. Before making a grant to M, X makes an inquiry concerning the identity, prior history and experience of the officials of M. X obtains information pertaining to the officials

of M from references supplied by these officials. Since one of the references indicated that A, an official of M, has an arrest record, police records are also checked and A's probation officer is interviewed.

The inquiry also shows M has no previous history of administering grants and that the officials of M have had no experience in administering programs of this nature. However, in the opinion of X's managers, M's officials (including A who appears to be fully rehabilitated after having been convicted of a narcotics violation several years ago) are well qualified to conduct this program since they are members of the communities in which the clinics are to be established and are more likely to be trusted by drug users in these communities than are outsiders. Under these circumstances X has complied with the requirements of this subparagraph and a grant to M for its proposed program will not be treated as a taxable expenditure solely because of the operation of this subparagraph.

Example 2. Foundation Y wishes to make a grant to foundation R for use in R's scholarship program. Y has made similar grants to R annually for the last several years and knows that R's managers have observed the terms of the previous grants and have made all requested reports with respect to such grants. No changes in R's management have occurred during the past several years. Under these circumstances, Y has enough information to have such assurance as a reasonable man would require that the grant to R will be used for proper purposes. Consequently, Y is under no obligation to make any further pregrant inquiry pursuant to this subparagraph.

Example 3. S foundation requests a grant from Z foundation for use in S's program of providing medical research fellowships. S has been engaged in this program for several years and has received large numbers of grants from other foundations. Z's managers know that the reputations of S and of S's officials are good. Z's managers also have been advised by managers of W foundation that W had recently made a grant to S and that W's managers were satisfied that such grant has been used for the purposes for which it was made. Under these circumstances Z has enough information to have such assurance as a reasonable man would require that the grant to S will be used for proper purposes. Consequently, Z is under no obligation to make any further pregrant inquiry pursuant to this subparagraph.

(3) *Terms of grants.* Except as provided in subparagraph (4) of this paragraph, in order to meet the expenditure responsibility requirements of section 4945(h), a private foundation must require that each grant to an organization, with respect to which expenditure responsibility must be exercised under this section, be made subject to a written commitment signed by an appropriate officer, director, or trustee of the grantee organization. Such commitment must include an agreement by the grantee:

(i) To repay any portion of the amount granted which is not used for the purposes of the grant,

(ii) To submit full and complete annual reports on the manner in which the funds are spent and the progress made in accomplishing the purposes of the grant, except as provided in paragraph (c)(2) of this section,

(iii) To maintain records of receipts and expenditures and to make its books and records available to the grantor at reasonable times, and

(iv) Not to use any of the funds:

(*a*) To carry on propaganda, or otherwise to attempt, to influence legislation (within the meaning of section 4945(d)(1)),

(*b*) To influence the outcome of any specific public election, or to carry on, directly or indirectly, any voter registration drive (within the meaning of section 4945(d)(2)),

(*c*) To make any grant which does not comply with the requirements of section 4945(d) (3) or (4), or

(*d*) To undertake any activity for any purpose other than one specified in section 170(c)(2)(B).

The agreement must also clearly specify the purposes of the grant. Such purposes may include contributing for capital endowment, for the purchase of capital equipment, or for general support provided that neither the grants nor the income therefrom may be used for purposes other than those described in section 170(c)(2)(B).

(4) *Terms of program-related investments.* In order to meet the expenditure responsibility requirements of section 4945(h), with regard to the making of a program-related investment (as defined in section 4944 and the regulations thereunder), a private foundation must require that each such investment with respect to which expenditure responsibility must be exercised under section 4945(d)(4) and (h) and this section be made subject to a written commitment

signed by an appropriate officer, director, or trustee of the recipient organization. Such commitment must specify the purpose of the investment and must include an agreement by the organization:

(i) To use all the funds received from the private foundation (as determined under paragraph (c)(3) of this section) only for the purposes of the investment and to repay any portion not used for such purposes, provided that, with respect to equity investments, such repayment shall be made only to the extent permitted by applicable law concerning distributions to holders of equity interests,

(ii) At least once a year during the existence of the program-related investment, to submit full and complete financial reports of the type ordinarily required by commercial investors under similar circumstances and a statement that it has complied with the terms of the investment,

(iii) To maintain books and records adequate to provide information ordinarily required by commercial investors under similar circumstances and to make such books and records available to the private foundation at reasonable times, and

(iv) Not to use any of the funds:

(*a*) To carry on propaganda, or otherwise to attempt, to influence legislation (within the meaning of section 4945(d)(1)),

(*b*) To influence the outcome of any specific public election, or to carry on directly or indirectly, and voter registration drive (within the meaning of section 4945(d)(2)), or

(*c*) With respect to any recipient which is a private foundation (as defined in section 509(a)), to make any grant which does not comply with the requirements of section 4945 (d) (3) or (4).

(5) *Certain grants to foreign organizations.* With respect to a grant to a foreign organization (other than an organization described in section 509(a)(1), (a)(2), or (a)(3) (other than an organization described in section 4942(g)(4)(A)(i) or (ii)) or in section 4940(d)(2) or treated as so described pursuant to paragraph (a)(4) or (5) of this section), paragraph (b)(3)(iv) or (b)(4)(iv) of this section shall be deemed satisfied if the agreement referred to in paragraph (b)(3) or (4) of this section imposes restrictions on the use of the grant substantially equivalent to the limitations imposed on a domestic private foundation under section 4945(d). Such restrictions may be phrased in appropriate terms under foreign law or custom and ordinarily will be considered sufficient if an affidavit or opinion of counsel (of the grantor or grantee) or written advice of a qualified tax practitioner is obtained stating that, under foreign law or custom, the agreement imposes restrictions on the use of the grant substantially equivalent to the restrictions imposed on a domestic private foundation under paragraph (b)(3) or (4) of this section.

(6) *Special rules for grants by foreign private foundations.* With respect to activities in jurisdictions other than those described in section 170(c)(2)(A), the failure of a foreign private foundation which is described in section 4948(b) to comply with subparagraph (3) or (4) of this paragraph with respect to a grant to an organization shall not constitute an act or failure to act which is a prohibited transaction (within the meaning of section 4948(c)(2)).

(7) *Expenditure responsibility with respect to certain transfers of assets described in section 507*—(i) *Transfers of assets described in section 507(b)(2).* For rules relating to the extent to which the expenditure responsibility rules contained in section 4945 (d)(4) and (h) and this section apply to transfers of assets described in section 507(b)(2), see §§ 1.507–3(a)(7), 1.507–3 (a)(8)(ii)(*f*), and 1.507–3(a)(9) of this chapter.

(ii) *Certain other transfers of assets.* For rules relating to the extent to which the expenditure responsibility rules contained in section 4945 (d)(4) and (h) and this section apply to certain other transfers of assets described in § 1.507–3(b) of this chapter, see § 1.507–3(b) of this chapter.

(8) *Restrictions on grants (other than program-related investments) to organizations not described in section 501(c)(3).* For other restrictions on certain grants (other than program-related investments) to organizations which are not described in section 501(c)(3), see § 53.4945–6(c).

(c) *Reports from grantees*—(1) *In general.* In the case of grants described in section 4945(d)(4), except as provided in subparagraph (2) of this paragraph, the granting private foundation shall require reports on the use of the funds, compliance with the terms of the grant, and the progress made by the grantee toward achieving the purposes for which the grant was made. The grantee shall make such reports as of the end of its annual accounting period within which the grant or any portion thereof is received and all such subsequent periods until the grant funds are expended in full or the period of the grantee for which such reports shall be furnished to the grantor within a reasonable period of time after the close of the annual accounting period of the grantee for which such reports are made. Within a reasonable period of time after the close of its annual accounting period during which the use of the grant funds is completed, the grantee must make a final report with respect to all expenditures made from such funds (including salaries, travel, and supplies), and indicating the progress made toward the goals of the grant. The grantor need not conduct any independent verification of such reports unless it has reason to doubt their accuracy or reliability.

(2) *Capital endowment grants to exempt private foundations.* If a private foundation makes a grant described in section 4945(d)(4) to a private foundation which is exempt from taxation under section 501(a) for endowment, for the purchase of capital equipment, or for other capital purposes, the grantor foundation shall require reports from the grantee on the use of the principal and the income (if any) from the grant funds. The grantee shall make such reports annually for its taxable year in which the grant was made and the immediately succeeding 2 taxable years. Only if it is reasonably apparent to the grantor that, before the end of such second succeeding taxable year, neither the principal, the income from the grant funds, nor the equipment purchased with the grant funds has been used for any purpose which would result in liability for tax under section 4945(d), the grantor may then allow such reports to be discontinued.

(3) *Grantees' accounting and recordkeeping procedures.* (i) A private foundation grantee exempt from taxation under section 501(a) (or the recipient of a program-related investment) need not segregate grant funds physically nor separately account for such funds on its books unless the grantor requires such treatment of the grant funds. If such a grantee neither physically segregates grant funds nor establishes separate accounts on its books, grants received within a given taxable year beginning after December 31, 1969, shall be deemed, for purposes of section 4945, to be expended before grants received in a succeeding taxable year. In such case expenditures of grants received within any such taxable year shall be prorated among all such grants.

In accounting for grant expenditures, private foundations may make the necessary computations on a cumulative annual basis (or, where appropriate, as of the date for which the computations are made). The rules set forth in the preceding three sentences shall apply to the extent they are consistent with the available records of the grantee and with the grantee's treatment of qualifying distributions under section 4942(h) and the regulations thereunder. The records of expenditures, as well as copies of the reports submitted to the grantor, must be kept for at least 4 years after completion of the use of the grant funds.

(ii) For rules relating to accounting and recordkeeping requirements for grantees other than those described in subdivision (i) of this subparagraph, see §§ 53.4945–5(b)(8) and 53.4945–6(c).

(4) *Reliance on information supplied by grantee.* A private foundation exercising expenditure responsibility with respect to its grants may rely on adequate records or other sufficient evidence supplied by the grantee organization (such as a statement by an appropriate officer, director or trustee of such grantee organization) showing, to the extent applicable, the information which the grantor must report to the Internal Revenue Service in accordance with paragraph (d)(2) of this section.

(d) *Reporting to Internal Revenue Service by grantor*—(1) *In general.* To satisfy

the reportmaking requirements of section 4945(h)(3), a granting foundation must provide the required information on its annual information return, required to be filed by section 6033, for each taxable year with respect to each grant made during the taxable year which is subject to the expenditure responsibility requirements of section 4945(h). Such information must also be provided on such return with respect to each grant subject to such requirements upon which any amount or any report is outstanding at any time during the taxable year. However, with respect to any grant made for endowment or other capital purposes, the grantor must provide the required information only for any taxable year for which the grantor must require a report from the grantee under paragraph (c)(2) of this section. The requirements of this subparagraph with respect to any grant may be satisfied by submission with the foundation's information return of a report received from the grantee, if the information required by subparagraph (2) of this paragraph is contained in such report.

(2) *Contents of report.* The report required by this paragraph shall include the following information:

(i) The name and address of the grantee.

(ii) The date and amount of the grant.

(iii) The purpose of the grant.

(iv) The amounts expended by the grantee (based upon the most recent report received from the grantee).

(v) Whether the grantee has diverted any portion of the funds (or the income therefrom in the case of an endowment grant) from the purpose of the grant (to the knowledge of the grantor).

(vi) The dates of any reports received from the grantee.

(vii) The date and results of any verification of the grantee's reports undertaken pursuant to and to the extent required under paragraph (c)(1) of this section by the grantor or by others at the direction of the grantor.

(3) *Recordkeeping requirements.* In addition to the information included on the information return, a granting foundation shall make available to the Internal Revenue Service at the foundation's principal office each of the following items:

(i) A copy of the agreement covering each ''expenditure responsibility'' grant made during the taxable year.

(ii) A copy of each report received during the taxable year from each grantee on any ''expenditure responsibility'' grant, and

(iii) A copy of each report made by the grantor's personnel or independent auditors of any audits or other investigations made during the taxable year with respect to any ''expenditure responsibility'' grant.

(4) *Reports received after the close of grantor's accounting year.* Data contained in reports required by this paragraph, which reports are received by a private foundation after the close of its accounting year but before the due date of its information return for that year, need not be reported on such return, but may be reported on the grantor's information return for the year in which such reports are received from the grantee.

(e) *Violations of expenditure responsibility requirements*—(1) *Diversions by grantee.* (i) Any diversion of grant funds (including the income therefrom in the case of an endowment grant) by the grantee to any use not in furtherance of a purpose specified in the grant may result in the diverted portion of such grant being treated as a taxable expenditure of the grantor under section 4945(d)(4). However, for purposes of this section, the fact that a grantee does not use any portion of the grant funds as indicated in the original budget projection shall not be treated as a diversion if the use to which the funds are committed is consistent with the purpose of the grant as stated in the grant agreement and does not result in a violation of the terms of such agreement required to be included by paragraph (b)(3) or (b)(4) of this section.

(ii) In any event, a grantor will not be treated as having made a taxable expenditure under section 4945(d)(4) solely by reason of a diversion by the grantee, if the grantor has complied with subdivision (iii) (*a*) and (*b*) or (iv) (*a*) and (*b*) of this subparagraph, whichever is applicable.

(iii) In cases in which the grantor foundation determines that any part of

a grant has been used for improper purposes and the grantee has not previously diverted grant funds, the foundation will not be treated as having made a taxable expenditure solely by reason of the diversion so long as the foundation:

(*a*) Is taking all reasonable and appropriate steps either to recover the grant funds or to insure the restoration of the diverted funds and the dedication (consistent with the requirements of (*b*) (*1*) and (*2*) of this subdivision) of the other grant funds held by the grantee to the purposes being financed by the grant, and

(*b*) Withholds any further payments to the grantee after the grantor becomes aware that a diversion may have taken place (hereinafter referred to as ''further payments'') until it has:

(*1*) Received the grantee's assurances that future diversions will not occur, and

(*2*) Required the grantee to take extraordinary precautions to prevent future diversions from occurring.

If a foundation is treated as having made a taxable expenditure under this subparagraph in a case to which this subdivision applies, then unless the foundation meets the requirements of (*a*) of this subdivision the amount of the taxable expenditure shall be the amount of the diversion (for example, the income diverted in the case of an endowment grant, or the rental value of capital equipment for the period of time for which diverted) plus the amount of any further payments to the same grantee. However, if the foundation complies with the requirements of (*a*) of this subdivision but not the requirements of (*b*) of this subdivision, the amount of the taxable expenditure shall be the amount of such further payments.

(iv) In cases where a grantee has previously diverted funds received from a grantor foundation, and the grantor foundation determines that any part of a grant has again been used for improper purposes, the foundation will not be treated as having made a taxable expenditure solely by reason of such diversion so long as the foundation:

(*a*) Is taking all reasonable and appropriate steps to recover the grant funds or to insure the restoration of the diverted funds and the dedication (consistent with the requirements of (*b*) (*2*) and (*3*) of this subdivision) of other grant funds held by the grantee to the purposes being financed by the grant, except that if, in fact, some or all of the diverted funds are not so restored or recovered, then the foundation must take all reasonable and appropriate steps to recover all of the grant funds, and

(*b*) Withholds further payments until:

(*1*) Such funds are in fact so recovered or restored,

(*2*) It has received the grantee's assurances that future diversions will not occur, and

(*3*) It requires the grantee to take extraordinary precautions to prevent future diversions from occurring.

If a foundation is treated as having made a taxable expenditure under this subparagraph in a case to which this subdivision applies, then unless the foundation meets the requirements of (*a*) of this subdivision, the amount of the taxable expenditure shall be the amount of the diversion plus the amount of any further payments to the same grantee. However, if the foundation complies with the requirements of (*a*) of this subdivision, but fails to withhold further payments until the requirements of (*b*) of this subdivision are met, the amount of the taxable expenditure shall be the amount of such further payments.

(v) The phrase ''all reasonable and appropriate steps'' (as used in subdivisions (iii) and (iv) of this subparagraph) includes legal action where appropriate but need not include legal action if such action would in all probability not result in the satisfaction of execution on a judgment.

(2) *Grantee's failure to make reports.* A failure by the grantee to make the reports required by paragraph (c) of this section (or the making of inadequate reports) shall result in the grant's being treated as a taxable expenditure by the grantor unless the grantor:

(i) Has made the grant in accordance with paragraph (b) of this section,

(ii) Has complied with the reporting requirements contained in paragraph (d) of this section,

(iii) Makes a reasonable effort to obtain the required report, and

(iv) Withholds all future payments on this grant and on any other grant to the same grantee until such report is furnished.

(3) *Violations by the grantor*. In addition to the situations described in subparagraphs (1) and (2) of this paragraph, a grant which is subject to the expenditure responsibility requirements of section 4945(h) will be considered a taxable expenditure of the granting foundation if the grantor:

(i) Fails to make a pregrant inquiry as described in paragraph (b)(2) of this section,

(ii) Fails to make the grant in accordance with a procedure consistent with the requirements of paragraph (b)(3) or (4) of this section, or

(iii) Fails to report to the Internal Revenue Service as provided in paragraph (d) of this section.

(f) *Effective dates*—(1) *In general*. This section shall apply to all grants which are subject to the expenditure responsibility requirements of section 4945(d)(4) and (h) and which are made by private foundations more than 90 days after October 30, 1972.

(2) *Transitional rules*—(i) *Certain grants awarded prior to May 27, 1969*. Section 4945(d)(4) and (h) and this section shall not apply to a grant to a private foundation which is not controlled, directly or indirectly, by the grantor foundation or one or more disqualified persons (as defined in section 4946) with respect to the grantor foundation, provided that such grant:

(*a*) Is made pursuant to a written commitment which was binding on May 26, 1969, and at all times thereafter,

(*b*) Is made for one or more of the purposes described in section 170(c)(2)(B), and

(*c*) Is to be paid out to such grantee foundation on or before December 31, 1974.

(ii) *Grants or expenditures committed prior to January 1, 1970*. Except as provided in paragraph (e)(2)(i) of § 53.4945–4, section 4945 shall not apply to a grant or an expenditure for section 170(c)(2)(B) purposes made on or after January 1, 1970, if the grant or expenditure was made pursuant to a commitment entered into prior to such date, but only if (in the case of a grant or an expenditure other than an unlimited general-purpose grant to an organization) such commitment is reasonable in amount in light of the purposes of the grant. For purposes of this subdivision, a commitment will be considered entered into prior to January 1, 1970, if prior to such date, the amount and nature of the payments to be made and the name of the payee were entered on the records of the payor, or were otherwise adequately evidenced, or the notice of the payment to be received was communicated to the payee in writing.

(iii) *Grants awarded on or after January 1, 1970*. Paragraphs (b), (c), and (d) of this section shall not apply to grants awarded on or after January 1, 1970, but prior to the expiration of 90 days after October 30, 1972, if the grantor has made reasonable efforts, and has established adequate procedures such as a prudent man would adopt in managing his own property, to see that the grant is spent solely for the purpose for which made, to obtain full and complete reports from the grantee on how the funds are spent, and to make full and detailed reports with respect to such grant to the Commissioner. With respect to any return filed with the Internal Revenue Service before the expiration of 90 days after October 30, 1972, the grantor may treat reports which satisfy the requirements of the statement to be attached to Form 4720 for the year 1970 under ''Specific Instructions—Question B'' (items (1) through (5)) as satisfying the grantor reporting requirements with respect to ''expenditure responsibility'' grants. In the case of a private foundation required to file an annual return for a taxable year ending after January 1, 1970, and before December 31, 1970, the reporting requirements imposed by section 4945(h)(3) for such period shall be regarded as satisfied if such reports are made on the annual return for its first taxable year beginning after December 31, 1969.

(3) *Effective/applicability date of paragraphs (a)(1), (a)(5), (a)(6)(ii), and (b)(5) and transition relief*. Paragraphs (a)(1), (a)(5), (a)(6)(ii), and (b)(5) of this section are effective on and apply with respect to grants paid after September

25, 2015. However, foundations may continue to rely on paragraph (a)(5) as contained in 26 CFR part 53, revised April 1, 2015, with respect to grants paid on or before December 24, 2015 pursuant to a good faith determination made in accordance with such provisions. Also, foundations may continue to rely on paragraph (a)(5) as contained in 26 CFR part 53, revised April 1, 2015, with respect to grants paid pursuant to a written commitment made on or before September 25, 2015 and pursuant to a good faith determination made on or before such date in accordance with such provisions if the committed amount is paid out within five years of such date.

[T.D. 7215, 37 FR 23161, Oct. 31, 1972; 37 FR 23918, Nov. 10, 1972, as amended by T.D. 7233, 37 FR 28162, Dec. 21, 1972; T.D. 7290, 38 FR 31834, Nov. 19, 1973; T.D. 9740, 80 FR 57716, Sept. 25, 2015]

§ 53.4945–6 Expenditures for noncharitable purposes.

(a) *In general.* Under section 4945(d)(5) the term ''taxable expenditure'' includes any amount paid or incurred by a private foundation for any purpose other than one specified in section 170(c)(2)(B). Thus, ordinarily only an expenditure for an activity which, if it were a substantial part of the organization's total activities, would cause loss of tax exemption is a taxable expenditure under section 4945(d)(5). For purposes of this section and §§ 53.4945–1 through 53.4945–5, the term ''purposes described in section 170(c)(2)(B)'' shall be treated as including purposes described in section 170(c)(2)(B) whether or not carried out by an organization described in section 170(c).

(b) *Particular expenditures.* (1) The following types of expenditures ordinarily will not be treated as taxable expenditures under section 4945(d)(5):

(i) Expenditures to acquire investments entered into for the purpose of obtaining income or funds to be used in furtherance of purposes described in section 170(c)(2)(B),

(ii) Reasonable expenses with respect to investments described in subdivision (i) of this subparagraph,

(iii) Payment of taxes,

(iv) Any expenses which qualify as deductions in the computation of unrelated business income tax under section 511,

(v) Any payment which constitutes a qualifying distribution under section 4942(g) or an allowable deduction under section 4940,

(vi) Reasonable expenditures to evaluate, acquire, modify, and dispose of program-related investments, or

(vii) Business expenditures by the recipient of a program-related investment.

(2) Conversely, any expenditures for unreasonable administrative expenses, including compensation, consultant fees, and other fees for services rendered, will ordinarily be taxable expenditures under section 4945(d)(5) unless the foundation can demonstrate that such expenses were paid or incurred in the good faith belief that they were reasonable and that the payment or incurrence of such expenses in such amounts was consistent with ordinary business care and prudence. The determination whether an expenditure is unreasonable shall depend upon the facts and circumstances of the particular case.

(c) *Grants to ''noncharitable'' organizations*—(1) *In general.* Since a private foundation cannot make an expenditure for a purpose other than a purpose described in section 170(c)(2)(B), a private foundation may not make a grant to an organization other than an organization described in section 501(c)(3) unless

(i) The making of the grant itself constitutes a direct charitable act or the making of a program-related investment, or

(ii) Through compliance with the requirements of subparagraph (2) of this paragraph, the grantor is reasonably assured that the grant will be used exclusively for purposes described in section 170(c)(2)(B).

For purposes of this paragraph, an organization treated as a section 509(a)(1) organization under § 53.4945–5(a)(4) shall be treated as an organization described in section 501(c)(3).

(2) *Grants other than transfers of assets described in § 1.507–3(c)(1).* (i) If a private foundation makes a grant which is not

a transfer of assets pursuant to any liquidation, merger, redemption, recapitalization, or other adjustment, organization or reorganization to any organization (other than an organization described in section 501(c)(3) except an organization described in section 509(a)(4)), the grantor is reasonably assured (within the meaning of subparagraph (1)(ii) of this paragraph) that the grant will be used exclusively for purposes described in section 170(c)(2)(B) only if the grantee organization agrees to maintain and, during the period in which any portion of such grant funds remain unexpended, does continuously maintain the grant funds (or other assets transferred) in a separate fund dedicated to one or more purposes described in section 170(c)(2)(B). The grantor of a grant described in this paragraph must also comply with the expenditure responsibility provisions contained in sections 4945(d) and (h) and § 53.4945–5.

(ii) For purposes of this paragraph, a foreign organization which does not have a ruling or determination letter that it is an organization described in section 501(c)(3) (other than section 509(a)(4)) will be treated as an organization described in section 501(c)(3) (other than section 509(a)(4)) if in the reasonable judgment of a foundation manager of the transferor private foundation, the grantee organization is an organization described in section 501(c)(3) (other than section 509(a)(4)). The term ''reasonable judgment'' shall be given its generally accepted legal sense within the outlines developed by judicial decisions in the law of trusts.

(3) *Transfers of assets described in § 1.507–3(c)(1).* If a private foundation makes a transfer of assets (other than a transfer described in subparagraph (1)(i) of this paragraph) pursuant to any liquidation, merger, redemption, recapitalization, or other adjustment, organization, or reorganization to any person, the transferred assets will not be considered used exclusively for purposes described in section 170(c)(2)(B) unless the assets are transferred to a fund or organization described in section 501(c)(3) (other than an organization described in section 509(a)(4)) or treated as so described under section 4947(a)(1).

[T.D. 7215, 37 FR 23161, Oct. 31, 1972, as amended by T.D. 7233, 37 FR 28162, Dec. 21, 1972]

Subpart G—Definitions and Special Rules

§ 53.4946–1 Definitions and special rules.

(a) *Disqualified person.* (1) For purposes of Chapter 42 and the regulations thereunder, the following are disqualified persons with respect to a private foundation:

(i) All substantial contributors to the foundation, as defined in section 507 (d)(2) and the regulations thereunder.

(ii) All foundation managers of the foundation as defined in section 4946 (b)(1) and paragraph (f)(1)(i) of this section,

(iii) An owner of more than 20 percent of:

(*a*) The total combined voting power of a corporation,

(*b*) The profits interest of a partnership,

(*c*) The beneficial interest of a trust or unincorporated enterprise.

which is (during such ownership) a substantial contributor to the foundation, as defined in section 507(d)(2) and the regulations thereunder,

(iv) A member of the family, as defined in section 4946(d) and paragraph (h) of this section, of any of the individuals described in subdivision (i), (ii), or (iii) of this subparagraph,

(v) A corporation of which more than 35 percent of the total combined voting power is owned by persons described in subdivision (i), (ii), (iii), or (iv) of this subparagraph,

(vi) A partnership of which more than 35 percent of the profits interest is owned by persons described in subdivision (i), (ii), (iii), or (iv) of this subparagraph, and

(vii) A trust, estate, or unincorporated enterprise of which more than 35 percent of the beneficial interest is owned by persons described in subdivision (i), (ii), (iii), or (iv) of this subparagraph.

(2) For purposes of subparagraphs (1)(iii) (*b*) and (vi) of this paragraph, the profits interest of a partner shall

be equal to his distributive share of income of the partnership, as determined under section 707(b)(3) and the regulations thereunder as modified by section 4946(a)(4).

(3) For purposes of subparagraph (1)(iii)(*c*) and (vii) of this paragraph, the beneficial interest in an unincorporated enterprise (other than a trust or estate) includes any right to receive a portion of distributions from profits of such enterprise, and, if the portion of distributions is not fixed by an agreement among the participants, any right to receive a portion of the assets (if any) upon liquidation of the enterprise, except as a creditor or employee. For purposes of this subparagraph, a right to receive distributions of profits includes a right to receive any amount from such profits other than as a creditor or employee, whether as a sum certain or as a portion of profits realized by the enterprise. Where there is no agreement fixing the rights of the participants in such enterprise, the fraction of the respective interests of each participant in such enterprise shall be determined by dividing the amount of all investments or contributions to the capital of the enterprise made or obligated to be made by such participant by the amount of all investments or contributions to capital made or obligated to be made by all of them.

(4) For purposes of subparagraph (1)(iii) (*c*) and (vii) of this paragraph, a person's beneficial interest in a trust shall be determined in proportion to the actuarial interest of such person in the trust.

(5) For purposes of subparagraph (1)(iii) (*a*) and (v) of this paragraph, the term ''combined voting power'' includes voting power represented by holdings of voting stock, actual or constructive (under section 4946(a)(3)), but does not include voting rights held only as a director or trustee.

(6) For purposes of subparagraph (1)(iii) (*a*) and (v) of this paragraph, the term ''voting power'' includes outstanding voting power and does not include voting power obtainable but not obtained, such as, for example, voting power obtainable by converting securities or nonvoting stock into voting stock or by exercising warrants or options to obtain voting stock, and voting power which will vest in preferred stockholders only if and when the corporation has failed to pay preferred dividends for a specified period of time or has otherwise failed to meet specified requirements. Similarly, for purposes of subparagraph (1)(iii) (*b*) and (*c*), (vi), and (vii) of this paragraph, the terms ''profits interest'' and ''beneficial interest'' include any such interest that is outstanding, but do not include any such interest that is obtainable but has not been obtained.

(7) For purposes of sections 170(b)(1)(E)(iii), 507(d)(1), 508(d), 509(a) (1) and (3), and Chapter 42, the term ''disqualified person'' shall not include an organization which is described in section 509(a) (1), (2), or (3), or any other organization which is wholly owned by such section 509(a) (1), (2), or (3) organization.

(8) For purposes of section 4941 only, the term ''disqualified person'' shall not include any organization which is described in section 501(c)(3) (other than an organization described in section 509(a)(4)).

(b) *Section 4943.* (1) For purposes of section 4943 only, the term ''disqualified person'' includes a private foundation:

(i) Which is effectively controlled (within the meaning of § 1.482–1(a)(3) of this chapter), directly or indirectly, by the same person or persons (other than a bank, trust company, or similar organization acting only as a foundation manager) who control the private foundation in question, or

(ii) Substantially all the contributions to which were made, directly or indirectly, by persons described in subdivision (i), (ii), (iii), or (iv) of paragraph (a)(1) of this section who made, directly or indirectly, substantially all of the contributions to the private foundation in question.

(2) For purposes of subparagraph (1)(ii) of this paragraph, one or more persons will be considered to have made substantially all of the contributions to a private foundation, if such persons have contributed or bequeathed at least 85 percent (and each such person has contributed or bequeathed at least 2 percent) of the total contributions and bequests (within the meaning of section 507(d)(2) and

the regulations thereunder) which have been received by such private foundation during its entire existence.

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

Example 1. A, a private foundation, has a board of directors made up of X, Y, Z, M, N, and O. Foundation B's board of directors is made up of Y, M, N, and O. The board of directors in each case has plenary power to determine the manner in which the foundation is operated. For purposes of section 4943, foundation A is a disqualified person with respect to foundation B, and foundation B, is a disqualified person with respect to foundation A.

Example 2. Private foundation A has received contributions of $100,000 throughout its existence: $35,000 from X, $51,000 from Y (who is X's father), and $14,000 from Z (an unrelated person). Private foundation B has received $100,000 in contributions during its existence: $50,000 from X and $50,000 from W, X's wife.

For purposes of section 4943, private foundation A is a disqualified person with respect to private foundation B, and private foundation B is a disqualified person with respect to private foundation A.

(c) *Section 4941.* For purposes of section 4941, a government official, as defined in section 4946(c) and paragraph (g) of this section, is a disqualified person.

(d) *Attribution of stockholdings.* (1) For purposes of paragraph (a)(1)(iii) (*a*) and (v) of this section, indirect stockholdings shall be taken into account under section 267(c) and the regulations thereunder. However, for purposes of this paragraph:

(i) Section 267(c)(4) shall be treated as though it provided that the members of the family of an individual are the members within the meaning of section 4946(d) and paragraph (h) of this section; and

(ii) Any stockholdings which have been counted once (whether by reason of actual or constructive ownership) in applying section 4946(a)(1)(E) shall not be counted a second time.

For purposes of paragraph (a)(1)(v) or this section, section 267(c) shall be applied without regard to section 267(c)(3), and stock constructively owned by an individual by reason of the application of section 267(c)(2) shall not be treated as owned by him if he is described in section 4946(a)(1)(D) but not also in section 4946(a)(1) (A), (B), or (C).

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

Example 1. D is a substantial contributor to private foundation Y. D owns 20 percent of the outstanding stock of corporation P. E, D's wife, owns none of the outstanding stock of P. F, E's father, owns 10 percent of the outstanding stock of P. E is treated under section 507(d)(2) as a substantial contributor to Y. E is also treated under section 267(c)(2) as owning both D's 20 percent and F's 10 percent of P, but E is treated as owning nothing for purposes of section 4946(a)(1)(E) because D's 20 percent and F's 10 percent have already been taken into account once (because of their actual ownership of the stock of P) for such purposes. Hence, corporation P is not a disqualified person under section 4946(a)(1)(E) with respect to private foundation Y because persons described in section 4946(a)(1) (A), (B), (C), and (D) own only 30 percent of the stock of P.

Example 2. I, a substantial contributor to private foundation X, is the son of J. I owns 100 percent of the stock of corporation R, which in turn owns 18 percent of the stock of corporation S. J owns 18 percent of the stock of S. I constructively owns 36 percent of the stock of S (J's 18 percent plus R's 18 percent). Both J's actual holdings and R's actual holdings are counted in determining I's constructive holdings because this does not result in counting either of the holdings more than once for purposes of section 4946 (a)(1)(E). Therefore, S is a disqualified person with respect to private foundation X, since I, a substantial contributor, constructively owns more than 35 percent of S's stock.

(e) *Attribution of profits or beneficial interests.* (1) For purposes of paragraph (a) (1) (iii) (*b*), (iii) (*c*) (vi), and (vii) of this section, ownership of profits or beneficial interests shall be taken into account as though such ownership related to stockholdings, if such stockholdings would be taken into account under section 267(c) and the regulations thereunder, except that section 267(c)(3) shall not apply to attribute the ownership of one partner to another solely by reason of such partner relationship. However, for purposes of this paragraph:

(i) Section 267(c)(4) shall be treated as though it provided that the members of the family of an individual are the members within the meaning of

section 4946(d) and paragraph (h) of this section; and

(ii) Any profits interest or beneficial interest which has been counted once (whether by reason of actual or constructive ownership) in applying section 4946(a)(1) (F) or (G) shall not be counted a second time.

For purposes of paragraph (a)(1) (vi) and (vii) of this section, profits or beneficial interests constructively owned by an individual by reason of the application of section 267(c)(2) shall not be treated as owned by him if he is described in section 4946(a)(1)(D) but not in section 4946(a)(1)(A), (B) or (C).

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

Example. Partnership S is a substantial contributor to private foundation X. Trust T, of which G is sole beneficiary, owns 12 percent of the profits interest of S. G's husband, H, owns 10 percent of the profits interest of S. H is a disqualified person with respect to X (under section 4946(a)(1)(C)) because he is considered to own 22 percent of the profits interest of S (10 percent actual ownership, plus G's 12 percent constructively under section 267(c)(2)). G is a disqualified person with respect to X (under section 4946(a)(1)(C) because she is considered to own 22 percent of the profits interest of S (12 percent constructively by reason of her beneficial interest in trust T, plus 10 percent constructively under section 267(c)(2) by reason of being a member of the family of H).

(f) *Foundation manager*. (1) For purposes of Chapter 42 and the regulations thereunder, the term ''foundation manager'' means:

(i) An officer, director, or trustee of a foundation (or a person having powers or responsibilities similar to those of officers, directors, or trustees of the foundation), and

(ii) With respect to any act or failure to act, any employee of the foundation having final authority or responsibility (either officially or effectively) with respect to such act or failure to act.

(2) For purposes of subparagraph (1)(i) of this paragraph, a person shall be considered an officer of a foundation if:

(i) He is specifically so designated under the certificate of incorporation, bylaws, or other constitutive documents of the foundation; or

(ii) He regularly exercises general authority to make administrative or policy decisions on behalf of the foundation.

With respect to any act or failure to act, any person described in subdivision (ii) of this subparagraph who has authority merely to recommend particular administrative or policy decisions, but not to implement them without approval of a superior, is not an officer. Moreover, such independent contractors as attorneys, accountants, and investment managers and advisers, acting in their capacities as such, are not officers within the meaning of subparagraph (1)(i) of this paragraph.

(3) For purposes of subparagraph (1)(ii) of this paragraph, an individual rendering services to a private foundation shall be considered an employee of the foundation only if he is an employee within the meaning of section 3121(d)(2).

(4) Since the definition of the term ''disqualified person'' contained in section 4946(a)(1)(B) incorporates only so much of the definition of the term ''foundation manager'' as is found in section 4946(b)(1) and subparagraph (1)(i) of this paragraph, any references, in section 4946 and this section, to ''disqualified persons'' do not constitute references to persons who are ''foundation managers'' solely by reason of the definition of that term contained in section 4946(b)(2) and subparagraph (1)(ii) of this paragraph.

(g) *Government official*—(1) *In general*. Except as provided in subparagraph (3) of this paragraph, for purposes of section 4941 and paragraph (c) of this section, the term ''government official'' means, with respect to an act of selfdealing described in section 4941, an individual who, at the time of such act, is described in subdivision (i), (ii), (iii), (iv), or (v) of this subparagraph (other than a ''special Government employee'' as defined in 18 U.S.C. 202(a)):

(i)(*a*) An individual who holds an elective public office in the executive or legislative branch of the Government of the United States.

(*b*) An individual who holds an office in the executive or judicial branch of the Government of the United States, appointment to which was made by the President.

(ii) An individual who holds a position in the executive, legislative or judicial branch of the Government of the United States:

(*a*) Which is listed in schedule C of rule VI of the Civil Service Rules, or

(*b*) The compensation for which is equal to or greater than the lowest rate prescribed for GS–16 of the General Schedule under 5 U.S.C. 5332.

(iii) An individual who holds a position under the House of Representatives or the Senate of the United States, as an employee of either of such bodies, who receives gross compensation therefrom at an annual rate of $15,000 or more.

(iv) The holder of an elective or appointive public office in the executive, legislative, or judicial branch of the government of a State, possession of the United States, or political subdivision or other area of any of the foregoing, or of the District of Columbia, for which the gross compensation is at an annual rate of $15,000 or more, who is described in subparagraph (2) of this paragraph.

(v) The holder of a position as personal or executive assistant or secretary to any individual described in subdivision (i), (ii), (iii), or (iv) of this subparagraph.

(2) *Public office*—(i) *Definition*. In defining the term ''public office'' for purposes of section 4946(c)(5) and subparagraph (1)(iv) of this paragraph, such term must be distinguished from mere public employment. Although holding a public office is one form of public employment, not every position in the employ of a State or other governmental subdivision (as described in section 4946 (c)(5)) constitutes a ''public office''. Although a determination whether a public employee holds a public office depends on the facts and circumstances of the case, the essential element is whether a significant part of the activities of a public employee is the independent performance of policymaking functions. In applying this subparagraph, several factors may be considered as indications that a position in the executive, legislative, or judicial branch of the government of a State, possession of the United States, or political subdivision or other area of any of the foregoing, or of the District of Columbia, constitutes a ''public office''. Among such factors to be considered in addition to that set forth above, are that the office is created by the Congress, a State constitution, or the State legislature, or by a municipality or other governmental body pursuant to authority conferred by the Congress, State constitution, or State legislature, and the powers conferred on the office and the duties to be discharged by such office are defined either directly or indirectly by the Congress, State constitution, or State legislature, or through legislative authority.

(ii) *Illustrations*. The following are illustrations of positions of public employment which do not involve policymaking functions within the meaning of subdivision (i) of this subparagraph and which are thus not a ''public office'' for purposes of section 4946(c)(5) and subparagraph (1)(iv) of this paragraph:

(*a*) The chancellor, president, provost, dean, and other officers of a State university who are appointed, elected, or otherwise hired by a State Board of Regents or equivalent public body and who are subject to the direction and supervision of such body;

(*b*) Professors, instructors, and other members of the faculty of a State educational institution who are appointed, elected, or otherwise hired by the officers of the institution or by the State Board of Regents or equivalent public body;

(*c*) The superintendent of public schools and other public school officials who are appointed, elected, or otherwise hired by a Board of Education or equivalent public body and who are subject to the direction and supervision of such body;

(*d*) Public school teachers who are appointed, elected, or otherwise hired by the superintendent of public schools or by a Board of Education or equivalent public body;

(*e*) Physicians, nurses, and other professional persons associated with public hospitals and State boards of health who are appointed, elected, or otherwise hired by the governing board or officers of such hospitals or agencies; and

(*f*) Members of police and fire departments, except for those department heads who, under the facts and circumstances of the case, independently perform policymaking functions as a significant part of their activities.

(3) *Certain government officials on leave of absence.* For purposes of this paragraph, an individual who is otherwise described in section 4946(c) and this paragraph who was on leave of absence without pay on December 31, 1969, from his position or office pursuant to a commitment entered into on or before such date to engage in certain activities for which he is paid by one or more private foundations, is not to be treated as holding such position or office for any continuous period after December 31, 1969, and prior to January 1, 1971, during which such individual remains on leave of absence to engage in the same activities for which he is paid by such foundations. For purposes of this subparagraph, a commitment is considered entered into on or before December 31, 1969, if on or before such date, the amount and nature of the payments to be made and the name of the individual receiving such payments were entered on the records of the payor, or were otherwise adequately evidenced, or the notice of the payment to be received was communicated to the payee orally or in writing.

(h) *Members of the family.* For purposes of this section, the members of the family of an individual include only:

(1) His spouse,

(2) His ancestors,

(3) His lineal descendants, and

(4) Spouses of his lineal descendants.

For example, a brother or sister of an individual is not a member of his family for purposes of this section. However, for example, the wife of a grandchild of an individual is a member of his family for such purposes. For purposes of this paragraph, a legally adopted child of an individual shall be treated as a child of such individual by blood.

[T.D. 7241, 37 FR 28744, Dec. 29, 1972]

Subpart H—Application to Certain Nonexempt Trusts

§ 53.4947–1 Application of tax.

(a) *In general.* Section 4947 subjects trusts which are not exempt from taxation under section 501(a), all or part of the unexpired interests in which are devoted to one or more of the purposes described in section 170(c)(2)(B), and which have amounts in trust for which a deduction was allowed under section 170, 545(b)(2), 556(b)(2), 642(c), 2055, 2106(a)(2), or 2522 to the same requirements and restrictions as are imposed on private foundations. The basic purpose of section 4947 is to prevent these trusts from being used to avoid the requirements and restrictions applicable to private foundations. For purposes of this section, a trust shall be presumed (in the absence of proof to the contrary) to have amounts under section 170, 545(b)(2), 556(b)(2), 642(c), 2055, 2106(a)(2), or 2522 if a deduction would have been allowable under one of these sections. Also for purposes of this section and § 53.4947–2, the term ''purposes described in section 170(c)(2)(B)'' shall be treated as including purposes described in section 170(c)(1).

(b) *Charitable trusts*—(1) *General rule.* (i) For purposes of this section and § 53.4947–2, a *charitable trust,* within the meaning of section 4947(a)(1), is a trust which is not exempt from taxation under section 501(a), all of the unexpired interests in which are devoted to one or more of the purposes described in section 170(c)(2)(B), and for which a deduction was allowed under section 170, 545(b)(2), 556(b)(2), 642(c), 2055, 2106(a)(2), or 2522 (or the corresponding provisions of prior law). A trust is one for which a deduction was allowed under section 642(c), within the meaning of section 4947(a)(1), once a deduction is allowed under section 642(c) to the trust for any amount paid or permanently set aside. (See sections 642(c) and § 1.642–4 for the limitation on such deduction in certain cases.) A charitable trust (as defined in this paragraph) shall be treated as an organization described in section 501(c)(3) and, if it is determined under section 509 that the trust is a private foundation, then Part II of Subchapter F of chapter 1 of the Code (other than section 508

(a), (b) and (c) and Chapter 42 shall apply to the trust. However, the charitable trust is not treated as an organization described in section 501(c)(3) for purposes of exemption from taxation under section 501(a). Thus, the trust is subject to the excise tax on its investment income under section 4940(b) rather than the tax imposed by section 4940(a). For purposes of satisfying the organizational test described in § 1.501 (c)(3)–1(b) when a charitable trust seeks an exemption from taxation under section 501(a), a charitable trust (as defined in this paragraph) shall be considered organized on the day it first becomes subject to section 4947(a)(1). However, for purposes of the special and transistional rules in section 4940(c)(4)(B), 4942(f)(4), 4943(c)(4)(A)(i) and (B) and section 101(1)(2)(A), (B), (C), and (D), and (1)(3) of the Tax Reform Act of 1969, a charitable trust (as defined in this paragraph) shall be considered organized on the first day it has amounts in trust for which a deduction was allowed (within the meaning of paragraph (a) of this section) under section 170, 545(b)(2), 556(b)(2), 642(c), 2055, 2106(a)(2), or 2522. Thus, under this rule, a trust may be treated as a private foundation in existence on a date governing one of the applicable special and transistional rules even though the trust did not otherwise become subject to the provisions of Chapter 42 until a later date.

(ii) The provisions of paragraph (b)(1) of this section may be illustrated by the following examples:

Example 1. On January 30, 1970, X creates an inter vivos trust under which M receives 50 percent and N receives 50 percent of the trust's income for 10 years, and upon the termination of which, at the end of the 10-year period, the corpus is to be distributed to O. M, N and O are all organizations described in section 501(c)(3) and X is allowed a deduction under section 170 for the value of all interests placed in trust. The trustees of the trust do not give notice to the Internal Revenue Service under the provisions of section 508(a), and the trust will therefore not be exempt from taxation under section 501(a). The trust is a charitable trust within the meaning of section 4947(a)(1) from the date of its creation.

Example 2. On March 1, 1971, Y creates a charitable remainder annuity trust described in section 664(d)(1) under which Z, Y's son, receives $10,000 per year for life, remainder to be held in trust for P, an organization described in section 501(c)(3). Y is allowed a deduction under section 170 for the present value of the remainder interest to P. During Z's lifetime, the trust is a split-interest trust described in section 4947(a)(2) and paragraph (c) of this section. Upon the death of Z, all unexpected interests (consisting of P's remainder interest) will be devoted to section 170(c)(2)(B) purposes. Except as provided in § 53.4947–1(b)(2)(iv) (relating to a reasonable period of settlement) the trust will be treated as a charitable trust within the meaning of section 4947(a)(1) from the date of the death of Z unless the trustees of the trust apply for recognition of section 501(c)(3) status under the provisions of section 508(a).

(2) *Scope of application of section 4947(a)(1)*—(i) *In general.* Subject to paragraph (b)(2) (ii) through (vii) of this section, section 4947(a)(1) applies to nonexempt trusts in which all unexpired interests are charitable. For purposes of this section, the term *charitable* when used to describe an interest or beneficiary refers to the purposes described in section 170(c)(2)(B). An estate from which the executor or administrator is required to distribute all of the net assets in trust to such beneficiaries will not be considered a charitable trust under section 4947(a)(1) during the period of estate administration or settlement, except as provided in paragraph (b)(2)(ii) of this section. A charitable trust created by will shall be considered a charitable trust under section 4947(a)(1) as of the date of death of the decedent-grantor, except as provided in paragraph (b)(2)(v) of this section (relating to trusts which wind up. For the circumstances under which segregated amounts are treated as charitable trusts, see § 53.4947–1(c)(3)(iii).

(ii) *Estates.* (A) When an estate from which the executor or administrator is required to distribute all of the net assets in trust for charitable beneficiaries, or free of trust to such beneficiaries, is considered terminated for Federal income tax purposes under § 1.641(b)–3(a), then the estate will be treated as a charitable trust under section 4947(a)(1) between the date on which the estate is considered terminated under § 1.641(b)–3(a) and the date final distribution of all of the net assets is made to or for the benefit of the charitable beneficiaries. This (ii) does not affect the determination of the tax

liability under Subtitle A of the beneficiaries of the estates.

(B) The provisions of this (ii) may be illustrated by the following example:

Example. X bequeaths his entire estate, including 100 percent of the stock of a wholly-owned corporation, to M, an organization described in section 501(c)(3), under a will which gives his executor authority to hold the stock and manage the corporation for a period of up to 10 years for the benefit of M prior to its ultimate disposition. A deduction for the charitable bequest was allowed to X's estate under section 2055. The executor is vested with a full range of powers, including the power of sale. Upon the death of X, his executor distributes X's assets to M except for the stock of the corporation, which he holds for 5 years prior to its disposition. The continued holding of the stock of the corporation by the executor after the expiration of a reasonable time for performance of all the ordinary duties of administration causes the estate to be considered terminated for Federal income tax purposes pursuant to § 1.641(b)–3(a) and thereby subjects it to the provisions of section 4947(a)(1) from the date of such termination to the date of final disposition of the stock of the corporation.

(iii) *Certain split-interest trusts which wind up*. A split-interest trust (as defined in paragraph (c) of this section) in which all of the unexpired interests are charitable remainder interests and in which the charitable beneficiaries have become entitled to distributions of corpus in trust or free of trust shall continue to be treated as as split-interest trust under section 4947(a)(2) until the date on which final distribution of all the net assets is made. However, if after the expiration of any intervening interests the trust is considered terminated for Federal income tax purposes under § 1.641(b)–3(b), then the trust will be treated as a charitable trust under section 4947(a)(1), rather than a split interest trust under section 4947(a)(2), between the date on which the trust is considered terminated under § 1.641(b)–3(b) and the date on which such final distribution of all of the net assets is made to or for the benefit of the charitable remainder beneficiaries. This (iii) does not affect the determination of the tax liability under subtitle A of the beneficiaries of the trusts.

(iv) *Split-interest trusts which become charitable trusts*. (A) A split-interest trust (as defined in paragraph (c) of this section) in which all of the unexpired interests are charitable remainder interests and in which some or all of the charitable beneficiaries are not entitled to distributions of corpus within the meaning of paragraph (b)(2)(iii) of this section shall continue to be treated as a split-interest trust under section 4947(a)(2) rather than a charitable trust under section 4947(a)(1) for a reasonable period of settlement after the expiration of the noncharitable interest. Thus, a split-interest trust which under its terms is to continue to hold assets for charitable beneficiaries after the expiration of the noncharitable interest rather than distributing them as in paragraph (b)(2)(iii) of this section is given a reasonable period of settlement before being treated as a charitable trust. For purposes of this paragraph, the term *reasonable period of settlement* means that period reasonably required (or if shorter, actually required) by the trustee to perform the ordinary duties of administration necessary for the settlement of the trust. These duties include, for example, the collection of assets, the payment of debts, taxes, and distributions, and the determination of the rights of the subsequent beneficiaries.

(B) This (iv) may be illustrated by the following example:

Example. On January 15, 1971, A creates a charitable remainder annuity trust described in section 661(d)(1) under which the trustees are required to distribute $10,000 a year to B, A's wife, for life, remainder to be held in trust for the use of M, an organization described in section 501(c)(3). A is allowed a deduction under section 170 for the amount of the charitable interest, and the trust is, therefore, treated as a split-interest trust under section 4947(a)(2) from the date of its creation. B dies on February 10, 1975. On April 15, 1975, the trustees complete performance of the ordinary duties of administration necessary for the settlement of the trust brought about by the death of B. These duties include, for example, an accounting for and payment to the estate of B of amounts accrued by B while alive during 1975. However, the trustees do not distribute the corpus to M by April 15, 1975. The trust shall continue to be treated as a split-interest trust under section 4947(a)(2) until April 15, 1975. After April 15, 1975, the trust shall be treated as a charitable trust under section 4947(a)(1).

(v) *Certain revocable and testamentary trusts which wind up.* A revocable trust that becomes irrevocable upon the death of the decedent-grantor, or a trust created by will, from which the trustee is required to distribute all of the net assets in trust for or free of trust to charitable beneficiaries is not considered a charitable trust under section 4947(a)(1) for a reasonable period of settlement (within the meaning of paragraph (b)(2)(iv) of this section) after becoming irrevocable. After that period the trust is considered a charitable trust under section 4947(a)(1).

(vi) *Revocable trusts which become charitable trusts.* A revocable trust that becomes irrevocable upon the death of the decedent-grantor in which all of the unexpired interests are charitable and under the terms of the governing instrument of which the trustee is required to hold some or all of the net assets in trust after becoming irrevocable solely for charitable beneficiaries is not considered a trust under section 4947(a)(1) for a reasonable period of settlement (within the meaning of paragraph (b)(2)(iv) of this section) after becoming irrevocable except that section 4941 may apply if the requirements of § 53.4941(d)–1 (b)(3) are not met. After that period, the trust is considered a charitable trust under section 4947(a)(1).

(vii) *Trust devoted to 170(c) purposes.* (A) A trust all of the unexpired interests in which are devoted to section 170 (c) (3) or (5) purposes together with section 170(c)(2)(B) purposes shall be considered a charitable trust except that payments under the terms of the governing instrument to an organization described in section 170(c) (3) or (5) shall not be considered a violation of section 4945(d)(5) or any other provisions of Chapter 42 and shall be considered qualifying distributions under section 4942.

(B) *Example.* The application of paragraph (b)(2)(vii) of this section may be illustrated by the following example:

Example. On January 30, 1970, H creates an inter vivos trust under the terms of the governing instruments of which M, an organization described in section 170(c)(3), and N, an organization described in section 501(c)(3), are each to receive 50 percent of the income for a period of 10 years. At the end of the 10 year period, the corpus is to be distributed to O, an organization also described in section 501(c)(3). H is allowed a deduction under section 170 for the value of all interests placed in trust. The payments to M do not constitute a violation of section 4945(d)(5) or any other provision of Chapter 42 and constitute qualifying distributions under section 4942. However, except as provided in the previous sentence, the trust shall be considered a charitable trust.

(3) *Charitable trusts described in section 509(a)(3).* For purposes of section 509(a)(3)(A), a charitable trust shall be treated as if organized on the day on which it first becomes subject to section 4947(a)(1). However, for purposes of applying §§ 1.509(a)–4(d) (2)(iv)(*a*), and 1.509(a)–4(i)(1) (ii) and (iii)(*c*) the previous relationship between the charitable trust and the section 509(a) (1) or (2) organizations it benefits or supports may be considered. If the charitable trust otherwise meets the requirements of section 509(a)(3), it may obtain recognition of its status as a section 509(a)(3) organization by requesting a ruling from the Internal Revenue Service. For the special rules pertaining to the application of the organizational test to organizations terminating their private foundation status under the 12-month or 60-month termination period provided under section 507(b)(1)(B) by becoming ''public'' under section 509(a)(3), see the regulations under section 507(b)(1).

(c) *Split-interest trusts*—(1) *General rule*—(i) *Definition.* For purposes of this section and § 53.4947–2, a *split-interest trust,* within the meaning of section 4947(a)(2), is a trust which is not exempt from taxation under section 501(a), not all of the unexpired interests in which are devoted to one or more of the purposes described in section 170(c)(2)(B), and which has amounts in trust for which a deduction was allowed (within the meaning of paragraph (a) of this section) under section 170, 545(b)(2), 556(b)(2), 642(c), 2055, 2106(a)(2), or 2522. A trust is one which has amounts in trust for which a deduction was allowed under section 642(c) within the meaning of section 4947(a)(2) once a deduction is allowed under section 642(c) to the trust for any amount permanently set aside. This (i) also includes any trust which is not treated as a charitable trust by operation of paragraph (b)(2) (iii) or (iv) of

this section (relating to split-interest trusts in the process of winding up or during a reasonable period of settlement). Section 4947(a)(1) shall apply to a trust described in this (i) (without regard to section 4947(a)(2)(A), (B), or (C)) from the first date upon which the provisions of paragraph (b)(2) (iii) or (iv) of this section are satisfied. For the circumstances under which a trust all of the unexpired interests in which are devoted to section 170(c) (3) or (5) purposes together with section 170(c)(2)(B) purposes is considered a charitable trust, see § 53.4947–1(b)(2)(vii).

(ii) *Applicability of statutory rules.* A split-interest trust is subject to the provisions of section 507 (except as provided in paragraph (e) of this section), 508(e) (to the extent applicable to a split-interest trust), 4941, 4943 (except as provided in section 4947(b)(3)), 4944 (except as provided in section 4947(b)(3)), and 4945 in the same manner as if such trust were a private foundation.

(iii) *Special rules.* A newly created trust shall, for purposes of section 4947(a)(2), be treated as having amounts in trust for which a deduction was allowed under section 170, 545(b)(2), 556(b)(2), 642(c), 2055, 2106(a)(2), or 2522 from the date of its creation, even if a deduction was allowed for such amounts only at a later date. For purposes of this (iii), the date of creation of a charitable remainder trust shall be determined by applying the rules in § 1.664–1(a)(4).

(2) *Exception for amounts payable to income beneficiaries.* (i) Under section 4947(a)(2)(A), paragraph (c)(1)(ii) of this section does not apply to any amounts payable under the terms of a split-interest trust to income beneficiaries unless a deduction was allowed under section 170(f)(2)(B), 2055(e)(2) (B), or 2522(c)(2)(B) with respect to the income interest of any such beneficiary. See § 1.170A–6(c), § 20.2055(e)(2), and § 25.2522(c)–3(c)(2) for rules regarding the allowance of these deductions. However, section 4947(a)(2)(A) does not apply when the value of all interests in property transferred in trust are deductible under section 170, 545(b)(2), 556(b)(2), 642(c), 2055, 2106(a)(2), or 2522.

(ii) The application of this subparagraph may be illustrated by the following examples:

Example 1. H creates a charitable remainder unitrust (described in section 664(d)(2)) which is required annually to pay W, H's wife, 5 percent of the net fair market value of the trust assets, valued annually, for her life; and to pay the remainder to Y, a section 501(c)(3) organization. A deduction under section 170(f)(2)(A) was allowed with respect to the remainder interest of Y. Under section 4947(a)(2)(A), each annual amount which becomes payable to W during her life is not subject to paragraph (c)(1)(ii) of this section on or after the date upon which it becomes so payable and the payment of each amount to W is not an act of self-dealing under section 4941(d)(1) and does not violate any other provision of chapter 42. However, except as provided in the preceding sentence, the trust is subject to paragraph (c)(1)(ii) of this section in the same manner as any other split-interest trust.

Example 2. H bequeaths the residue of his estate in trust for the benefit of S, his son, and Y, an organization described in section 501(c)(3). A guaranteed annuity interest of $10,000 is to be paid to S for 20 years. A guaranteed annuity interest of $5,000 which meets the requirements contained in § 20.2055–2(e)(2)(v)(*a*) is also to be paid to Y for 20 years. Upon termination of the 20-year term, the corpus is to be distributed to Z, another organization described in section 501(c)(3). The trust is a charitable remainder annuity trust as described in section 664(d)(1) and the regulations thereunder, and a deduction under section 2055(e)(2)(A) was allowed with respect to the remainder interest of Z. A deduction was also allowed under section 2055(e)(2)(B) with respect to the guaranteed annuity interest of Y. The assets in the trust are not segregated under section 4947(a)(2)(B) and paragraph (c)(3) of this section. Under section 4947(a)(2)(A), each payment of $10,000 to S is not subject to section 4947(a)(2) and paragraph (c)(1)(ii) of this section. The payment of each amount to S is not an act of self-dealing under section 4941(d)(1) and does not violate any other provision of chapter 42. However, except as provided in the preceding sentence, the trust is subject to section 4947(a)(2) and paragraph (c)(1)(ii) of this section in the same manner as any other split-interest trust.

Example 3. H creates a trust under which the trustees are required to pay over an annuity interest of $20,000 to W. H's wife, for her life. A guaranteed annuity interest of $10,000 which meets the requirements contained in § 25.2522(c)–3(c)(2)(v) is also to be paid X, an organization described in section 501(c)(3), for the life of W. Upon the death of W, the corpus of the trust, which consists of office buildings M and N, is to be distributed

to S. H's son. H received a deduction under section 2522(c)(2)(B) for the value of X's income interest in the trust. The assets in the trust are not segregated under section 4947(a)(2)(B) and paragraph (c)(3) of this section. Under section 4947(a)(2)(A), each payment of $20,000 to W is not subject to section 4947(a)(2) and paragraph (c)(1)(ii) of this section. The payment of each amount to W is not an act of self-dealing under section 4941(d)(1) and does not violate any other provision of chapter 42. However, except as provided in the preceding sentence, the trust is subject to paragraph (c)(1)(ii) of this section in the same manner as any other split-interest trust. See example (1) of paragraph (c)(3)(v) of this section for the application of section 4947(a)(2)(B) to a similar trust where the trustees segregate the assets of the trust.

(3) *Exception for certain segregated amount*—(i) *In general.* Under section 4947(a)(2)(B) paragraph (c)(1)(ii) of this section does not apply to assets held in trust (together with the income and capital gains derived from the assets), which are segregated from other assets held in trust for which a deduction was allowed for an income or remainder interest under section 170, 545(b)(2), 556(b)(2), 642(c), 2055, 2106(a)(2), or 2522.

(ii) *Segregation of amounts.* Amounts will generally be considered segregated (within the meaning of section 4947(a)(2)(B) if:

(A) Assets with respect to which no deduction was allowed (for an income or remainder interest) under section 170, 545(b)(2), 556(b)(2), 642(c), 2055, 2106(a)(2), or 2522, are separately accounted for under section 4947(a)(3) and paragraph (c)(4) of this section from assets for which such a deduction was allowed for any income or remainder interest and,

(B) By reason of the separate accounting the trust can be treated as two separate trusts, one of which is devoted exclusively to noncharitable income and remainder interests and the other of which is a charitable trust described in section 4947(a)(1) or a split-interest trust described in section 4947(a)(2).

Under these circumstances, only the ''trust'' which is devoted exclusively to noncharitable income and remainder interests will be considered a segregated amount which under section 4947(a)(2)(B), is not subject to section 4947(a)(2) and paragraph (c)(1)(ii) of this section.

(iii) *Exclusively charitable amounts.* If, under section 4947(a)(2)(B),

(A) An amount held in trust which is devoted exclusively to noncharitable income and remainder interests is segregated from

(B) An amount held in trust which is devoted exclusively to charitable income and remainder interests,

Then for purposes of this section the amount described in paragraph (c)(3)(iii)(B) of this section will be treated as a charitable trust which is subject to the provisions of section 4947(a)(1).

(iv) *Charitable and noncharitable amounts.* If, under section 4947(a) (2)(B),

(A) An amount held in trust which is devoted exclusively to noncharitable income and remainder interests is segregated from

(B) An amount held in trust which is devoted to both charitable income or remainder interests and noncharitable income or remainder interests,

Then for purposes of this section the amount described in paragraph (c)(3)(iv)(B) of this section will be treated as a split-interest trust which is subject to the provisions of section 4947(a)(2).

(v) *Examples.* The application of paragraph (c)(3) of this section may be illustrated by the following examples:

Example 1. H creates a trust under which the trustees are required to pay over annually 5 percent of the net fair market value of M building, valued annually, to W, H's wife, for life, remainder to S, H's son. The other asset in the trust is N building, with respect to which the trustees are required to pay over annually 5 percent of the net fair market value of the building, valued annually, to X, a section 501(c)(3) organization, for a period of 15 years, remainder to S. Each asset is separately accounted for under section 4947(a)(3) and paragraph (c)(4) of this section. He received a deduction under section 2522 for the value of X's income interest in N building. Under these circumstances, M building is considered segregated (within the meaning of section 4947(a)(2)(B)) from N building and is not subject to section 4947 (a)(2). The remainder interest of S in N building is not considered segregated from the income interest of X in N building, since both are interests in the same asset. N building is considered held in a split-interest trust which is subject to section 4947 (a)(2) and paragraph (c)(1)(ii) of this section.

Example 2. H transfers $50,000 in trust to pay $2,500 per year to Z, a section 501(c)(3) organization, for a term of 20 years, remainder to S. H's son. H is allowed a deduction under section 2522 for the present value of Z's income interest. The income interest of Z in the trust asset cannot be segregated (within the meaning of section 4947(a)(2)(B)) from the remainder interest of S since both are interests in the same asset. Therefore, the entire trust is subject to section 4947(a)(2) and paragraph (c)(1)(ii) of this section.

(4) *Accounting for segregated amounts*—(i) *General rule.* Under section 4947(a)(2)(B), a trust with respect to which amounts are segregated within the meaning of paragraph (c)(3) of this section must separately account for the various income, deduction, and other items properly attributable to each segregated amount in the books of account and separately account to each of the beneficiaries of the trust.

(ii) *Method.* Separate accounting shall be made:

(A) According to the method regularly employed by the trust, if the method is reasonable, and

(B) In all other cases in a manner which, in the opinion of the Commissioner, is reasonable.

A method of separate accounting will be considered ''regularly employed'' by a trust when the method has been consistently followed in prior taxable years or when a trust which has never before maintained segregated amounts initiates a reasonable method of separate accounting for its segregated amounts and consistently follows such method thereafter. The trust shall keep permanent records and other data relating to the segregated amounts as are necessary to enable the district director to determine the correctness of the application of the rules prescribed in paragraph (c) (3) and (4) of this section.

(5) *Amounts transferred in trust before May 27, 1969*—(i) *General rule.* Under section 4947(a)(2)(C), paragraph (c)(1)(ii) of this section does not apply to any amounts transferred in trust before May 27, 1969. For purposes of this (5), an amount shall be considered to be transferred in trust only when the transfer is one which meets the requirements for the allowance of a deduction under section 170, 545(b)(2), 556(b)(2), 642(c), 2055, 2106(a)(2), or 2522 (or the corresponding provisions of prior law). Income and capital gains which are derived at any time from amounts transferred in trust before May 27, 1969, shall also be excluded from the application of paragraph (c)(1)(ii) of this section. If an asset which was transferred in trust before May 27, 1969, is sold or exchanged after May 26, 1969, any asset received by the trust upon the sale or exchange shall be treated as an asset which was transferred in trust before May 27, 1969.

(ii) *Requirement for separate accounting for amounts transferred in trust before May 27, 1969.* If:

(A) Amounts are transferred in trust after May 26, 1969, and the trust to which the amounts are transferred also contains

(B) Amounts transferred in trust before May 27, 1969,

the general rule of paragraph (c)(5)(i) of this section applicable to the amounts described in paragraph (c)(5)(ii)(B) of this section will apply only if the amounts described in paragraph (c)(5)(ii)(A) of this section (together with all income and capital gains derived therefrom) are separately accounted for (within the meaning of paragraph (c)(4) of this section) from the amounts described in paragraph (c)(5)(ii)(B) of this section, together with all income and capital gains derived therefrom. For the application of section 508(e) to a trust with respect to which amounts were transferred both before and after May 27, 1969, see section 508(e) and the regulations thereunder.

(iii) *Exception for certain testamentary trusts.* (A) Amounts transferred in trust before May 27, 1969 include amounts transferred in trust after May 26, 1969 when the transfer is made under the terms of a testamentary trust created by the will of a decedent who died before May 27, 1969, (regardless of whether the executors or the testamentary trustees are required to execute testamentary trusts by court order under applicable local law). Amounts transferred in trust before May 27, 1969, also include amounts transferred to a testamentary trust created by the will of a decedent who died after May 26, 1969 if the will was executed before May 27, 1969 and no dispositive provision of the

will was amended (within the meaning of § 20.2055–2(e)(4) and (5)) by the decedent by codicil or otherwise, after May 26, 1969, and the decedent was on May 27, 1969, and at all times thereafter under a mental disability (as defined in § 1.642(c)–2(b)(3)(ii)) to amend the will by codicil or otherwise.

(B) The provisions of this (iii) may be illustrated by the following example:

Example. X executed a will in 1960 which provided for the creation of a testamentary trust which meets the description of a split-interest trust under section 4947(a)(2). X died on April 15, 1969. Under the provisions of his will, the probate court permitted certain property in X's estate to be transferred to the testamentary trust at fixed intervals over a period of two years during the administration of the estate. Section 4947(a)(2) does not apply to any amount described in this example, including the amounts transferred after May 26, 1969, because, for purposes of section 4947(a)(2)(C), each such transfer will be treated as an amount transferred in trust before May 27, 1969, within the meaning of section 4947(a)(2)(C).

(6) *Scope of application of section 4947(a)(2)*—(i) *In general*. Subject to paragraph (c)(6) (ii), (iii), and (iv) of this section, section 4947(a)(2) applies to trusts in which some but not all unexpired interests are charitable. An estate from which the executor or administrator is required to distribute all of the net assets in trust or free of trust to both charitable and noncharitable beneficiaries will not be considered to be a split-interest trust under section 4947(a)(2) during the period of estate administration or settlement, except as provided in paragraph (c)(6)(ii) of this section. A split-interest trust created by will shall be considered a split-interest trust under section 4947(a)(2) as of the date of death of the decedent-grantor, except as provided in paragraph (c)(6)(iv) of this section.

(ii) *Estates*. (A) When an estate from which the executor or administrator is required to distribute all of the net assets in trust or free of trust to both charitable and noncharitable beneficiaries is considered terminated for Federal income tax purposes under § 1.641(b)–3(a), then the estate will be treated as a split-interest trust under section 4947(a)(2) (or a charitable trust under section 4957(a)(1), if applicable) between the date on which the estate is considered terminated under § 1.641(b)–3(a) and the date on which final distribution of the net assets to the last remaining charitable beneficiary is made. This (ii) does not affect the determination of the tax liability under subtitle A of either charitable or noncharitable beneficiaries of the estates.

(B) The provisions of this (ii) may be illustrated by the following example:

Example. X dies on January 15, 1973 and bequeaths $10,000 to M, an organization described in section 501(c)(3), and the residue of his estate to W, his wife. A deduction for the charitable bequest was allowed to X's estate under section 2055. Substantially all of X's estate consists of 100 percent of the stock of a wholly owned corporation, certain liquid assets such as marketable stocks and securities and bank accounts, and X's home, automobile, and other personal property. X's will gives his executor a full range of powers, including the power to sell the stock of the wholly owned corporation. After the death of X, his executor continues to manage the wholly owned corporation while attempting to sell the stock of the corporation. During this period, the executor makes no distributions to M. On May 24, 1978, the Internal Revenue Service determines under § 1.641(b)–3(a) that the administration of the estate has been unduly prolonged and the estate is considered terminated as of that date for Federal income tax purposes. X's estate will be treated as a split-interest trust described in section 4947(a)(2) between May 24, 1978 and the date on which the $10,000 bequest to M is satisfied. X's estate will therefore be subject to the applicable private foundation provisions during that period and, for example, a sale of the house by the estate to any disqualified person (as defined in section 4946) will be an act of self-dealing under section 4941.

(iii) *Revocable trusts which become split-interest trusts*. A revocable trust that becomes irrevocable upon the death of the decedent-grantor under the terms of the governing instrument of which the trustee is required to hold some or all of its net assets in trust after becoming irrevocable for both charitable and noncharitable beneficiaries is not considered a split-interest trust under section 4947(a)(2) for a reasonable period of settlement after becoming irrevocable except that section 4941 may apply if the requirements of § 53.4941(d)–1(b)(3) are not met.

After that period, the trust is considered a split-interest trust under section 4947(a)(2). For purposes of this (iii), the

term *reasonable period of settlement* means that period reasonably required (or if shorter, actually required) by the trustee to perform the ordinary duties of administration necessary for the settlement of the trust. These duties include, for example, the collection of assets, the payment of debts, taxes, and distributions, and the determination of rights of the subsequent beneficiaries.

(iv) *Certain revocable and testamentary trusts which wind up.* A revocable trust that becomes irrevocable upon the death of the decedent-grantor, or a trust created by will, from which the trustee is required to distribute all of the net assets in trust or free of trust to both charitable and noncharitable beneficiaries is not considered a split-interest trust under section 4947(a)(2) for a reasonable period of settlement (within the meaning of paragraph (c)(6)(iii) of this section) after becoming irrevocable. After that period, the trust is considered a split-interest trust under section 4947(a)(2) (or a charitable trust under section 4947(a)(1), if applicable).

(d) *Cross references; Governing instrument requirements and charitable deduction limitations.* For the application of section 642(c)(6) (relating to section 170 limitations on charitable deductions of non-exempt private foundation trusts) to a trust described in section 4947(a)(1), see § 1.642(c)–4. For the denial of a deduction under section 170, 545(b)(2), 556(b)(2), 642(c), 2055, 2106(a)(2), or 2522 for a gift, a bequest, or an amount paid to (and the denial of a deduction under section 642(c) for an amount set aside in) a trust described in section 4947(a)(1) or (2) that fails to meet the applicable governing instrument requirements of section 508(e) by the end of the taxable year of the trust, see section 508(d)(2) and § 1.508–2(b). Since a charitable remainder trust (as defined in section 664) is not exempt under section 501(a), it is subject to section 4947(a)(2), and thus to the governing instrument requirements of section 508(e) to the extent they are applicable.

(e) *Application of section 507(a)*—(1) *General rule.* The provisions of section 507(a) shall not apply to a trust described in section 4947(a) (1) or (2) by reason of any payment to a beneficiary that is directed by the terms of the governing instrument of the trust and is not discretionary with the trustee or, in the case of a discretionary payment, by reason of, or following, the expiration of the last remaining charitable interest in the trust.

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

Example 1. H creates a section 4947(a)(1) trust under which the income is to be paid for 15 years to R, a section 501(c)(3) organization. Upon the expiration of 15 years, the trust is to terminate and distribute all of its assets to S, another section 501(c)(3) organization. Distribution of the corpus of the trust to S will not be considered a termination of the trust's private foundation status within the meaning of section 507(a).

Example 2. H creates a trust under which X, a section 501(c)(3) organization, receives $20,000 per year for a period of 20 years, remainder to S, H's son. H is allowed a deduction under section 2522 for the present value of X's interest.

When the final payment to X has been made at the end of the 20-year period in accordance with the terms of the trust, the provisions of section 4947(a)(2) will cease to apply to the trust because the trust no longer retains any amounts for which the deduction under section 2522 was allowed. However, the final payment to X will not be considered a termination of the trust's private foundation status within the meaning of section 507(a).

Example 3. J creates a charitable remainder annuity trust described in section 664(d)(1) under which S, J's son, receives $10,000 per year for life, remainder to be distributed outright to P, an organization described in section 501(c)(3). J is allowed a deduction under section 170 for the value of the remainder interest placed in trust for the benefit of P, and the provisions of section 4947(a)(2) apply to the trust. At the death of S, the trust will terminate and all assets will be distributed to P. However, such final distribution to P will not be considered a termination of the trust's private foundation status within the meaning of section 507(a).

[T.D. 7431, 41 FR 35515, Aug. 23, 1976]

§ 53.4947–2 Special rules.

(a) *Limit to segregated amounts.* If any amounts held in trust are segregated within the meaning of § 53.4947–1(c)(3), the value of the net assets for purposes of section 507(c)(2) and (g) shall be limited to the segregated amounts with respect to which a deduction under section 170, 545(b)(2), 556(b)(2), 642(c), 2055,

2106(a)(2), or 2522 was allowed. See the regulations under section 507(c)(2) and (g).

(b) *Applicability of section 4943 and 4944 to split-interests trusts*—(1) *General rule*. Under section 4947(b)(3), section 4943 and 4944 do not apply to a split-interest trust described in section 4947(a)(2) if:

(i) All the income interest (and none of the remainder interest) of the trust is devoted solely to one or more of the purposes described in section 170(c)(2)(B) and all amounts in the trust for which a deduction was allowed under section 170, 545(b)(2), 556(b)(2), 642(c), 2055, 2106(a)(2), or 2522 have an aggregate value (at the time for which the deduction was allowed) of not more than 60 percent of the aggregate fair market value of all amounts in the trust (after the payment of estate taxes and all other liabilities), or

(ii) A deduction was allowed under section 170, 545(b)(2), 556(b)(2), 642(c), 2055, 2106(a)(2) or 2522 for amounts payable under the terms of the trust to every remainder beneficiary, but not to any income beneficiary.

This (1) shall apply to a trust described in paragraph (b)(1)(ii) of this section only if all amounts payable under the terms of the trust to every remainder beneficiary are to be devoted solely to one or more of the purposes described in section 170(c)(2)(B). After the expiration of all income interests in a trust described in paragraph (b)(1)(ii) of this section, the trust shall become subject to section 4947(a)(1) under § 53.4947–1(b)(2), and section 4947(b)(3) shall no longer apply to the trust. A pooled income fund described in section 642(c)(5) will generally meet the requirements of paragraph (b)(1)(ii) of this section, as will a charitable remainder trust described in section 664(d)(1), if in either case it does not make payments to any income beneficiary described in section 170(c).

(2) *Definitions*. (i) For purposes of section 4947(b)(3)(A), the term ''income interest'' shall include an interest in property transferred in trust which is in the form of a guaranteed annuity interest or unitrust interest as described in § 1.170A–6(c), § 20.2055–2(e)(2) or § 25.2522(c)–3(c)(2) and the term ''remainder interest'' shall include an interest which succeeds an ''income interest'' within the meaning of this (i).

(ii) For purposes of section 4947(b)(3)(B), the term ''income beneficiary'' shall include a recipient of payments described in section 642(c)(5)(F) from a pooled income fund, payments described in section 664(d)(1)(A) from a charitable remainder annuity trust, or payments described in section 664(d)(2)(A) or (3) from a charitable remainder unitrust. The term ''remainder beneficiary'' shall include a beneficiary of a remainder interest described in section 642(c)(5) or 664(d)(1)(C) or (2)(C).

(c) *Effective date*. Except as otherwise provided in §§ 53.4947–1 and 53.4947–2 and the regulations under sections 508 (d) and (e), §§ 53.4947–1 and 53.4947–2 shall take effect on January 1, 1970.

(Secs. 4947 and 7805, Internal Revenue Code of 1954 (68A Stat. 917: 26 U.S.C. 7805))

[T.D. 7431, 41 FR 35515, Aug. 23, 1976]

Subpart I—Tax on Investment Income of and Denial of Exemption to Certain Foreign Organizations

§ 53.4948–1 Application of taxes and denial of exemption with respect to certain foreign organizations.

(a) *Tax on income of certain foreign organizations*. (1) In lieu of the tax imposed by section 4940 and the regulations thereunder, there is hereby imposed for each taxable year beginning after December 31, 1969, on the gross investment income (within the meaning of section 4940(c)(2) and the regulations thereunder) derived from sources within the United States (within the meaning of section 861 and the regulations thereunder) by every foreign organization which is a private foundation (within the meaning of section 509 and the regulations thereunder) and exempt from taxation under section 501(a) for the taxable year a tax equal to 4 percent of such income, except as provided in subparagraph (3) of this paragraph. The tax (if any) will be reported on the form the foundation is required to file under section 6033 and will be paid annually for the taxable year, at the time prescribed for filing

such annual return (determined without regard to any extension of time for filing). For purposes of this section, the term *foreign organization* means any organization which is not described in section 170(o)(2)(A).

(2) With respect to the deduction and withholding of tax imposed by section 4948(a), see section 1443(b) and the regulations thereunder.

(3) Whenever there exists a tax treaty between the United States and a foreign country, and a foreign private foundation subject to section 4948(a) is a resident of such country or is otherwise entitled to the benefits of such treaty (whether or not such benefits are available to all residents), if the treaty provides that any item or items (or all items with respect to an organization exempt from income taxation) of gross investment income (within the meaning of section 4940(c)(2)) shall be exempt from income tax, such item or items shall not be taken into account by such foundation in computing the tax to be imposed under section 4948(a) for any taxable year for which the treaty is effective.

(b) *Certain sections inapplicable.* Section 507 (relating to termination of private foundation status), section 508 (relating to special rules with respect to section 501(c)(3) organizations), and Chapter 42 (other than section 4948) of the Code shall not apply to any foreign organization which from the date of its creation has received at least 85 percent of its support (as defined in section 509(d), other than section 509(d)(4)) from sources outside the United States. For purposes of this paragraph, gifts, grants, contributions, or membership fees directly or indirectly from a United States person (as defined in section 7701(a)(30)) are from sources within the United States.

(c) *Denial of exemption to foreign organizations engaged in prohibited transactions*—(1) *In general.* A foreign private foundation described in section 4948(b) and paragraph (b) of this section shall not be exempt from taxation under section 501(a) if it has engaged in a prohibited transaction (within the meaning of subparagraph (2) of this paragraph) after December 31, 1969.

(2) *Prohibited transactions.* (i) For purposes of this section, the term ''prohibited transaction'' means any act or failure to act (other than with respect to section 4942(e), relating to minimum investment return) which would subject a foreign private foundation described in paragraph (b) of this section, or a disqualified person (as defined in section 4946) with respect thereto, to liability for a penalty under section 6684 (relating to assessable penalties with respect to liability for tax under Chapter 42) or a tax under section 507 (relating to termination of private foundation status) if such foreign private foundation were a domestic private foundation.

(ii) For purposes of subdivision (i) of this subparagraph:

(*a*) Approval by an appropriate foreign government of grants by the foreign private foundation to individuals is sufficient to satisfy the requirements of section 4945(g) and the regulations thereunder.

(*b*) In determining whether a grantee of the foreign organization is a private foundation which is not an operating foundation for purposes of section 4942(g)(1)(A)(ii) or is an organization which is not described in section 509(a)(1), (2), or (3) for purposes of section 4945 (d)(4) and (h), a determination made by such foreign organization will be accepted if such determination is made in good faith after a reasonable effort to identify the status of its grantee.

(iii) For purposes of subdivision (i) of this subparagraph, in order for an act or failure to act (without regard to section 4942(e)) to be treated as a prohibited transaction under section 4948(c)(2) by reason of the application of section 6684(1), there must have been a prior act or failure to act (without regard to section 4942(e)), which:

(*a*) Would have resulted in liability for tax under Chapter 42 (other than section 4940 or 4948(a)) if the foreign private foundation had been a domestic private foundation, and

(*b*) Had been the subject of a warning from the Commissioner that a second act or failure to act (without regard to section 4942(e)) would result in a prohibited transaction.

The second act or failure to act (with respect to which a warning described in subparagraph (3)(i) of this paragraph is

given) need not be related to the prior act or failure to act with respect to which a warning from the Commissioner was given under (*b*) of this subdivision.

(3) *Taxable years affected.* (i) Except as provided in subdivision (ii) of this subparagraph, a foreign private foundation described in paragraph (b) of this section shall be denied exemption from taxation under section 501(a) by reason of subparagraph (1) of this paragraph for all taxable years beginning with the taxable year during which it is notified by the Commissioner that it has engaged in a prohibited transaction. The Commissioner shall publish such notice in the FEDERAL REGISTER on the day on which he so notifies such foreign private foundation. In the case of an act or failure to act (without regard to section 4942(e)) which would result in a penalty under section 6684(1) if the foreign private foundation were a domestic private foundation, before giving notice under this subdivision the Commissioner shall warn such foreign private foundation that such act or failure to act may be treated as a prohibited transaction. However, such act or failure to act will not be treated as a prohibited transaction if it is corrected (within the meaning of Chapter 42 and the regulations thereunder) within 90 days after the making of such warning.

(ii)(*a*) Any foreign private foundation described in paragraph (b) of this section which is denied exemption from taxation under section 501(a) by reason of subparagraph (1) of this paragraph may, with respect to the second taxable year following the taxable year in which notice is given under subdivision (i) of this subparagraph (or any taxable year subsequent to such second taxable year), file a request for exemption from taxation under section 501(a) on Form 1023. In addition to the information generally required of an organization requesting exemption as an organization described in section 501(a), a request under this subdivision must contain or have attached to it a written declaration, made under the penalties of perjury, by a principal officer of such organization authorized to make such declaration, that the organization will not knowingly again engage in a prohibited transaction.

(*b*) If the Commissioner is satisfied that such organization will not knowingly again engage in a prohibited transaction and that the organization has satisfied all other requirements under section 501, the organization will be so notified in writing. In such case the organization shall not, with respect to taxable years beginning with the taxable year with respect to which a request under this subdivision is filed, be denied exemption from taxation under section 501(a) by reason of any prohibited transaction which was engaged in before the date on which notice was given under subdivision (i) of this subparagraph. Section 4948(c) provides that an organization denied exemption under such section will not be exempt from taxation under section 501(a) for the taxable year in which notice of loss of exemption is given and at least one immediately subsequent taxable year.

(d) *Disallowance of certain charitable deductions.* No gift, bequest, legacy, devise, or transfer shall be allowed as a deduction under section 170, 545(b)(2), 556(b)(2), 642(c), 2055, 2106(a)(2), or 2522, if made:

(1) To a foreign private foundation described in paragraph (b) of this section after the date on which the Commissioner publishes notice under paragraph (c)(3)(i) of this section that he has notified such organization that it has engaged in a prohibited transaction, and

(2) In a taxable year of such organization for which it is not exempt from taxation under section 501(a) by reason of paragraph (c)(1) of this section.

For purposes of this paragraph, a bequest, legacy, devise, or transfer under section 2055 or 2106(a)(2) shall be treated as made on the date of death of the decedent. For example, assume that an individual gives money to a foreign private foundation described in section 4948(b) in January 1970, January 1971, and January 1972. The organization has a taxable year from June 1 through May 31. In February 1970, notice is duly published that the foreign organization has engaged in a prohibited transaction. In December 1970, the organization duly submits a request for exemption under paragraph (c)(3)(ii)(*a*) of this

section which is granted for the taxable year ending May 31, 1972. The January 1970 gift is allowable as a deduction under section 2522 since it was made before the notice (February 1970). The January 1971 gift is not allowable as a deduction because the taxable year ending May 31, 1971, is a nonexempt year (the first taxable year subsequent to the taxable year of the notice) for the foreign organization. The January 1972 gift is allowable as a deduction under section 2522 because the taxable year ending May 31, 1972, is an exempt year for the organization.

[T.D. 7218, 37 FR 23918, Nov. 10, 1972; 37 FR 24748, Nov. 21, 1972; 38 FR 4324, Feb. 13, 1973]

Subpart J—Black Lung Benefit Trust Excise Taxes

SOURCE: T.D. 7644, 44 FR 52198, Sept. 7, 1979, unless otherwise noted.

§ 53.4951–1 Black lung trusts—taxes on self-dealing.

(a) *In general.* Section 4951 contains provisions that correspond to provisions of section 4941 (relating to taxes on foundation self-dealing) and section 4946 (relating to definitions and special rules). Regulations and rulings under these corresponding provisions apply to section 4951 where appropriate.

(b) *Transfer of property to trust.* A transfer of personal property without consideration to a trust for which a deduction is allowable under section 192 does not constitute a sale or exchange for purposes of section 4951 unless the property is subject to a mortgage or similar lien within section 4951(d)(2)(A). The transfer to a trust of a note or other evidence of indebtedness constitutes an extension of credit to the obligor for purposes of section 4951(d)(1)(B).

(c) *Deposits.* A time or demand deposit made with a bank or credit union that is a trustee or other disqualified person with respect to a trust constitutes a lending of money for purposes of section 4951(d)(1)(B) even though the deposit is of a kind generally authorized for investments by the trust.

(d) *Trustee.* The term ''trustee'' as used in section 4951(e)(5)(B) includes any person having powers or responsibilities with respect to a trust similar to those of trustees.

(e) *Misallocation of insurance premium.* Under section 501(c)(21)(A)(ii) and § 1.501(c)(21)-1(d), a trust may pay a portion of a premium for insurance which covers both black lung liabilities and other liabilities, so long as the requirements of section 501(c)(21)(A)(i) concerning allocation of the total premium are met. However, if an insurance company misallocates the total premium in a manner which benefits a disqualified person, the amount of misallocation constitutes a use of trust assets for the benefit of the disqualified person within section 4951(d)(1)(D). For these purposes, it is irrelevant whether the combination of insurance is sold under one policy or more than one policy.

(f) *Effective date.* Section 4951 applies with respect to acts that occur after December 31, 1977, in and for trust *taxable* years beginning after December 31, 1977.

§ 53.4952–1 Black lung trusts—taxes on taxable expenditures.

(a) *In general.* Section 4952 contains provisions that generally correspond to provisions of section 4945 (relating to taxes on taxable expenditures by private foundations) and section 4946 (relating to definitions and special rules). Regulations and rulings under these corresponding provisions apply to section 4952 where appropriate. See section 4952(e)(1) for the definition of *correction.*

(b) *Unauthorized investments.* The term ''taxable expenditure'' in section 4952(d) includes an investment that is not authorized under section 501(c)(21)(B)(ii).

(c) *Effective date.* Section 4952 applies with respect to expenditures made after December 31, 1977, in and for trust taxable years beginning after December 31, 1977.

Subpart K—Second Tier Excise Taxes

SOURCE: T.D. 8084, 51 FR 16303, May 2, 1986, unless otherwise noted.

§ 53.4955–1 Tax on political expenditures.

(a) *Relationship between section 4955 excise taxes and substantive standards for exemption under section 501(c)(3).* The excise taxes imposed by section 4955 do not affect the substantive standards for tax exemption under section 501(c)(3), under which an organization is described in section 501(c)(3) only if it does not participate or intervene in any political campaign on behalf of any candidate for public office.

(b) *Imposition of initial taxes on organization managers*—(1) *In general.* The excise tax under section 4955(a)(2) on the agreement of any organization manager to the making of a political expenditure by a section 501(c)(3) organization is imposed only in cases where—

(i) A tax is imposed by section 4955(a)(1);

(ii) The organization manager knows that the expenditure to which the manager agrees is a political expenditure; and

(iii) The agreement is willful and is not due to reasonable cause.

(2) *Type of organization managers covered*—(i) *In general.* The tax under section 4955(a)(2) is imposed only on those organization managers who are authorized to approve, or to exercise discretion in recommending approval of, the making of the expenditure by the organization and on those organization managers who are members of a group (such as the organization's board of directors or trustees) which is so authorized.

(ii) *Officer.* For purposes of section 4955(f)(2)(A), a person is an officer of an organization if—

(A) That person is specifically so designated under the certificate of incorporation, bylaws, or other constitutive documents of the foundation; or

(B) That person regularly exercises general authority to make administrative or policy decisions on behalf of the organization. Independent contractors, acting in a capacity as attorneys, accountants, and investment managers and advisors, are not officers. With respect to any expenditure, any person described in this paragraph (b)(2)(ii)(B) who has authority merely to recommend particular administrative or policy decisions, but not to implement them without approval of a superior, is not an officer.

(iii) *Employee.* For purposes of section 4955(f)(2)(B), an individual rendering services to an organization is an employee of the organization only if that individual is an employee within the meaning of section 3121(d)(2). With respect to any expenditure, an employee (other than an officer, director, or trustee of the organization) is described in section 4955(f)(2)(B) only if he or she has final authority or responsibility (either officially or effectively) with respect to such expenditure.

(3) *Type of agreement required.* An organization manager agrees to the making of a political expenditure if the manager manifests approval of the expenditure which is sufficient to constitute an exercise of the organization manager's authority to approve, or to exercise discretion in recommending approval of, the making of the expenditure by the organization. The manifestation of approval need not be the final or decisive approval on behalf of the organization.

(4) *Knowing*—(i) *General rule.* For purposes of section 4955, an organization manager is considered to have agreed to an expenditure *knowing* that it is a political expenditure only if—

(A) The manager has actual knowledge of sufficient facts so that, based solely upon these facts, the expenditure would be a political expenditure;

(B) The manager is aware that such an expenditure under these circumstances may violate the provisions of federal tax law governing political expenditures; and

(C) The manager negligently fails to make reasonable attempts to ascertain whether the expenditure is a political expenditure, or the manager is aware that it is a political expenditure.

(ii) *Amplification of general rule.* For purposes of section 4955, knowing does not mean having reason to know. However, evidence tending to show that an organization manager has reason to know of a particular fact or particular rule is relevant in determining whether the manager had actual knowledge of the fact or rule. Thus, for example, evidence tending to show that an organization manager has reason to know of sufficient facts so that, based solely

upon those facts, an expenditure would be a political expenditure is relevant in determining whether the manager has actual knowledge of the facts.

(5) *Willful.* An organization manager's agreement to a political expenditure is willful if it is voluntary, conscious, and intentional. No motive to avoid the restrictions of the law or the incurrence of any tax is necessary to make an agreement willful. However, an organization manager's agreement to a political expenditure is not willful if the manager does not know that it is a political expenditure.

(6) *Due to reasonable cause.* An organization manager's actions are due to reasonable cause if the manager has exercised his or her responsibility on behalf of the organization with ordinary business care and prudence.

(7) *Advice of counsel.* An organization manager's agreement to an expenditure is ordinarily not considered knowing or willful and is ordinarily considered due to reasonable cause if the manager, after full disclosure of the factual situation to legal counsel (including house counsel), relies on the advice of counsel expressed in a reasoned written legal opinion that an expenditure is not a political expenditure under section 4955 (or that expenditures conforming to certain guidelines are not political expenditures). For this purpose, a written legal opinion is considered reasoned even if it reaches a conclusion which is subsequently determined to be incorrect, so long as the opinion addresses itself to the facts and applicable law. A written legal opinion is not considered reasoned if it does nothing more than recite the facts and express a conclusion. However, the absence of advice of counsel with respect to an expenditure does not, by itself, give rise to any inference that an organization manager agreed to the making of the expenditure knowingly, willfully, or without reasonable cause.

(8) *Cross reference.* For provisions relating to the burden of proof in cases involving the issue of whether an organization manager has knowingly agreed to the making of a political expenditure, see section 7454(b).

(c) *Amplification of political expenditure definition*—(1) *General rule.* Any expenditure that would cause an organization that makes the expenditure to be classified as an action organization by reason of §1.501(c)(3)–1(c)(3)(iii) of this chapter is a political expenditure within the meaning of section 4955(d)(1).

(2) *Other political expenditures*—(i) For purposes of section 4955(d)(2), an organization is effectively controlled by a candidate or prospective candidate only if the individual has a continuing, substantial involvement in the day-to-day operations or management of the organization. An organization is not effectively controlled by a candidate or a prospective candidate merely because it is affiliated with the candidate, or merely because the candidate knows the directors, officers, or employees of the organization. The effectively controlled test is not met merely because the organization carries on its research, study, or other educational activities with respect to subject matter or issues in which the individual is interested or with which the individual is associated.

(ii) For purposes of section 4955(d)(2), a determination of whether the primary purpose of an organization is promoting the candidacy or prospective candidacy of an individual for public office is made on the basis of all the facts and circumstances. The factors to be considered include whether the surveys, studies, materials, etc. prepared by the organization are made available only to the candidate or are made available to the general public; and whether the organization pays for speeches and travel expenses for only one individual, or for speeches or travel expenses of several persons. The fact that a candidate or prospective candidate utilizes studies, papers, materials, etc., prepared by the organization (such as in a speech by the candidate) is not to be considered as a factor indicating that the organization has a purpose of promoting the candidacy or prospective candidacy of that individual where such studies, papers, materials, etc. are not made available only to that individual.

(iii) Expenditures for voter registration, voter turnout, or voter education constitute other expenses, treated as

political expenditures by reason of section 4955(d)(2)(E), only if the expenditures violate the prohibition on political activity provided in section 501(c)(3).

(d) *Abatement, refund, or no assessment of initial tax.* No initial (first-tier) tax will be imposed under section 4955(a), or the initial tax will be abated or refunded, if the organization or an organization manager establishes to the satisfaction of the IRS that—

(1) The political expenditure was not willful and flagrant; and

(2) The political expenditure was corrected.

(e) *Correction*—(1) *Recovery of expenditure.* For purposes of section 4955(f)(3) and this section, correction of a political expenditure is accomplished by recovering part or all of the expenditure to the extent recovery is possible, and, where full recovery cannot be accomplished, by any additional corrective action which the Commissioner may prescribe. The organization making the political expenditure is not under any obligation to attempt to recover the expenditure by legal action if the action would in all probability not result in the satisfaction of execution on a judgment.

(2) *Establishing safeguards.* Correction of a political expenditure must also involve the establishment of sufficient safeguards to prevent future political expenditures by the organization. The determination of whether safeguards are sufficient to prevent future political expenditures by the organization is made by the District Director.

(f) *Effective date.* This section is effective December 5, 1995.

[T.D. 8628, 60 FR 62210, Dec. 5, 1995]

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[T.D. 8978, 67 FR 3083, Jan. 23, 2002]

§ 53.4958–1 Taxes on excess benefit transactions.

(a) *In general.* Section 4958 imposes excise taxes on each excess benefit transaction (as defined in section 4958(c) and § 53.4958–4) between an applicable tax-exempt organization (as defined in section 4958(e) and § 53.4958–2) and a disqualified person (as defined in section 4958(f)(1) and § 53.4958–3). A disqualified person who receives an excess benefit from an excess benefit transaction is liable for payment of a section 4958(a)(1) excise tax equal to 25 percent of the excess benefit. If an initial tax is imposed by section 4958(a)(1) on an excess benefit transaction and the transaction is not corrected (as defined in section 4958(f)(6) and § 53.4958–7) within the taxable period (as defined in section 4958(f)(5) and paragraph (c)(2)(ii) of this section), then any disqualified person who received an excess benefit from the excess benefit transaction on which the initial tax was imposed is liable for an additional tax of 200 percent of the excess benefit. An organization manager (as defined in section 4958(f)(2) and paragraph (d) of this section) who participates in an excess benefit transaction, knowing that it was such a transaction, is liable for payment of a section 4958(a)(2) excise tax equal to 10 percent of the excess benefit, unless the participation was not willful and was due to reasonable cause. If an organization manager also receives an excess benefit from an excess benefit transaction, the manager may be liable for both taxes imposed by section 4958(a).

(b) *Excess benefit defined.* An excess benefit is the amount by which the value of the economic benefit provided by an applicable tax-exempt organization directly or indirectly to or for the use of any disqualified person exceeds the value of the consideration (including the performance of services) received for providing such benefit.

(c) *Taxes paid by disqualified person*—(1) *Initial tax.* Section 4958(a)(1) imposes a tax equal to 25 percent of the excess benefit on each excess benefit transaction. The section 4958(a)(1) tax shall be paid by any disqualified person who received an excess benefit from that excess benefit transaction. With respect to any excess benefit transaction, if more than one disqualified person is liable for the tax imposed by section 4958(a)(1), all such persons are jointly and severally liable for that tax.

(2) *Additional tax on disqualified person*—(i) *In general.* Section 4958(b) imposes a tax equal to 200 percent of the excess benefit in any case in which section 4958(a)(1) imposes a 25-percent tax on an excess benefit transaction and the transaction is not corrected (as defined in section 4958(f)(6) and § 53.4958–7) within the taxable period (as defined in section 4958(f)(5) and paragraph (c)(2)(ii) of this section). If a disqualified person makes a payment of less than the full correction amount under the rules of § 53.4958–7, the 200-percent tax is imposed only on the unpaid portion of the correction amount (as described in § 53.4958–7(c)). The tax imposed by section 4958(b) is payable by any disqualified person who received an excess benefit from the excess benefit transaction on which the initial tax was imposed by section 4958(a)(1). With respect to any excess benefit transaction, if more than one disqualified person is liable for the tax imposed by section 4958(b), all such persons are jointly and severally liable for that tax.

(ii) *Taxable period. Taxable period* means, with respect to any excess benefit transaction, the period beginning with the date on which the transaction occurs and ending on the earlier of—

(A) The date of mailing a notice of deficiency under section 6212 with respect to the section 4958(a)(1) tax; or

(B) The date on which the tax imposed by section 4958(a)(1) is assessed.

(iii) *Abatement if correction during the correction period.* For rules relating to abatement of taxes on excess benefit transactions that are corrected within the correction period, as defined in section 4963(e), see sections 4961(a), 4962(a), and the regulations thereunder. The abatement rules of section 4961 specifically provide for a 90-day correction period after the date of mailing a notice of deficiency under section 6212 with respect to the section 4958(b) 200-percent tax. If the excess benefit is corrected during that correction period, the 200-percent tax imposed shall not be assessed, and if assessed the assessment shall be abated, and if collected shall be credited or refunded as an overpayment. For special rules relating to abatement of the 25-percent tax, see section 4962.

(d) *Tax paid by organization managers*—(1) *In general.* In any case in which section 4958(a)(1) imposes a tax, section 4958(a)(2) imposes a tax equal to 10 percent of the excess benefit on the participation of any organization manager who knowingly participated in the excess benefit transaction, unless such participation was not willful and was due to reasonable cause. Any organization manager who so participated in the excess benefit transaction must pay the tax.

(2) *Organization manager defined*—(i) *In general.* An organization manager is, with respect to any applicable tax-exempt organization, any officer, director, or trustee of such organization, or any individual having powers or responsibilities similar to those of officers, directors, or trustees of the organization, regardless of title. A person is an officer of an organization if that person—

(A) Is specifically so designated under the certificate of incorporation, by-laws, or other constitutive documents of the organization; or

(B) Regularly exercises general authority to make administrative or policy decisions on behalf of the organization. A contractor who acts solely in a capacity as an attorney, accountant, or investment manager or advisor, is not an officer. For purposes of this paragraph (d)(2)(i)(B), any person who has authority merely to recommend particular administrative or policy decisions, but not to implement them without approval of a superior, is not an officer.

(ii) *Special rule for certain committee members.* An individual who is not an officer, director, or trustee, yet serves on a committee of the governing body of an applicable tax-exempt organization (or as a designee of the governing body described in § 53.4958–6(c)(1)) that is attempting to invoke the rebuttable presumption of reasonableness described in § 53.4958–6 based on the committee's (or designee's) actions, is an organization manager for purposes of the tax imposed by section 4958(a)(2).

(3) *Participation.* For purposes of section 4958(a)(2) and this paragraph (d), participation includes silence or inaction on the part of an organization manager where the manager is under a duty to speak or act, as well as any affirmative action by such manager. An organization manager is not considered to have participated in an excess benefit transaction, however, where the manager has opposed the transaction in a manner consistent with the fulfillment of the manager's responsibilities to the applicable tax-exempt organization.

(4) *Knowing*—(i) *In general.* For purposes of section 4958(a)(2) and this paragraph (d), a manager participates in a transaction knowingly only if the person—

(A) Has actual knowledge of sufficient facts so that, based solely upon those facts, such transaction would be an excess benefit transaction;

(B) Is aware that such a transaction under these circumstances may violate the provisions of Federal tax law governing excess benefit transactions; and

(C) Negligently fails to make reasonable attempts to ascertain whether the transaction is an excess benefit transaction, or the manager is in fact aware that it is such a transaction.

(ii) *Amplification of general rule. Knowing* does not mean having reason to know. However, evidence tending to show that a manager has reason to know of a particular fact or particular

rule is relevant in determining whether the manager had actual knowledge of such a fact or rule. Thus, for example, evidence tending to show that a manager has reason to know of sufficient facts so that, based solely upon such facts, a transaction would be an excess benefit transaction is relevant in determining whether the manager has actual knowledge of such facts.

(iii) *Reliance on professional advice.* An organization manager's participation in a transaction is ordinarily not considered knowing within the meaning of section 4958(a)(2), even though the transaction is subsequently held to be an excess benefit transaction, to the extent that, after full disclosure of the factual situation to an appropriate professional, the organization manager relies on a reasoned written opinion of that professional with respect to elements of the transaction within the professional's expertise. For purposes of section 4958(a)(2) and this paragraph (d), a written opinion is reasoned even though it reaches a conclusion that is subsequently determined to be incorrect so long as the opinion addresses itself to the facts and the applicable standards. However, a written opinion is not reasoned if it does nothing more than recite the facts and express a conclusion. The absence of a written opinion of an appropriate professional with respect to a transaction shall not, by itself, however, give rise to any inference that an organization manager participated in the transaction knowingly. For purposes of this paragraph, appropriate professionals on whose written opinion an organization manager may rely, are limited to—

(A) Legal counsel, including in-house counsel;

(B) Certified public accountants or accounting firms with expertise regarding the relevant tax law matters; and

(C) Independent valuation experts who—

(*1*) Hold themselves out to the public as appraisers or compensation consultants;

(*2*) Perform the relevant valuations on a regular basis;

(*3*) Are qualified to make valuations of the type of property or services involved; and

(*4*) Include in the written opinion a certification that the requirements of paragraphs (d)(4)(iii)(C)(*1*) through (*3*) of this section are met.

(iv) *Satisfaction of rebuttable presumption of reasonableness.* An organization manager's participation in a transaction is ordinarily not considered knowing within the meaning of section 4958(a)(2), even though the transaction is subsequently held to be an excess benefit transaction, if the appropriate authorized body has met the requirements of § 53.4958–6(a) with respect to the transaction.

(5) *Willful.* For purposes of section 4958(a)(2) and this paragraph (d), participation by an organization manager is willful if it is voluntary, conscious, and intentional. No motive to avoid the restrictions of the law or the incurrence of any tax is necessary to make the participation willful. However, participation by an organization manager is not willful if the manager does not know that the transaction in which the manager is participating is an excess benefit transaction.

(6) *Due to reasonable cause.* An organization manager's participation is due to reasonable cause if the manager has exercised responsibility on behalf of the organization with ordinary business care and prudence.

(7) *Limits on liability for management.* The maximum aggregate amount of tax collectible under section 4958(a)(2) and this paragraph (d) from organization managers with respect to any one excess benefit transaction is $10,000.

(8) *Joint and several liability.* In any case where more than one person is liable for a tax imposed by section 4958(a)(2), all such persons shall be jointly and severally liable for the taxes imposed under section 4958(a)(2) with respect to that excess benefit transaction.

(9) *Burden of proof.* For provisions relating to the burden of proof in cases involving the issue of whether an organization manager has knowingly participated in an excess benefit transaction, see section 7454(b) and § 301.7454–2 of this chapter. In these cases, the Commissioner bears the burden of proof.

(e) *Date of occurrence*—(1) *In general.* Except as otherwise provided, an excess

benefit transaction occurs on the date on which the disqualified person receives the economic benefit for Federal income tax purposes. When a single contractual arrangement provides for a series of compensation or other payments to (or for the use of) a disqualified person over the course of the disqualified person's taxable year (or part of a taxable year), any excess benefit transaction with respect to these aggregate payments is deemed to occur on the last day of the taxable year (or if the payments continue for part of the year, the date of the last payment in the series).

(2) *Special rules*. In the case of benefits provided pursuant to a qualified pension, profit-sharing, or stock bonus plan, the transaction occurs on the date the benefit is vested. In the case of a transfer of property that is subject to a substantial risk of forfeiture or in the case of rights to future compensation or property (including benefits under a nonqualified deferred compensation plan), the transaction occurs on the date the property, or the rights to future compensation or property, is not subject to a substantial risk of forfeiture. However, where the disqualified person elects to include an amount in gross income in the taxable year of transfer pursuant to section 83(b), the general rule of paragraph (e)(1) of this section applies to the property with respect to which the section 83(b) election is made. Any excess benefit transaction with respect to benefits under a deferred compensation plan which vest during any taxable year of the disqualified person is deemed to occur on the last day of such taxable year. For the rules governing the timing of the reasonableness determination for deferred, contingent, and certain other noncash compensation, see § 53.4958–4(b)(2).

(3) *Statute of limitations rules*. See sections 6501(e)(3) and (l) and the regulations thereunder for statute of limitations rules as they apply to section 4958 excise taxes.

(f) *Effective date for imposition of taxes*—(1) *In general*. The section 4958 taxes imposed on excess benefit transactions or on participation in excess benefit transactions apply to transactions occurring on or after September 14, 1995.

(2) *Existing binding contracts*. The section 4958 taxes do not apply to any transaction occurring pursuant to a written contract that was binding on September 13, 1995, and at all times thereafter before the transaction occurs. A written binding contract that is terminable or subject to cancellation by the applicable tax-exempt organization without the disqualified person's consent (including as the result of a breach of contract by the disqualified person) and without substantial penalty to the organization, is no longer treated as a binding contract as of the earliest date that any such termination or cancellation, if made, would be effective. If a binding written contract is materially changed, it is treated as a new contract entered into as of the date the material change is effective. A material change includes an extension or renewal of the contract (other than an extension or renewal that results from the person contracting with the applicable tax-exempt organization unilaterally exercising an option expressly granted by the contract), or a more than incidental change to any payment under the contract.

[T.D. 8978, 67 FR 3083, Jan. 23, 2002]

§ 53.4958–2 Definition of applicable tax-exempt organization.

(a) *Organizations described in section 501(c)(3) or (4) and exempt from tax under section 501(a)*—(1) *In general*. An applicable tax-exempt organization is any organization that, without regard to any excess benefit, would be described in section 501(c)(3) or (4) and exempt from tax under section 501(a). An applicable tax-exempt organization also includes any organization that was described in section 501(c)(3) or (4) and was exempt from tax under section 501(a) at any time during a five-year period ending on the date of an excess benefit transaction (the lookback period).

(2) *Exceptions from definition of applicable tax-exempt organization*—(i) *Private foundation*. A private foundation as defined in section 509(a) is not an applicable tax-exempt organization for section 4958 purposes.

(ii) *Governmental unit or affiliate*. A governmental unit or an affiliate of a

governmental unit is not an applicable tax-exempt organization for section 4958 purposes if it is—

(A) Exempt from (or not subject to) taxation without regard to section 501(a); or

(B) Relieved from filing an annual return pursuant to the authority of § 1.6033–2(g)(6).

(3) *Organizations described in section 501(c)(3).* An organization is described in section 501(c)(3) for purposes of section 4958 only if the organization—

(i) Provides the notice described in section 508; or

(ii) Is described in section 501(c)(3) and specifically is excluded from the requirements of section 508 by that section.

(4) *Organizations described in section 501(c)(4).* An organization is described in section 501(c)(4) for purposes of section 4958 only if the organization—

(i) Has applied for and received recognition from the Internal Revenue Service as an organization described in section 501(c)(4); or

(ii) Has filed an application for recognition under section 501(c)(4) with the Internal Revenue Service, has filed an annual information return as a section 501(c)(4) organization under the Internal Revenue Code or regulations promulgated thereunder, or has otherwise held itself out as being described in section 501(c)(4) and exempt from tax under section 501(a).

(5) *Effect of non-recognition or revocation of exempt status.* An organization is not described in paragraph (a)(3) or (4) of this section during any period covered by a final determination or adjudication that the organization is not exempt from tax under section 501(a) as an organization described in section 501(c)(3) or (4), so long as that determination or adjudication is not based upon participation in inurement or one or more excess benefit transactions. However, the organization may be an applicable tax-exempt organization for that period as a result of the five-year lookback period described in paragraph (a)(1) of this section.

(6) *Examples.* The following examples illustrate the principles of this section, which defines an applicable tax-exempt organization for purposes of section 4958:

Example 1. O is a nonprofit corporation formed under state law. O filed its application for recognition of exemption under section 501(c)(3) within the time prescribed under section 508(a). In its application, O described its plans for purchasing property from some of its directors at prices that would exceed fair market value. After reviewing the application, the IRS determined that because of the proposed property purchase transactions, O failed to establish that it met the requirements for an organization described in section 501(c)(3). Accordingly, the IRS denied O's application. While O's application was pending, O engaged in the purchase transactions described in its application at prices that exceeded the fair market values of the properties. Although these transactions would constitute excess benefit transactions under section 4958, because the IRS never recognized O as an organization described in section 501(c)(3), O was never an applicable tax-exempt organization under section 4958. Therefore, these transactions are not subject to the excise taxes provided in section 4958.

Example 2. O is a nonprofit corporation formed under state law. O files its application for recognition of exemption under section 501(c)(3) within the time prescribed under section 508(a). The IRS issues a favorable determination letter in Year 1 that recognizes O as an organization described in section 501(c)(3). Subsequently, in Year 5 of O's operations, O engages in certain transactions that constitute excess benefit transactions under section 4958 and violate the proscription against inurement under section 501(c)(3) and § 1.501(c)(3)–1(c)(2). The IRS examines the Form 990, ''Return of Organization Exempt From Income Tax'', that O filed for Year 5. After considering all the relevant facts and circumstances in accordance with § 1.501(c)(3)–1(f), the IRS concludes that O is no longer described in section 501(c)(3) effective in Year 5. The IRS does not examine the Forms 990 that O filed for its first four years of operations and, accordingly, does not revoke O's exempt status for those years. Although O's tax-exempt status is revoked effective in Year 5, under the *lookback* rules in paragraph (a)(1) of this section and § 53.4958–3(a)(1) of this chapter, during the five-year period prior to the excess benefit transactions that occurred in Year 5, O was an applicable tax-exempt organization and O's directors were disqualified persons as to O. Therefore, the transactions between O and its directors during Year 5 are subject to the applicable excise taxes provided in section 4958.

(b) *Special rules*—(1) *Transition rule for lookback period.* In the case of any excess benefit transaction occurring before September 14, 2000, the lookback period described in paragraph (a)(1) of

this section begins on September 14, 1995, and ends on the date of the transaction.

(2) *Certain foreign organizations.* A foreign organization, recognized by the Internal Revenue Service or by treaty, that receives substantially all of its support (other than gross investment income) from sources outside of the United States is not an organization described in section 501(c)(3) or (4) for purposes of section 4958.

[T.D. 8978, 67 FR 3083, Jan. 23, 2002, as amended by T.D. 9390, 73 FR 16524, Mar. 28, 2008]

§ 53.4958–3 Definition of disqualified person.

(a) *In general*—(1) *Scope of definition.* Section 4958(f)(1) defines *disqualified person*, with respect to any transaction, as any person who was in a position to exercise substantial influence over the affairs of an applicable tax-exempt organization at any time during the five-year period ending on the date of the transaction (the lookback period). Paragraph (b) of this section describes persons who are defined to be disqualified persons under the statute, including certain family members of an individual in a position to exercise substantial influence, and certain 35-percent controlled entities. Paragraph (c) of this section describes persons in a position to exercise substantial influence over the affairs of an applicable tax-exempt organization by virtue of their powers and responsibilities or certain interests they hold. Paragraph (d) of this section describes persons deemed not to be in a position to exercise substantial influence. Whether any person who is not described in paragraph (b), (c) or (d) of this section is a disqualified person with respect to a transaction for purposes of section 4958 is based on all relevant facts and circumstances, as described in paragraph (e) of this section. Paragraph (f) of this section describes special rules for affiliated organizations. Examples in paragraph (g) of this section illustrate these categories of persons.

(2) *Transition rule for lookback period.* In the case of any excess benefit transaction occurring before September 14, 2000, the lookback period described in paragraph (a)(1) of this section begins on September 14, 1995, and ends on the date of the transaction.

(b) *Statutory categories of disqualified persons*—(1) *Family members.* A person is a disqualified person with respect to any transaction with an applicable tax-exempt organization if the person is a member of the family of a person who is a disqualified person described in paragraph (a) of this section (other than as a result of this paragraph) with respect to any transaction with the same organization. For purposes of the following sentence, a legally adopted child of an individual is treated as a child of such individual by blood. A person's family is limited to—

(i) Spouse;

(ii) Brothers or sisters (by whole or half blood);

(iii) Spouses of brothers or sisters (by whole or half blood);

(iv) Ancestors;

(v) Children;

(vi) Grandchildren;

(vii) Great grandchildren; and

(viii) Spouses of children, grandchildren, and great grandchildren.

(2) *Thirty-five percent controlled entities*—(i) *In general.* A person is a disqualified person with respect to any transaction with an applicable tax-exempt organization if the person is a 35-percent controlled entity. A 35-percent controlled entity is—

(A) A corporation in which persons described in this section (except in paragraphs (b)(2) and (d) of this section) own more than 35 percent of the combined voting power;

(B) A partnership in which persons described in this section (except in paragraphs (b)(2) and (d) of this section) own more than 35 percent of the profits interest; or

(C) A trust or estate in which persons described in this section (except in paragraphs (b)(2) and (d) of this section) own more than 35 percent of the beneficial interest.

(ii) *Combined voting power.* For purposes of this paragraph (b)(2), combined voting power includes voting power represented by holdings of voting stock, direct or indirect, but does not include voting rights held only as a director, trustee, or other fiduciary.

(iii) *Constructive ownership rules*—(A) *Stockholdings.* For purposes of section

4958(f)(3) and this paragraph (b)(2), indirect stockholdings are taken into account as under section 267(c), except that in applying section 267(c)(4), the family of an individual shall include the members of the family specified in section 4958(f)(4) and paragraph (b)(1) of this section.

(B) *Profits or beneficial interest.* For purposes of section 4958(f)(3) and this paragraph (b)(2), the ownership of profits or beneficial interests shall be determined in accordance with the rules for constructive ownership of stock provided in section 267(c) (other than section 267(c)(3)), except that in applying section 267(c)(4), the family of an individual shall include the members of the family specified in section 4958(f)(4) and paragraph (b)(1) of this section.

(c) *Persons having substantial influence.* A person who holds any of the following powers, responsibilities, or interests is in a position to exercise substantial influence over the affairs of an applicable tax-exempt organization:

(1) *Voting members of the governing body.* This category includes any individual serving on the governing body of the organization who is entitled to vote on any matter over which the governing body has authority.

(2) *Presidents, chief executive officers, or chief operating officers.* This category includes any person who, regardless of title, has ultimate responsibility for implementing the decisions of the governing body or for supervising the management, administration, or operation of the organization. A person who serves as president, chief executive officer, or chief operating officer has this ultimate responsibility unless the person demonstrates otherwise. If this ultimate responsibility resides with two or more individuals (e.g., co-presidents), who may exercise such responsibility in concert or individually, then each individual is in a position to exercise substantial influence over the affairs of the organization.

(3) *Treasurers and chief financial officers.* This category includes any person who, regardless of title, has ultimate responsibility for managing the finances of the organization. A person who serves as treasurer or chief financial officer has this ultimate responsibility unless the person demonstrates otherwise. If this ultimate responsibility resides with two or more individuals who may exercise the responsibility in concert or individually, then each individual is in a position to exercise substantial influence over the affairs of the organization.

(4) *Persons with a material financial interest in a provider-sponsored organization.* For purposes of section 4958, if a hospital that participates in a provider-sponsored organization (as defined in section 1855(e) of the Social Security Act, 42 U.S.C. 1395w–25) is an applicable tax-exempt organization, then any person with a material financial interest (within the meaning of section 501(o)) in the provider-sponsored organization has substantial influence with respect to the hospital.

(d) *Persons deemed not to have substantial influence.* A person is deemed not to be in a position to exercise substantial influence over the affairs of an applicable tax-exempt organization if that person is described in one of the following categories:

(1) *Tax-exempt organizations described in section 501(c)(3).* This category includes any organization described in section 501(c)(3) and exempt from tax under section 501(a).

(2) *Certain section 501(c)(4) organizations.* Only with respect to an applicable tax-exempt organization described in section 501(c)(4) and § 53.4958–2(a)(4), this category includes any other organization so described.

(3) *Employees receiving economic benefits of less than a specified amount in a taxable year.* This category includes, for the taxable year in which benefits are provided, any full- or part-time employee of the applicable tax-exempt organization who—

(i) Receives economic benefits, directly or indirectly from the organization, of less than the amount referenced for a highly compensated employee in section 414(q)(1)(B)(i);

(ii) Is not described in paragraph (b) or (c) of this section with respect to the organization; and

(iii) Is not a substantial contributor to the organization within the meaning of section 507(d)(2)(A), taking into account only contributions received by the organization during its current

taxable year and the four preceding taxable years.

(e) *Facts and circumstances govern in all other cases*—(1) *In general*. Whether a person who is not described in paragraph (b), (c) or (d) of this section is a disqualified person depends upon all relevant facts and circumstances.

(2) *Facts and circumstances tending to show substantial influence*. Facts and circumstances tending to show that a person has substantial influence over the affairs of an organization include, but are not limited to, the following—

(i) The person founded the organization;

(ii) The person is a substantial contributor to the organization (within the meaning of section 507(d)(2)(A)), taking into account only contributions received by the organization during its current taxable year and the four preceding taxable years;

(iii) The person's compensation is primarily based on revenues derived from activities of the organization, or of a particular department or function of the organization, that the person controls;

(iv) The person has or shares authority to control or determine a substantial portion of the organization's capital expenditures, operating budget, or compensation for employees;

(v) The person manages a discrete segment or activity of the organization that represents a substantial portion of the activities, assets, income, or expenses of the organization, as compared to the organization as a whole;

(vi) The person owns a controlling interest (measured by either vote or value) in a corporation, partnership, or trust that is a disqualified person; or

(vii) The person is a non-stock organization controlled, directly or indirectly, by one or more disqualified persons.

(3) *Facts and circumstances tending to show no substantial influence*. Facts and circumstances tending to show that a person does not have substantial influence over the affairs of an organization include, but are not limited to, the following—

(i) The person has taken a bona fide vow of poverty as an employee, agent, or on behalf, of a religious organization;

(ii) The person is a contractor (such as an attorney, accountant, or investment manager or advisor) whose sole relationship to the organization is providing professional advice (without having decision-making authority) with respect to transactions from which the contractor will not economically benefit either directly or indirectly (aside from customary fees received for the professional advice rendered);

(iii) The direct supervisor of the individual is not a disqualified person;

(iv) The person does not participate in any management decisions affecting the organization as a whole or a discrete segment or activity of the organization that represents a substantial portion of the activities, assets, income, or expenses of the organization, as compared to the organization as a whole; or

(v) Any preferential treatment a person receives based on the size of that person's contribution is also offered to all other donors making a comparable contribution as part of a solicitation intended to attract a substantial number of contributions.

(f) *Affiliated organizations*. In the case of multiple organizations affiliated by common control or governing documents, the determination of whether a person does or does not have substantial influence shall be made separately for each applicable tax-exempt organization. A person may be a disqualified person with respect to transactions with more than one applicable tax-exempt organization.

(g) *Examples*. The following examples illustrate the principles of this section. A finding that a person is a disqualified person in the following examples does not indicate that an excess benefit transaction has occurred. If a person is a disqualified person, the rules of section 4958(c) and § 53.4958–4 apply to determine whether an excess benefit transaction has occurred. The examples are as follows:

Example 1. N, an artist by profession, works part-time at R, a local museum. In the first taxable year in which R employs N, R pays N a salary and provides no additional benefits to N except for free admission to the museum, a benefit R provides to all of its employees and volunteers. The total economic

benefits N receives from R during the taxable year are less than the amount referenced for a highly compensated employee in section 414(q)(1)(B)(i). The part-time job constitutes N's only relationship with R. N is not related to any other disqualified person with respect to R. N is deemed not to be in a position to exercise substantial influence over the affairs of R. Therefore, N is not a disqualified person with respect to R in that year.

Example 2. The facts are the same as in *Example 1*, except that in addition to the salary that R pays N for N's services during the taxable year, R also purchases one of N's paintings for $x. The total of N's salary plus $x exceeds the amount referenced for highly compensated employees in section 414(q)(1)(B)(i). Consequently, whether N is in a position to exercise substantial influence over the affairs of R for that taxable year depends upon all of the relevant facts and circumstances.

Example 3. Q is a member of K, a section 501(c)(3) organization with a broad-based public membership. Members of K are entitled to vote only with respect to the annual election of directors and the approval of major organizational transactions such as a merger or dissolution. Q is not related to any other disqualified person of K. Q has no other relationship to K besides being a member of K and occasionally making modest donations to K. Whether Q is a disqualified person is determined by all relevant facts and circumstances. Q's voting rights, which are the same as granted to all members of K, do not place Q in a position to exercise substantial influence over K. Under these facts and circumstances, Q is not a disqualified person with respect to K.

Example 4. E is the headmaster of Z, a school that is an applicable tax-exempt organization for purposes of section 4958. E reports to Z's board of trustees and has ultimate responsibility for supervising Z's day-to-day operations. For example, E can hire faculty members and staff, make changes to the school's curriculum and discipline students without specific board approval. Because E has ultimate responsibility for supervising the operation of Z, E is in a position to exercise substantial influence over the affairs of Z. Therefore, E is a disqualified person with respect to Z.

Example 5. Y is an applicable tax-exempt organization for purposes of section 4958 that decides to use bingo games as a method of generating revenue. Y enters into a contract with B, a company that operates bingo games. Under the contract, B manages the promotion and operation of the bingo activity, provides all necessary staff, equipment, and services, and pays Y *q* percent of the revenue from this activity. B retains the balance of the proceeds. Y provides no goods or services in connection with the bingo operation other than the use of its hall for the bingo games. The annual gross revenue earned from the bingo games represents more than half of Y's total annual revenue. B's compensation is primarily based on revenues from an activity B controls. B also manages a discrete activity of Y that represents a substantial portion of Y's income compared to the organization as a whole. Under these facts and circumstances, B is in a position to exercise substantial influence over the affairs of Y. Therefore, B is a disqualified person with respect to Y.

Example 6. The facts are the same as in *Example 5*, with the additional fact that P owns a majority of the stock of B and is actively involved in managing B. Because P owns a controlling interest (measured by either vote or value) in and actively manages B, P is also in a position to exercise substantial influence over the affairs of Y. Therefore, under these facts and circumstances, P is a disqualified person with respect to Y.

Example 7. A, an applicable tax-exempt organization for purposes of section 4958, owns and operates one acute care hospital. B, a for-profit corporation, owns and operates a number of hospitals. A and B form C, a limited liability company. In exchange for proportional ownership interests, A contributes its hospital, and B contributes other assets, to C. All of A's assets then consist of its membership interest in C. A continues to be operated for exempt purposes based almost exclusively on the activities it conducts through C. C enters into a management agreement with a management company, M, to provide day to day management services to C. Subject to supervision by C's board, M is given broad discretion to manage C's day to day operation and has ultimate responsibility for supervising the management of the hospital. Because M has ultimate responsibility for supervising the management of the hospital operated by C, A's ownership interest in C is its primary asset, and C's activities form the basis for A's continued exemption as an organization described in section 501(c)(3), M is in a position to exercise substantial influence over the affairs of A. Therefore, M is a disqualified person with respect to A.

Example 8. T is a large university and an applicable tax-exempt organization for purposes of section 4958. L is the dean of the College of Law of T, a substantial source of revenue for T, including contributions from alumni and foundations. L is not related to any other disqualified person of T. L does not serve on T's governing body or have ultimate responsibility for managing the university as whole. However, as dean of the College of Law, L plays a key role in faculty hiring and determines a substantial portion of the capital expenditures and operating budget of the College of Law. L's compensation is greater than the amount referenced

for a highly compensated employee in section 414(q)(1)(B)(i) in the year benefits are provided. L's management of a discrete segment of T that represents a substantial portion of the income of T (as compared to T as a whole) places L in a position to exercise substantial influence over the affairs of T. Under these facts and circumstances L is a disqualified person with respect to T.

Example 9. S chairs a small academic department in the College of Arts and Sciences of the same university T described in *Example 8*. S is not related to any other disqualified person of T. S does not serve on T's governing body or as an officer of T. As department chair, S supervises faculty in the department, approves the course curriculum, and oversees the operating budget for the department. S's compensation is greater than the amount referenced for a highly compensated employee in section 414(q)(1)(B)(i) in the year benefits are provided. Even though S manages the department, that department does not represent a substantial portion of T's activities, assets, income, expenses, or operating budget. Therefore, S does not participate in any management decisions affecting either T as a whole, or a discrete segment or activity of T that represents a substantial portion of its activities, assets, income, or expenses. Under these facts and circumstances, S does not have substantial influence over the affairs of T, and therefore S is not a disqualified person with respect to T.

Example 10. U is a large acute-care hospital that is an applicable tax-exempt organization for purposes of section 4958. U employs X as a radiologist. X gives instructions to staff with respect to the radiology work X conducts, but X does not supervise other U employees or manage any substantial part of U's operations. X's compensation is primarily in the form of a fixed salary. In addition, X is eligible to receive an incentive award based on revenues of the radiology department. X's compensation is greater than the amount referenced for a highly compensated employee in section 414(q)(1)(B)(i) in the year benefits are provided. X is not related to any other disqualified person of U. X does not serve on U's governing body or as an officer of U. Although U participates in a provider-sponsored organization (as defined in section 1855(e) of the Social Security Act), X does not have a material financial interest in that organization. X does not receive compensation primarily based on revenues derived from activities of U that X controls. X does not participate in any management decisions affecting either U as a whole or a discrete segment of U that represents a substantial portion of its activities, assets, income, or expenses. Under these facts and circumstances, X does not have substantial influence over the affairs of U, and therefore X is not a disqualified person with respect to U.

Example 11. W is a cardiologist and head of the cardiology department of the same hospital U described in *Example 10*. The cardiology department is a major source of patients admitted to U and consequently represents a substantial portion of U's income, as compared to U as a whole. W does not serve on U's governing board or as an officer of U. W does not have a material financial interest in the provider-sponsored organization (as defined in section 1855(e) of the Social Security Act) in which U participates. W receives a salary and retirement and welfare benefits fixed by a three-year renewable employment contract with U. W's compensation is greater than the amount referenced for a highly compensated employee in section 414(q)(1)(B)(i) in the year benefits are provided. As department head, W manages the cardiology department and has authority to allocate the budget for that department, which includes authority to distribute incentive bonuses among cardiologists according to criteria that W has authority to set. W's management of a discrete segment of U that represents a substantial portion of its income and activities (as compared to U as a whole) places W in a position to exercise substantial influence over the affairs of U. Under these facts and circumstances, W is a disqualified person with respect to U.

Example 12. M is a museum that is an applicable tax-exempt organization for purposes of section 4958. D provides accounting services and tax advice to M as a contractor in return for a fee. D has no other relationship with M and is not related to any disqualified person of M. D does not provide professional advice with respect to any transaction from which D might economically benefit either directly or indirectly (aside from fees received for the professional advice rendered). Because D's sole relationship to M is providing professional advice (without having decision-making authority) with respect to transactions from which D will not economically benefit either directly or indirectly (aside from customary fees received for the professional advice rendered), under these facts and circumstances, D is not a disqualified person with respect to M.

Example 13. F is a repertory theater company that is an applicable tax-exempt organization for purposes of section 4958. F holds a fund-raising campaign to pay for the construction of a new theater. J is a regular subscriber to F's productions who has made modest gifts to F in the past. J has no relationship to F other than as a subscriber and contributor. F solicits contributions as part of a broad public campaign intended to attract a large number of donors, including a substantial number of donors making large gifts. In its solicitations for contributions, F promises to invite all contributors giving $*z*

or more to a special opening production and party held at the new theater. These contributors are also given a special number to call in F's office to reserve tickets for performances, make ticket exchanges, and make other special arrangements for their convenience. J makes a contribution of $*z* to F, which makes J a substantial contributor within the meaning of section 507(d)(2)(A), taking into account only contributions received by F during its current and the four preceding taxable years. J receives the benefits described in F's solicitation. Because F offers the same benefit to all donors of $*z* or more, the preferential treatment that J receives does not indicate that J is in a position to exercise substantial influence over the affairs of the organization. Therefore, under these facts and circumstances, J is not a disqualified person with respect to F.

[T.D. 8978, 67 FR 3083, Jan. 23, 2002]

§ 53.4958–4 Excess benefit transaction.

(a) *Definition of excess benefit transaction*—(1) *In general.* An *excess benefit transaction* means any transaction in which an economic benefit is provided by an applicable tax-exempt organization directly or indirectly to or for the use of any disqualified person, and the value of the economic benefit provided exceeds the value of the consideration (including the performance of services) received for providing the benefit. Subject to the limitations of paragraph (c) of this section (relating to the treatment of economic benefits as compensation for the performance of services), to determine whether an excess benefit transaction has occurred, all consideration and benefits (except disregarded benefits described in paragraph (a)(4) of this section) exchanged between a disqualified person and the applicable tax-exempt organization and all entities the organization controls (within the meaning of paragraph (a)(2)(ii)(B) of this section) are taken into account. For example, in determining the reasonableness of compensation that is paid (or vests, or is no longer subject to a substantial risk of forfeiture) in one year, services performed in prior years may be taken into account. The rules of this section apply to all transactions with disqualified persons, regardless of whether the amount of the benefit provided is determined, in whole or in part, by the revenues of one or more activities of the organization. For rules regarding valuation standards, see paragraph (b) of this section. For the requirement that an applicable tax-exempt organization clearly indicate its intent to treat a benefit as compensation for services when paid, see paragraph (c) of this section.

(2) *Economic benefit provided indirectly*—(i) *In general.* A transaction that would be an excess benefit transaction if the applicable tax-exempt organization engaged in it directly with a disqualified person is likewise an excess benefit transaction when it is accomplished indirectly. An applicable tax-exempt organization may provide an excess benefit indirectly to a disqualified person through a controlled entity or through an intermediary, as described in paragraphs (a)(2)(ii) and (iii) of this section, respectively.

(ii) *Through a controlled entity*—(A) *In general.* An applicable tax-exempt organization may provide an excess benefit indirectly through the use of one or more entities it controls. For purposes of section 4958, economic benefits provided by a controlled entity will be treated as provided by the applicable tax-exempt organization.

(B) *Definition of control*—(*1*) *In general.* For purposes of this paragraph, *control* by an applicable tax-exempt organization means—

(*i*) In the case of a stock corporation, ownership (by vote or value) of more than 50 percent of the stock in such corporation;

(*ii*) In the case of a partnership, ownership of more than 50 percent of the profits interests or capital interests in the partnership;

(*iii*) In the case of a nonstock organization (*i.e.*, an entity in which no person holds a proprietary interest), that at least 50 percent of the directors or trustees of the organization are either representatives (including trustees, directors, agents, or employees) of, or directly or indirectly controlled by, an applicable tax-exempt organization; or

(*iv*) In the case of any other entity, ownership of more than 50 percent of the beneficial interest in the entity.

(*2*) *Constructive ownership.* Section 318 (relating to constructive ownership of stock) shall apply for purposes of determining ownership of stock in a corporation. Similar principles shall apply

for purposes of determining ownership of interests in any other entity.

(iii) *Through an intermediary*. An applicable tax-exempt organization may provide an excess benefit indirectly through an intermediary. An intermediary is any person (including an individual or a taxable or tax-exempt entity) who participates in a transaction with one or more disqualified persons of an applicable tax-exempt organization. For purposes of section 4958, economic benefits provided by an intermediary will be treated as provided by the applicable tax-exempt organization when—

(A) An applicable tax-exempt organization provides an economic benefit to an intermediary; and

(B) In connection with the receipt of the benefit by the intermediary—

(*1*) There is evidence of an oral or written agreement or understanding that the intermediary will provide economic benefits to or for the use of a disqualified person; or

(*2*) The intermediary provides economic benefits to or for the use of a disqualified person without a significant business purpose or exempt purpose of its own.

(iv) *Examples*. The following examples illustrate when economic benefits are provided indirectly under the rules of this paragraph (a)(2):

Example 1. K is an applicable tax-exempt organization for purposes of section 4958. L is a wholly-owned taxable subsidiary of K. J is employed by K, and is a disqualified person with respect to K. K pays J an annual salary of $*12m*, and reports that amount as compensation during calendar year 2001. Although J only performed services for K for nine months of 2001, J performed equivalent services for L during the remaining three months of 2001. Taking into account all of the economic benefits K provided to J, and all of the services J performed for K and L, $*12m* does not exceed the fair market value of the services J performed for K and L during 2001. Therefore, under these facts, K does not provide an excess benefit to J directly or indirectly.

Example 2. F is an applicable tax-exempt organization for purposes of section 4958. D is an entity controlled by F within the meaning of paragraph (a)(2)(ii)(B) of this section. T is the chief executive officer (CEO) of F. As CEO, T is responsible for overseeing the activities of F. T's duties as CEO make him a disqualified person with respect to F. T's compensation package with F represents the maximum reasonable compensation for T's services as CEO. Thus, any additional economic benefits that F provides to T without T providing additional consideration constitute an excess benefit. D contracts with T to provide enumerated consulting services to D. However, the contract does not require T to perform any additional services for D that T is not already obligated to perform as F's chief executive officer. Therefore, any payment to T pursuant to the consulting contract with D represents an indirect excess benefit that F provides through a controlled entity, even if F, D, or T treats the additional payment to T as compensation.

Example 3. P is an applicable tax-exempt organization for purposes of section 4958. S is a taxable entity controlled by P within the meaning of paragraph (a)(2)(ii)(B) of this section. V is the chief executive officer of S, for which S pays V $*w* in salary and benefits. V also serves as a voting member of P's governing body. Consequently, V is a disqualified person with respect to P. P provides V with $*x* representing compensation for the services V provides P as a member of its governing body. Although $*x* represents reasonable compensation for the services V provides directly to P as a member of its governing body, the total compensation of $*w* + $*x* exceeds reasonable compensation for the services V provides to P and S collectively. Therefore, the portion of total compensation that exceeds reasonable compensation is an excess benefit provided to V.

Example 4. G is an applicable tax-exempt organization for section 4958 purposes. F is a disqualified person who was last employed by G in a position of substantial influence three years ago. H is an entity engaged in scientific research and is unrelated to either F or G. G makes a grant to H to fund a research position. H subsequently advertises for qualified candidates for the research position. F is among several highly qualified candidates who apply for the research position. H hires F. There was no evidence of an oral or written agreement or understanding with G that H will use G's grant to provide economic benefits to or for the use of F. Although G provided economic benefits to H, and in connection with the receipt of such benefits, H will provide economic benefits to or for the use of F, H acted with a significant business purpose or exempt purpose of its own. Under these facts, G did not provide an economic benefit to F indirectly through the use of an intermediary.

(3) *Exception for fixed payments made pursuant to an initial contract*—(i) *In general*. Except as provided in paragraph (a)(3)(iv) of this section, section 4958 does not apply to any fixed payment made to a person pursuant to an initial contract.

(ii) *Fixed payment*—(A) *In general.* For purposes of paragraph (a)(3)(i) of this section, *fixed payment* means an amount of cash or other property specified in the contract, or determined by a fixed formula specified in the contract, which is to be paid or transferred in exchange for the provision of specified services or property. A fixed formula may incorporate an amount that depends upon future specified events or contingencies, provided that no person exercises discretion when calculating the amount of a payment or deciding whether to make a payment (such as a bonus). A specified event or contingency may include the amount of revenues generated by (or other objective measure of) one or more activities of the applicable tax-exempt organization. A fixed payment does not include any amount paid to a person under a reimbursement (or similar) arrangement where discretion is exercised by any person with respect to the amount of expenses incurred or reimbursed.

(B) *Special rules.* Amounts payable pursuant to a qualified pension, profit-sharing, or stock bonus plan under section 401(a), or pursuant to an employee benefit program that is subject to and satisfies coverage and nondiscrimination rules under the Internal Revenue Code (e.g., sections 127 and 137), other than nondiscrimination rules under section 9802, are treated as fixed payments for purposes of this section, regardless of the applicable tax-exempt organization's discretion with respect to the plan or program. The fact that a person contracting with an applicable tax-exempt organization is expressly granted the choice whether to accept or reject any economic benefit is disregarded in determining whether the benefit constitutes a fixed payment for purposes of this paragraph.

(iii) *Initial contract.* For purposes of paragraph (a)(3)(i) of this section, *initial contract* means a binding written contract between an applicable tax-exempt organization and a person who was not a disqualified person within the meaning of section 4958(f)(1) and § 53.4958–3 immediately prior to entering into the contract.

(iv) *Substantial performance required.* Paragraph (a)(3)(i) of this section does not apply to any fixed payment made pursuant to the initial contract during any taxable year of the person contracting with the applicable tax-exempt organization if the person fails to perform substantially the person's obligations under the initial contract during that year.

(v) *Treatment as a new contract.* A written binding contract that provides that the contract is terminable or subject to cancellation by the applicable tax-exempt organization (other than as a result of a lack of substantial performance by the disqualified person, as described in paragraph (a)(3)(iv) of this section) without the other party's consent and without substantial penalty to the organization is treated as a new contract as of the earliest date that any such termination or cancellation, if made, would be effective. Additionally, if the parties make a material change to a contract, it is treated as a new contract as of the date the material change is effective. A material change includes an extension or renewal of the contract (other than an extension or renewal that results from the person contracting with the applicable tax-exempt organization unilaterally exercising an option expressly granted by the contract), or a more than incidental change to any amount payable under the contract. The new contract is tested under paragraph (a)(3)(iii) of this section to determine whether it is an initial contract for purposes of this section.

(vi) *Evaluation of non-fixed payments.* Any payment that is not a fixed payment (within the meaning of paragraph (a)(3)(ii) of this section) is evaluated to determine whether it constitutes an excess benefit transaction under section 4958. In making this determination, all payments and consideration exchanged between the parties are taken into account, including any fixed payments made pursuant to an initial contract with respect to which section 4958 does not apply.

(vii) *Examples.* The following examples illustrate the rules governing fixed payments made pursuant to an initial contract. Unless otherwise stated, assume that the person contracting with the applicable tax-exempt organization has performed substantially the person's obligations under the contract

with respect to the payment. The examples are as follows:

Example 1. T is an applicable tax-exempt organization for purposes of section 4958. On January 1, 2002, T hires S as its chief financial officer by entering into a five-year written employment contract with S. S was not a disqualified person within the meaning of section 4958(f)(1) and § 53.4958–3 immediately prior to entering into the January 1, 2002, contract (initial contract). S's duties and responsibilities under the contract make S a disqualified person with respect to T (see § 53.4958–3(c)(3)). Under the initial contract, T agrees to pay S an annual salary of $200,000, payable in monthly installments. The contract provides that, beginning in 2003, S's annual salary will be adjusted by the increase in the Consumer Price Index (CPI) for the prior year. Section 4958 does not apply because S's compensation under the contract is a fixed payment pursuant to an initial contract within the meaning of paragraph (a)(3) of this section. Thus, for section 4958 purposes, it is unnecessary to evaluate whether any portion of the compensation paid to S pursuant to the initial contract is an excess benefit transaction.

Example 2. The facts are the same as in *Example 1,* except that the initial contract provides that, in addition to a base salary of $200,000, T may pay S an annual performance-based bonus. The contract provides that T's governing body will determine the amount of the annual bonus as of the end of each year during the term of the contract, based on the board's evaluation of S's performance, but the bonus cannot exceed $100,000 per year. Unlike the base salary portion of S's compensation, the bonus portion of S's compensation is not a fixed payment pursuant to an initial contract, because the governing body has discretion over the amount, if any, of the bonus payment. Section 4958 does not apply to payment of the $200,000 base salary (as adjusted for inflation), because it is a fixed payment pursuant to an initial contract within the meaning of paragraph (a)(3) of this section. By contrast, the annual bonuses that may be paid to S under the initial contract are not protected by the initial contract exception. Therefore, each bonus payment will be evaluated under section 4958, taking into account all payments and consideration exchanged between the parties.

Example 3. The facts are the same as in *Example 1,* except that in 2003, T changes its payroll system, such that T makes biweekly, rather than monthly, salary payments to its employees. Beginning in 2003, T also grants its employees an additional two days of paid vacation each year. Neither change is a material change to S's initial contract within the meaning of paragraph (a)(3)(v) of this section. Therefore, section 4958 does not apply to the base salary payments to S due to the initial contract exception.

Example 4. The facts are the same as in *Example 1,* except that on January 1, 2003, S becomes the chief executive officer of T and a new chief financial officer is hired. At the same time, T's board of directors approves an increase in S's annual base salary from $200,000 to $240,000, effective on that day. These changes in S's employment relationship constitute material changes of the initial contract within the meaning of paragraph (a)(3)(v) of this section. As a result, S is treated as entering into a new contract with T on January 1, 2003, at which time S is a disqualified person within the meaning of section 4958(f)(1) and § 53.4958–3. T's payments to S made pursuant to the new contract will be evaluated under section 4958, taking into account all payments and consideration exchanged between the parties.

Example 5. J is a performing arts organization and an applicable tax-exempt organization for purposes of section 4958. J hires W to become the chief executive officer of J. W was not a disqualified person within the meaning of section 4958(f)(1) and § 53.4958–3 immediately prior to entering into the employment contract with J. As a result of this employment contract, W's duties and responsibilities make W a disqualified person with respect to J (see § 53.4958–3(c)(2)). Under the contract, J will pay W $*x* (a specified amount) plus a bonus equal to 2 percent of the total season subscription sales that exceed $*100z*. The $*x* base salary is a fixed payment pursuant to an initial contract within the meaning of paragraph (a)(3) of this section. The bonus payment is also a fixed payment pursuant to an initial contract within the meaning of paragraph (a)(3) of this section, because no person exercises discretion when calculating the amount of the bonus payment or deciding whether the bonus will be paid. Therefore, section 4958 does not apply to any of J's payments to W pursuant to the employment contract due to the initial contract exception.

Example 6. Hospital B is an applicable tax-exempt organization for purposes of section 4958. Hospital B hires E as its chief operating officer. E was not a disqualified person within the meaning of section 4958(f)(1) and § 53.4958–3 immediately prior to entering into the employment contract with Hospital B. As a result of this employment contract, E's duties and responsibilities make E a disqualified person with respect to Hospital B (see § 53.4958–3(c)(2)). E's initial employment contract provides that E will have authority to enter into hospital management arrangements on behalf of Hospital B. In E's personal capacity, E owns more than 35 percent of the combined voting power of Company X. Consequently, at the time E becomes a disqualified person with respect to B, Company

X also becomes a disqualified person with respect to B (see § 53.4958–3(b)(2)(i)(A)). E, acting on behalf of Hospital B as chief operating officer, enters into a contract with Company X under which Company X will provide billing and collection services to Hospital B. The initial contract exception of paragraph (a)(3)(i) of this section does not apply to the billing and collection services contract, because at the time that this contractual arrangement was entered into, Company X was a disqualified person with respect to Hospital B. Although E's employment contract (which is an initial contract) authorizes E to enter into hospital management arrangements on behalf of Hospital B, the payments made to Company X are not made pursuant to E's employment contract, but rather are made by Hospital B pursuant to a separate contractual arrangement with Company X. Therefore, even if payments made to Company X under the billing and collection services contract are fixed payments (within the meaning of paragraph (a)(3)(ii) of this section), section 4958 nonetheless applies to payments made by Hospital B to Company X because the billing and collection services contract itself does not constitute an initial contract under paragraph (a)(3)(iii) of this section. Accordingly, all payments made to Company X under the billing and collection services contract will be evaluated under section 4958.

Example 7. Hospital C, an applicable tax-exempt organization, enters into a contract with Company Y, under which Company Y will provide a wide range of hospital management services to Hospital C. Upon entering into this contractual arrangement, Company Y becomes a disqualified person with respect to Hospital C. The contract provides that Hospital C will pay Company Y a management fee of *x* percent of adjusted gross revenue (*i.e.*, gross revenue increased by the cost of charity care provided to indigents) annually for a five-year period. The management services contract specifies the cost accounting system and the standards for *indigents* to be used in calculating the cost of charity care. The cost accounting system objectively defines the direct and indirect costs of all health care goods and services provided as charity care. Because Company Y was not a disqualified person with respect to Hospital C immediately before entering into the management services contract, that contract is an initial contract within the meaning of paragraph (a)(3)(iii) of this section. The annual management fee paid to Company Y is determined by a fixed formula specified in the contract, and is therefore a fixed payment within the meaning of paragraph (a)(3)(ii) of this section. Accordingly, section 4958 does not apply to the annual management fee due to the initial contract exception.

Example 8. The facts are the same as in *Example 7*, except that the management services contract also provides that Hospital C will reimburse Company Y on a monthly basis for certain expenses incurred by Company Y that are attributable to management services provided to Hospital C (e.g., legal fees and travel expenses). Although the management fee itself is a fixed payment not subject to section 4958, the reimbursement payments that Hospital C makes to Company Y for the various expenses covered by the contract are not fixed payments within the meaning of paragraph (a)(3)(ii) of this section, because Company Y exercises discretion with respect to the amount of expenses incurred. Therefore, any reimbursement payments that Hospital C pays pursuant to the contract will be evaluated under section 4958.

Example 9. X, an applicable tax-exempt organization for purposes of section 4958, hires C to conduct scientific research. On January 1, 2003, C enters into a three-year written employment contract with X (initial contract). Under the terms of the contract, C is required to work full-time at X's laboratory for a fixed annual salary of $90,000. Immediately prior to entering into the employment contract, C was not a disqualified person within the meaning of section 4958(f)(1) and § 53.4958–3, nor did C become a disqualified person pursuant to the initial contract. However, two years after joining X, C marries D, who is the child of X's president. As D's spouse, C is a disqualified person within the meaning of section 4958(f)(1) and § 53.4958–3 with respect to X. Nonetheless, section 4958 does not apply to X's salary payments to C due to the initial contract exception.

Example 10. The facts are the same as in *Example 9*, except that the initial contract included a below-market loan provision under which C has the unilateral right to borrow up to a specified dollar amount from X at a specified interest rate for a specified term. After C's marriage to D, C borrows money from X to purchase a home under the terms of the initial contract. Section 4958 does not apply to X's loan to C due to the initial contract exception.

Example 11. The facts are the same as in *Example 9*, except that after C's marriage to D, C works only sporadically at the laboratory, and performs no other services for X. Notwithstanding that C fails to perform substantially C's obligations under the initial contract, X does not exercise its right to terminate the initial contract for nonperformance and continues to pay full salary to C. Pursuant to paragraph (a)(3)(iv) of this section, the initial contract exception does not apply to any payments made pursuant to the initial contract during any taxable year of C in which C fails to perform substantially C's obligations under the initial contract.

(4) *Certain economic benefits disregarded for purposes of section 4958.* The following economic benefits are disregarded for purposes of section 4958—

(i) *Nontaxable fringe benefits.* An economic benefit that is excluded from income under section 132, except any liability insurance premium, payment, or reimbursement that must be taken into account under paragraph (b)(1)(ii)(B)(*2*) of this section;

(ii) *Expense reimbursement payments pursuant to accountable plans.* Amounts paid under reimbursement arrangements that meet the requirements of § 1.62–2(c) of this chapter;

(iii) *Certain economic benefits provided to a volunteer for the organization.* An economic benefit provided to a volunteer for the organization if the benefit is provided to the general public in exchange for a membership fee or contribution of $75 or less per year;

(iv) *Certain economic benefits provided to a member of, or donor to, the organization.* An economic benefit provided to a member of an organization solely on account of the payment of a membership fee, or to a donor solely on account of a contribution for which a deduction is allowable under section 170 (charitable contribution), regardless of whether the donor is eligible to claim the deduction, if—

(A) Any non-disqualified person paying a membership fee or making a charitable contribution above a specified amount to the organization is given the option of receiving substantially the same economic benefit; and

(B) The disqualified person and a significant number of non-disqualified persons make a payment or charitable contribution of at least the specified amount;

(v) *Economic benefits provided to a charitable beneficiary.* An economic benefit provided to a person solely because the person is a member of a charitable class that the applicable tax-exempt organization intends to benefit as part of the accomplishment of the organization's exempt purpose; and

(vi) *Certain economic benefits provided to a governmental unit.* Any transfer of an economic benefit to or for the use of a governmental unit defined in section 170(c)(1), if the transfer is for exclusively public purposes.

(5) *Exception for certain payments made pursuant to an exemption granted by the Department of Labor under ERISA.* Section 4958 does not apply to any payment made pursuant to, and in accordance with, a final individual prohibited transaction exemption issued by the Department of Labor under section 408(a) of the Employee Retirement Income Security Act of 1974 (88 Stat. 854) (ERISA) with respect to a transaction involving a plan (as defined in section 3(3) of ERISA) that is an applicable tax exempt organization.

(b) *Valuation standards*—(1) *In general.* This section provides rules for determining the value of economic benefits for purposes of section 4958.

(i) *Fair market value of property.* The value of property, including the right to use property, for purposes of section 4958 is the fair market value (*i.e.*, the price at which property or the right to use property would change hands between a willing buyer and a willing seller, neither being under any compulsion to buy, sell or transfer property or the right to use property, and both having reasonable knowledge of relevant facts).

(ii) *Reasonable compensation*—(A) *In general.* The value of services is the amount that would ordinarily be paid for like services by like enterprises (whether taxable or tax-exempt) under like circumstances (*i.e.*, reasonable compensation). Section 162 standards apply in determining reasonableness of compensation, taking into account the aggregate benefits (other than any benefits specifically disregarded under paragraph (a)(4) of this section) provided to a person and the rate at which any deferred compensation accrues. The fact that a compensation arrangement is subject to a cap is a relevant factor in determining the reasonableness of compensation. The fact that a State or local legislative or agency body or court has authorized or approved a particular compensation package paid to a disqualified person is not determinative of the reasonableness of compensation for purposes of section 4958.

(B) *Items included in determining the value of compensation for purposes of determining reasonableness under section 4958.* Except for economic benefits that

are disregarded for purposes of section 4958 under paragraph (a)(4) of this section, compensation for purposes of determining reasonableness under section 4958 includes all economic benefits provided by an applicable tax-exempt organization in exchange for the performance of services. These benefits include, but are not limited to—

(*1*) All forms of cash and noncash compensation, including salary, fees, bonuses, severance payments, and deferred and noncash compensation described in § 53.4958–1(e)(2);

(*2*) Unless excludable from income as a *de minimis* fringe benefit pursuant to section 132(a)(4), the payment of liability insurance premiums for, or the payment or reimbursement by the organization of—

(*i*) Any penalty, tax, or expense of correction owed under section 4958;

(*ii*) Any expense not reasonably incurred by the person in connection with a civil judicial or civil administrative proceeding arising out of the person's performance of services on behalf of the applicable tax-exempt organization; or

(*iii*) Any expense resulting from an act or failure to act with respect to which the person has acted willfully and without reasonable cause; and

(*3*) All other compensatory benefits, whether or not included in gross income for income tax purposes, including payments to welfare benefit plans, such as plans providing medical, dental, life insurance, severance pay, and disability benefits, and both taxable and nontaxable fringe benefits (other than fringe benefits described in section 132), including expense allowances or reimbursements (other than expense reimbursements pursuant to an accountable plan that meets the requirements of § 1.62–2(c)), and the economic benefit of a below-market loan (within the meaning of section 7872(e)(1)). (For this purpose, the economic benefit of a below-market loan is the amount deemed transferred to the disqualified person under section 7872(a) or (b), regardless of whether section 7872 otherwise applies to the loan).

(C) *Inclusion in compensation for reasonableness determination does not govern income tax treatment*. The determination of whether any item listed in paragraph (b)(1)(ii)(B) of this section is included in the disqualified person's gross income for income tax purposes is made on the basis of the provisions of chapter 1 of Subtitle A of the Internal Revenue Code, without regard to whether the item is taken into account for purposes of determining reasonableness of compensation under section 4958.

(2) *Timing of reasonableness determination*—(i) *In general*. The facts and circumstances to be taken into consideration in determining reasonableness of a fixed payment (within the meaning of paragraph (a)(3)(ii) of this section) are those existing on the date the parties enter into the contract pursuant to which the payment is made. However, in the event of substantial non-performance, reasonableness is determined based on all facts and circumstances, up to and including circumstances as of the date of payment. In the case of any payment that is not a fixed payment under a contract, reasonableness is determined based on all facts and circumstances, up to and including circumstances as of the date of payment. In no event shall circumstances existing at the date when the payment is questioned be considered in making a determination of the reasonableness of the payment. These general timing rules also apply to property subject to a substantial risk of forfeiture. Therefore, if the property subject to a substantial risk of forfeiture satisfies the definition of fixed payment (within the meaning of paragraph (a)(3)(ii) of this section), reasonableness is determined at the time the parties enter into the contract providing for the transfer of the property. If the property is not a fixed payment, then reasonableness is determined based on all facts and circumstances up to and including circumstances as of the date of payment.

(ii) *Treatment as a new contract*. For purposes of paragraph (b)(2)(i) of this section, a written binding contract that provides that the contract is terminable or subject to cancellation by the applicable tax-exempt organization without the other party's consent and without substantial penalty to the organization is treated as a new contract as of the earliest date that any such

termination or cancellation, if made, would be effective. Additionally, if the parties make a material change to a contract (within the meaning of paragraph (a)(3)(v) of this section), it is treated as a new contract as of the date the material change is effective.

(iii) *Examples*. The following examples illustrate the timing of the reasonableness determination under the rules of this paragraph (b)(2):

Example 1. G is an applicable tax-exempt organization for purposes of section 4958. H is an employee of G and a disqualified person with respect to G. H's new multi-year employment contract provides for payment of a salary and provision of specific benefits pursuant to a qualified pension plan under section 401(a) and an accident and health plan that meets the requirements of section 105(h)(2). The contract provides that H's salary will be adjusted by the increase in the Consumer Price Index (CPI) for the prior year. The contributions G makes to the qualified pension plan are equal to the maximum amount G is permitted to contribute under the rules applicable to qualified plans. Under these facts, all items comprising H's total compensation are treated as fixed payments within the meaning of paragraph (a)(3)(ii) of this section. Therefore, the reasonableness of H's compensation is determined based on the circumstances existing at the time G and H enter into the employment contract.

Example 2. The facts are the same as in *Example 1*, except that the multi-year employment contract provides, in addition, that G will transfer title to a car to H under the condition that if H fails to complete *x* years of service with G, title to the car will be forfeited back to G. All relevant information about the type of car to be provided (including the make, model, and year) is included in the contract. Although ultimate vesting of title to the car is contingent on H continuing to work for G for *x* years, the amount of property to be vested (*i.e.*, the type of car) is specified in the contract, and no person exercises discretion regarding the type of property or whether H will retain title to the property at the time of vesting. Under these facts, the car is a fixed payment within the meaning of paragraph (a)(3)(ii) of this section. Therefore, the reasonableness of H's compensation, including the value of the car, is determined based on the circumstances existing at the time G and H enter into the employment contract.

Example 3. N is an applicable tax-exempt organization for purposes of section 4958. On January 2, N's governing body enters into a new one-year employment contract with K, its executive director, who is a disqualified person with respect to N. The contract provides that K will receive a specified amount of salary, contributions to a qualified pension plan under section 401(a), and other benefits pursuant to a section 125 cafeteria plan. In addition, the contract provides that N's governing body may, in its discretion, declare a bonus to be paid to K at any time during the year covered by the contract. K's salary and other specified benefits constitute fixed payments within the meaning of paragraph (a)(3)(ii) of this section. Therefore, the reasonableness of those economic benefits is determined on the date when the contract was made. However, because the bonus payment is not a fixed payment within the meaning of paragraph (a)(3)(ii) of this section, the determination of whether any bonus awarded to N is reasonable must be made based on all facts and circumstances (including all payments and consideration exchanged between the parties), up to and including circumstances as of the date of payment of the bonus.

(c) *Establishing intent to treat economic benefit as consideration for the performance of services*—(1) *In general*. An economic benefit is not treated as consideration for the performance of services unless the organization providing the benefit clearly indicates its intent to treat the benefit as compensation when the benefit is paid. Except as provided in paragraph (c)(2) of this section, an applicable tax-exempt organization (or entity controlled by an applicable tax-exempt organization, within the meaning of paragraph (a)(2)(ii)(B) of this section) is treated as clearly indicating its intent to provide an economic benefit as compensation for services only if the organization provides written substantiation that is contemporaneous with the transfer of the economic benefit at issue. If an organization fails to provide this contemporaneous substantiation, any services provided by the disqualified person will not be treated as provided in consideration for the economic benefit for purposes of determining the reasonableness of the transaction. In no event shall an economic benefit that a disqualified person obtains by theft or fraud be treated as consideration for the performance of services.

(2) *Nontaxable benefits*. For purposes of section 4958(c)(1)(A) and this section, an applicable tax-exempt organization is not required to indicate its intent to provide an economic benefit as compensation for services if the economic

benefit is excluded from the disqualified person's gross income for income tax purposes on the basis of the provisions of chapter 1 of Subtitle A of the Internal Revenue Code. Examples of these benefits include, but are not limited to, employer-provided health benefits and contributions to a qualified pension, profit-sharing, or stock bonus plan under section 401(a), and benefits described in sections 127 and 137. However, except for economic benefits that are disregarded for purposes of section 4958 under paragraph (a)(4) of this section, all compensatory benefits (regardless of the Federal income tax treatment) provided by an organization in exchange for the performance of services are taken into account in determining the reasonableness of a person's compensation for purposes of section 4958.

(3) *Contemporaneous substantiation*—(i) *Reporting of benefit*—(A) *In general.* An applicable tax-exempt organization provides contemporaneous written substantiation of its intent to provide an economic benefit as compensation if—

(*1*) The organization reports the economic benefit as compensation on an original Federal tax information return with respect to the payment (e.g., Form W-2, ''Wage and Tax Statement'', or Form 1099, ''Miscellaneous Income'') or with respect to the organization (e.g., Form 990, ''Return of Organization Exempt From Income Tax''), or on an amended Federal tax information return filed prior to the commencement of an Internal Revenue Service examination of the applicable tax-exempt organization or the disqualified person for the taxable year in which the transaction occurred (as determined under § 53.4958–1(e)); or

(*2*) The recipient disqualified person reports the benefit as income on the person's original Federal tax return (e.g., Form 1040, ''U.S. Individual Income Tax Return''), or on the person's amended Federal tax return filed prior to the earlier of the following dates—

(*i*) Commencement of an Internal Revenue Service examination described in paragraph (c)(3)(i)(A)(*1*) of this section; or

(*ii*) The first documentation in writing by the Internal Revenue Service of a potential excess benefit transaction involving either the applicable tax-exempt organization or the disqualified person.

(B) *Failure to report due to reasonable cause.* If an applicable tax-exempt organization's failure to report an economic benefit as required under the Internal Revenue Code is due to reasonable cause (within the meaning of § 301.6724–1 of this chapter), then the organization will be treated as having clearly indicated its intent to provide an economic benefit as compensation for services. To show that its failure to report an economic benefit that should have been reported on an information return was due to reasonable cause, an applicable tax-exempt organization must establish that there were significant mitigating factors with respect to its failure to report (as described in § 301.6724–1(b) of this chapter), or the failure arose from events beyond the organization's control (as described in § 301.6724–1(c) of this chapter), and that the organization acted in a responsible manner both before and after the failure occurred (as described in § 301.6724–1(d) of this chapter).

(ii) *Other written contemporaneous evidence.* In addition, other written contemporaneous evidence may be used to demonstrate that the appropriate decision-making body or an officer authorized to approve compensation approved a transfer as compensation for services in accordance with established procedures, including but not limited to—

(A) An approved written employment contract executed on or before the date of the transfer;

(B) Documentation satisfying the requirements of § 53.4958–6(a)(3) indicating that an authorized body approved the transfer as compensation for services on or before the date of the transfer; or

(C) Written evidence that was in existence on or before the due date of the applicable Federal tax return described in paragraph (c)(3)(i)(A)(*1*) or (*2*) of this section (including extensions but not amendments), of a reasonable belief by the applicable tax-exempt organization that a benefit was a nontaxable benefit as defined in paragraph (c)(2) of this section.

(4) *Examples*. The following examples illustrate the requirement that an organization contemporaneously substantiate its intent to provide an economic benefit as compensation for services, as defined in paragraph (c) of this section:

Example 1. G is an applicable tax-exempt organization for purposes of section 4958. G hires an individual contractor, P, who is also the child of a disqualified person of G, to design a computer program for it. G executes a contract with P for that purpose in accordance with G's established procedures, and pays P $1,000 during the year pursuant to the contract. Before January 31 of the next year, G reports the full amount paid to P under the contract on a Form 1099 filed with the Internal Revenue Service. G will be treated as providing contemporaneous written substantiation of its intent to provide the $1,000 paid to P as compensation for the services P performed under the contract by virtue of either the Form 1099 filed with the Internal Revenue Service reporting the amount, or by virtue of the written contract executed between G and P.

Example 2. G is an applicable tax-exempt organization for purposes of section 4958. D is the chief operating officer of G, and a disqualified person with respect to G. D receives a bonus at the end of the year. G's accounting department determines that the bonus is to be reported on D's Form W-2. Due to events beyond G's control, the bonus is not reflected on D's Form W-2. As a result, D fails to report the bonus on D's individual income tax return. G acts to amend Forms W-2 affected as soon as G is made aware of the error during an Internal Revenue Service examination. G's failure to report the bonus on an information return issued to D arose from events beyond G's control, and G acted in a responsible manner both before and after the failure occurred. Thus, because G had reasonable cause (within the meaning § 301.6724–1 of this chapter) for failing to report D's bonus, G will be treated as providing contemporaneous written substantiation of its intent to provide the bonus as compensation for services when paid.

Example 3. H is an applicable tax-exempt organization and J is a disqualified person with respect to H. J's written employment agreement provides for a fixed salary of $*y*. J's duties include soliciting funds for various programs of H. H raises a large portion of its funds in a major metropolitan area. Accordingly, H maintains an apartment there in order to provide a place to entertain potential donors. H makes the apartment available exclusively to J to assist in the fundraising. J's written employment contract does not mention the use of the apartment. H obtains the written opinion of a benefits compensation expert that the rental value of the apartment is not includable in J's income by reason of section 119, based on the expectation that the apartment will be used for fundraising activities. Consequently, H does not report the rental value of the apartment on J's Form W-2, which otherwise correctly reports J's taxable compensation. J does not report the rental value of the apartment on J's individual Form 1040. Later, the Internal Revenue Service correctly determines that the requirements of section 119 were not satisfied. Because of the written expert opinion, H has written evidence of its reasonable belief that use of the apartment was a nontaxable benefit as defined in paragraph (c)(2) of this section. That evidence was in existence on or before the due date of the applicable Federal tax return. Therefore, H has demonstrated its intent to treat the use of the apartment as compensation for services performed by J.

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§ 53.4958–5 Transaction in which the amount of the economic benefit is determined in whole or in part by the revenues of one or more activities of the organization. [Reserved]

§ 53.4958–6 Rebuttable presumption that a transaction is not an excess benefit transaction.

(a) *In general*. Payments under a compensation arrangement are presumed to be reasonable, and a transfer of property, or the right to use property, is presumed to be at fair market value, if the following conditions are satisfied—

(1) The compensation arrangement or the terms of the property transfer are approved in advance by an authorized body of the applicable tax-exempt organization (or an entity controlled by the organization within the meaning of § 53.4958–4(a)(2)(ii)(B)) composed entirely of individuals who do not have a conflict of interest (within the meaning of paragraph (c)(1)(iii) of this section) with respect to the compensation arrangement or property transfer, as described in paragraph (c)(1) of this section;

(2) The authorized body obtained and relied upon appropriate data as to comparability prior to making its determination, as described in paragraph (c)(2) of this section; and

(3) The authorized body adequately documented the basis for its determination concurrently with making that determination, as described in paragraph (c)(3) of this section.

(b) *Rebutting the presumption.* If the three requirements of paragraph (a) of this section are satisfied, then the Internal Revenue Service may rebut the presumption that arises under paragraph (a) of this section only if it develops sufficient contrary evidence to rebut the probative value of the comparability data relied upon by the authorized body. With respect to any fixed payment (within the meaning of § 53.4958–4(a)(3)(ii)), rebuttal evidence is limited to evidence relating to facts and circumstances existing on the date the parties enter into the contract pursuant to which the payment is made (except in the event of substantial nonperformance). With respect to all other payments (including non-fixed payments subject to a cap, as described in paragraph (d)(2) of this section), rebuttal evidence may include facts and circumstances up to and including the date of payment. See § 53.4958–4(b)(2)(i).

(c) *Requirements for invoking rebuttable presumption*—(1) *Approval by an authorized body*—(i) *In general.* An authorized body means—

(A) The governing body (*i.e.*, the board of directors, board of trustees, or equivalent controlling body) of the organization;

(B) A committee of the governing body, which may be composed of any individuals permitted under State law to serve on such a committee, to the extent that the committee is permitted by State law to act on behalf of the governing body; or

(C) To the extent permitted under State law, other parties authorized by the governing body of the organization to act on its behalf by following procedures specified by the governing body in approving compensation arrangements or property transfers.

(ii) *Individuals not included on authorized body.* For purposes of determining whether the requirements of paragraph (a) of this section have been met with respect to a specific compensation arrangement or property transfer, an individual is not included on the authorized body when it is reviewing a transaction if that individual meets with other members only to answer questions, and otherwise recuses himself or herself from the meeting and is not present during debate and voting on the compensation arrangement or property transfer.

(iii) *Absence of conflict of interest.* A member of the authorized body does not have a conflict of interest with respect to a compensation arrangement or property transfer only if the member—

(A) Is not a disqualified person participating in or economically benefitting from the compensation arrangement or property transfer, and is not a member of the family of any such disqualified person, as described in section 4958(f)(4) or § 53.4958–3(b)(1);

(B) Is not in an employment relationship subject to the direction or control of any disqualified person participating in or economically benefitting from the compensation arrangement or property transfer;

(C) Does not receive compensation or other payments subject to approval by any disqualified person participating in or economically benefitting from the compensation arrangement or property transfer;

(D) Has no material financial interest affected by the compensation arrangement or property transfer; and

(E) Does not approve a transaction providing economic benefits to any disqualified person participating in the compensation arrangement or property transfer, who in turn has approved or will approve a transaction providing economic benefits to the member.

(2) *Appropriate data as to comparability*—(i) *In general.* An authorized body has appropriate data as to comparability if, given the knowledge and expertise of its members, it has information sufficient to determine whether, under the standards set forth in § 53.4958–4(b), the compensation arrangement in its entirety is reasonable or the property transfer is at fair market value. In the case of compensation, relevant information includes, but is not limited to, compensation levels paid by similarly situated organizations, both taxable and tax-exempt, for functionally comparable positions; the availability of similar services in the

geographic area of the applicable tax-exempt organization; current compensation surveys compiled by independent firms; and actual written offers from similar institutions competing for the services of the disqualified person. In the case of property, relevant information includes, but is not limited to, current independent appraisals of the value of all property to be transferred; and offers received as part of an open and competitive bidding process.

(ii) *Special rule for compensation paid by small organizations.* For organizations with annual gross receipts (including contributions) of less than $1 million reviewing compensation arrangements, the authorized body will be considered to have appropriate data as to comparability if it has data on compensation paid by three comparable organizations in the same or similar communities for similar services. No inference is intended with respect to whether circumstances falling outside this safe harbor will meet the requirement with respect to the collection of appropriate data.

(iii) *Application of special rule for small organizations.* For purposes of determining whether the special rule for small organizations described in paragraph (c)(2)(ii) of this section applies, an organization may calculate its annual gross receipts based on an average of its gross receipts during the three prior taxable years. If any applicable tax-exempt organization is controlled by or controls another entity (as defined in § 53.4958–4(a)(2)(ii)(B)), the annual gross receipts of such organizations must be aggregated to determine applicability of the special rule stated in paragraph (c)(2)(ii) of this section.

(iv) *Examples.* The following examples illustrate the rules for appropriate data as to comparability for purposes of invoking the rebuttable presumption of reasonableness described in this section. In all examples, compensation refers to the aggregate value of all benefits provided in exchange for services. The examples are as follows:

Example 1. Z is a university that is an applicable tax-exempt organization for purposes of section 4958. Z is negotiating a new contract with Q, its president, because the old contract will expire at the end of the year. In setting Q's compensation for its president at $*600x* per annum, the executive committee of the Board of Trustees relies solely on a national survey of compensation for university presidents that indicates university presidents receive annual compensation in the range of $*100x* to $*700x*; this survey does not divide its data by any criteria, such as the number of students served by the institution, annual revenues, academic ranking, or geographic location. Although many members of the executive committee have significant business experience, none of the members has any particular expertise in higher education compensation matters. Given the failure of the survey to provide information specific to universities comparable to Z, and because no other information was presented, the executive committee's decision with respect to Q's compensation was not based upon appropriate data as to comparability.

Example 2. The facts are the same as *Example 1,* except that the national compensation survey divides the data regarding compensation for university presidents into categories based on various university-specific factors, including the size of the institution (in terms of the number of students it serves and the amount of its revenues) and geographic area. The survey data shows that university presidents at institutions comparable to and in the same geographic area as Z receive annual compensation in the range of $*200x* to $*300x*. The executive committee of the Board of Trustees of Z relies on the survey data and its evaluation of Q's many years of service as a tenured professor and high-ranking university official at Z in setting Q's compensation at $*275x* annually. The data relied upon by the executive committee constitutes appropriate data as to comparability.

Example 3. X is a tax-exempt hospital that is an applicable tax-exempt organization for purposes of section 4958. Before renewing the contracts of X's chief executive officer and chief financial officer, X's governing board commissioned a customized compensation survey from an independent firm that specializes in consulting on issues related to executive placement and compensation. The survey covered executives with comparable responsibilities at a significant number of taxable and tax-exempt hospitals. The survey data are sorted by a number of different variables, including the size of the hospitals and the nature of the services they provide, the level of experience and specific responsibilities of the executives, and the composition of the annual compensation packages. The board members were provided with the survey results, a detailed written analysis comparing the hospital's executives to those covered by the survey, and an opportunity to ask questions of a member of the firm that prepared the survey. The survey, as prepared

and presented to X's board, constitutes appropriate data as to comparability.

Example 4. The facts are the same as *Example 3*, except that one year later, X is negotiating a new contract with its chief executive officer. The governing board of X obtains information indicating that the relevant market conditions have not changed materially, and possesses no other information indicating that the results of the prior year's survey are no longer valid. Therefore, X may continue to rely on the independent compensation survey prepared for the prior year in setting annual compensation under the new contract.

Example 5. W is a local repertory theater and an applicable tax-exempt organization for purposes of section 4958. W has had annual gross receipts ranging from $400,000 to $800,000 over its past three taxable years. In determining the next year's compensation for W's artistic director, the board of directors of W relies on data compiled from a telephone survey of three other unrelated performing arts organizations of similar size in similar communities. A member of the board drafts a brief written summary of the annual compensation information obtained from this informal survey. The annual compensation information obtained in the telephone survey is appropriate data as to comparability.

(3) *Documentation*—(i) For a decision to be documented adequately, the written or electronic records of the authorized body must note—

(A) The terms of the transaction that was approved and the date it was approved;

(B) The members of the authorized body who were present during debate on the transaction that was approved and those who voted on it;

(C) The comparability data obtained and relied upon by the authorized body and how the data was obtained; and

(D) Any actions taken with respect to consideration of the transaction by anyone who is otherwise a member of the authorized body but who had a conflict of interest with respect to the transaction.

(ii) If the authorized body determines that reasonable compensation for a specific arrangement or fair market value in a specific property transfer is higher or lower than the range of comparability data obtained, the authorized body must record the basis for its determination. For a decision to be documented concurrently, records must be prepared before the later of the next meeting of the authorized body or 60 days after the final action or actions of the authorized body are taken. Records must be reviewed and approved by the authorized body as reasonable, accurate and complete within a reasonable time period thereafter.

(d) *No presumption with respect to non-fixed payments until amounts are determined*—(1) *In general.* Except as provided in paragraph (d)(2) of this section, in the case of a payment that is not a fixed payment (within the meaning of § 53.4958–4(a)(3)(ii)), the rebuttable presumption of this section arises only after the exact amount of the payment is determined, or a fixed formula for calculating the payment is specified, and the three requirements for the presumption under paragraph (a) of this section subsequently are satisfied. See § 53.4958–4(b)(2)(i).

(2) *Special rule for certain non-fixed payments subject to a cap.* If the authorized body approves an employment contract with a disqualified person that includes a non-fixed payment (such as a discretionary bonus) subject to a specified cap, the authorized body may establish a rebuttable presumption with respect to the non-fixed payment at the time the employment contract is entered into if—

(i) Prior to approving the contract, the authorized body obtains appropriate comparability data indicating that a fixed payment of up to a certain amount to the particular disqualified person would represent reasonable compensation;

(ii) The maximum amount payable under the contract (taking into account both fixed and non-fixed payments) does not exceed the amount referred to in paragraph (d)(2)(i) of this section; and

(iii) The other requirements for the rebuttable presumption of reasonableness under paragraph (a) of this section are satisfied.

(e) *No inference from absence of presumption.* The fact that a transaction between an applicable tax-exempt organization and a disqualified person is not subject to the presumption described in this section neither creates any inference that the transaction is

an excess benefit transaction, nor exempts or relieves any person from compliance with any Federal or state law imposing any obligation, duty, responsibility, or other standard of conduct with respect to the operation or administration of any applicable tax-exempt organization.

(f) *Period of reliance on rebuttable presumption.* Except as provided in paragraph (d) of this section with respect to non-fixed payments, the rebuttable presumption applies to all payments made or transactions completed in accordance with a contract, provided that the provisions of paragraph (a) of this section were met at the time the parties entered into the contract.

[T.D. 8978, 67 FR 3083, Jan. 23, 2002]

§ 53.4958–7 Correction.

(a) *In general.* An excess benefit transaction is corrected by undoing the excess benefit to the extent possible, and taking any additional measures necessary to place the applicable tax-exempt organization involved in the excess benefit transaction in a financial position not worse than that in which it would be if the disqualified person were dealing under the highest fiduciary standards. Paragraph (b) of this section describes the acceptable forms of correction. Paragraph (c) of this section defines the correction amount. Paragraph (d) of this section describes correction where a contract has been partially performed. Paragraph (e) of this section describes correction where the applicable tax-exempt organization involved in the transaction has ceased to exist or is no longer tax-exempt. Paragraph (f) of this section provides examples illustrating correction.

(b) *Form of correction*—(1) *Cash or cash equivalents.* Except as provided in paragraphs (b)(3) and (4) of this section, a disqualified person corrects an excess benefit only by making a payment in cash or cash equivalents, excluding payment by a promissory note, to the applicable tax-exempt organization equal to the correction amount, as defined in paragraph (c) of this section.

(2) *Anti-abuse rule.* A disqualified person will not satisfy the requirements of paragraph (b)(1) of this section if the Commissioner determines that the disqualified person engaged in one or more transactions with the applicable tax-exempt organization to circumvent the requirements of this correction section, and as a result, the disqualified person effectively transferred property other than cash or cash equivalents.

(3) *Special rule relating to nonqualified deferred compensation.* If an excess benefit transaction results, in whole or in part, from the vesting (as described in § 53.4958–1(e)(2)) of benefits provided under a nonqualified deferred compensation plan, then, to the extent that such benefits have not yet been distributed to the disqualified person, the disqualified person may correct the portion of the excess benefit resulting from the undistributed deferred compensation by relinquishing any right to receive the excess portion of the undistributed deferred compensation (including any earnings thereon).

(4) *Return of specific property*—(i) *In general.* A disqualified person may, with the agreement of the applicable tax-exempt organization, make a payment by returning specific property previously transferred in the excess benefit transaction. In this case, the disqualified person is treated as making a payment equal to the lesser of—

(A) The fair market value of the property determined on the date the property is returned to the organization; or

(B) The fair market value of the property on the date the excess benefit transaction occurred.

(ii) *Payment not equal to correction amount.* If the payment described in paragraph (b)(4)(i) of this section is less than the correction amount (as described in paragraph (c) of this section), the disqualified person must make an additional cash payment to the organization equal to the difference. Conversely, if the payment described in paragraph (b)(4)(i) of this section exceeds the correction amount (as described in paragraph (c) of this section), the organization may make a cash payment to the disqualified person equal to the difference.

(iii) *Disqualified person may not participate in decision.* Any disqualified person who received an excess benefit from the excess benefit transaction may not participate in the applicable

tax-exempt organization's decision whether to accept the return of specific property under paragraph (b)(4)(i) of this section.

(c) *Correction amount*. The correction amount with respect to an excess benefit transaction equals the sum of the excess benefit (as defined in § 53.4958–1(b)) and interest on the excess benefit. The amount of the interest charge for purposes of this section is determined by multiplying the excess benefit by an interest rate, compounded annually, for the period from the date the excess benefit transaction occurred (as defined in § 53.4958–1(e)) to the date of correction. The interest rate used for this purpose must be a rate that equals or exceeds the applicable Federal rate (AFR), compounded annually, for the month in which the transaction occurred. The period from the date the excess benefit transaction occurred to the date of correction is used to determine whether the appropriate AFR is the Federal short-term rate, the Federal mid-term rate, or the Federal long-term rate. See section 1274(d)(1)(A).

(d) *Correction where contract has been partially performed*. If the excess benefit transaction arises under a contract that has been partially performed, termination of the contractual relationship between the organization and the disqualified person is not required in order to correct. However, the parties may need to modify the terms of any ongoing contract to avoid future excess benefit transactions.

(e) *Correction in the case of an applicable tax-exempt organization that has ceased to exist, or is no longer tax-exempt*—(1) *In general*. A disqualified person must correct an excess benefit transaction in accordance with this paragraph where the applicable tax-exempt organization that engaged in the transaction no longer exists or is no longer described in section 501(c)(3) or (4) and exempt from tax under section 501(a).

(2) *Section 501(c)(3) organizations*. In the case of an excess benefit transaction with a section 501(c)(3) applicable tax-exempt organization, the disqualified person must pay the correction amount, as defined in paragraph (c) of this section, to another organization described in section 501(c)(3) and exempt from tax under section 501(a) in accordance with the dissolution clause contained in the constitutive documents of the applicable tax-exempt organization involved in the excess benefit transaction, provided that—

(i) The organization receiving the correction amount is described in section 170(b)(1)(A) (other than in section 170(b)(1)(A)(vii) and (viii)) and has been in existence and so described for a continuous period of at least 60 calendar months ending on the correction date;

(ii) The disqualified person is not also a disqualified person (as defined in § 53.4958–3) with respect to the organization receiving the correction amount; and

(iii) The organization receiving the correction amount does not allow the disqualified person (or persons described in § 53.4958–3(b) with respect to that person) to make or recommend any grants or distributions by the organization.

(3) *Section 501(c)(4) organizations*. In the case of an excess benefit transaction with a section 501(c)(4) applicable tax-exempt organization, the disqualified person must pay the correction amount, as defined in paragraph (c) of this section, to a successor section 501(c)(4) organization or, if no tax-exempt successor, to any organization described in section 501(c)(3) or (4) and exempt from tax under section 501(a), provided that the requirements of paragraphs (e)(2)(i) through (iii) of this section are satisfied (except that the requirement that the organization receiving the correction amount is described in section 170(b)(1)(A) (other than in section 170(b)(1)(A)(vii) and (viii)) shall not apply if the organization is described in section 501(c)(4)).

(f) *Examples*. The following examples illustrate the principles of this section describing the requirements of correction:

Example 1. W is an applicable tax-exempt organization for purposes of section 4958. D is a disqualified person with respect to W. W employed D in 1999 and made payments totaling $*12t* to D as compensation throughout the taxable year. The fair market value of D's services in 1999 was $*7t*. Thus, D received excess compensation in the amount of $*5t*, the excess benefit for purposes of section 4958. In accordance with § 53.4958–1(e)(1), the

excess benefit transaction with respect to the series of compensatory payments during 1999 is deemed to occur on December 31, 1999, the last day of D's taxable year. In order to correct the excess benefit transaction on June 30, 2002, D must pay W, in cash or cash equivalents, excluding payment with a promissory note, $*5t* (the excess benefit) plus interest on $*5t* for the period from the date the excess benefit transaction occurred to the date of correction (*i.e.*, December 31, 1999, to June 30, 2002). Because this period is not more than three years, the interest rate D must use to determine the interest on the excess benefit must equal or exceed the short-term AFR, compounded annually, for December, 1999 (5.74%, compounded annually).

Example 2. X is an applicable tax-exempt organization for purposes of section 4958. B is a disqualified person with respect to X. On January 1, 2000, B paid X $*6v* for Property F. Property F had a fair market value of $*10v* on January 1, 2000. Thus, the sales transaction on that date provided an excess benefit to B in the amount of $*4v*. In order to correct the excess benefit on July 5, 2005, B pays X, in cash or cash equivalents, excluding payment with a promissory note, $*4v* (the excess benefit) plus interest on $*4v* for the period from the date the excess benefit transaction occurred to the date of correction (*i.e.*, January 1, 2000, to July 5, 2005). Because this period is over three but not over nine years, the interest rate B must use to determine the interest on the excess benefit must equal or exceed the mid-term AFR, compounded annually, for January, 2000 (6.21%, compounded annually).

Example 3. The facts are the same as in *Example 2,* except that B offers to return Property F. X agrees to accept the return of Property F, a decision in which B does not participate. Property F has declined in value since the date of the excess benefit transaction. On July 5, 2005, the property has a fair market value of $*9v*. For purposes of correction, B's return of Property F to X is treated as a payment of $*9v,* the fair market value of the property determined on the date the property is returned to the organization. If $*9v* is greater than the correction amount ($*4v* plus interest on $*4v* at a rate that equals or exceeds 6.21%, compounded annually, for the period from January 1, 2000, to July 5, 2005), then X may make a cash payment to B equal to the difference.

Example 4. The facts are the same as in *Example 3,* except that Property F has increased in value since January 1, 2000, the date the excess benefit transaction occurred, and on July 5, 2005, has a fair market value of $*13v*. For purposes of correction, B's return of Property F to X is treated as a payment of $*10v,* the fair market value of the property on the date the excess benefit transaction occurred. If $*10v* is greater than the correction amount ($*4v* plus interest on $*4v* at a rate that equals or exceeds 6.21%, compounded annually, for the period from January 1, 2000, to July 5, 2005), then X may make a cash payment to B equal to the difference.

Example 5. The facts are the same as in *Example 2.* Assume that the correction amount B paid X in cash on July 5, 2005, was $*5.58v*. On July 4, 2005, X loaned $*5.58v* to B, in exchange for a promissory note signed by B in the amount of $*5.58v*, payable with interest at a future date. These facts indicate that B engaged in the loan transaction to circumvent the requirement of this section that (except as provided in paragraph (b)(3) or (4) of this section), the correction amount must be paid only in cash or cash equivalents. As a result, the Commissioner may determine that B effectively transferred property other than cash or cash equivalents, and therefore did not satisfy the correction requirements of this section.

[T.D. 8978, 67 FR 3083, Jan. 23, 2002]

§ 53.4958–8 Special rules.

(a) *Substantive requirements for exemption still apply.* Section 4958 does not affect the substantive standards for tax exemption under section 501(c)(3) or (4), including the requirements that the organization be organized and operated exclusively for exempt purposes, and that no part of its net earnings inure to the benefit of any private shareholder or individual. Thus, regardless of whether a particular transaction is subject to excise taxes under section 4958, existing principles and rules may be implicated, such as the limitation on private benefit. For example, transactions that are not subject to section 4958 because of the initial contract exception described in § 53.4958–4(a)(3) may, under certain circumstances, jeopardize the organization's tax-exempt status.

(b) *Interaction between section 4958 and section 7611 rules for church tax inquiries and examinations.* The procedures of section 7611 will be used in initiating and conducting any inquiry or examination into whether an excess benefit transaction has occurred between a church and a disqualified person. For purposes of this rule, the reasonable belief required to initiate a church tax inquiry is satisfied if there is a reasonable belief that a section 4958 tax is due from a disqualified person with respect to a transaction involving a church. See § 301.7611–1 Q&A 19 of this chapter.

(c) *Other substantiation requirements.* These regulations, in § 53.4958–4(c)(3), set forth specific substantiation rules. Compliance with the specific substantiation rules of that section does not relieve applicable tax-exempt organizations of other rules and requirements of the Internal Revenue Code, regulations, Revenue Rulings, and other guidance issued by the Internal Revenue Service (including the substantiation rules of sections 162 and 274, or § 1.6001–1(a) and (c) of this chapter).

[T.D. 8978, 67 FR 3083, Jan. 23, 2002]

§ 53.4959–1 Taxes on failures by hospital organizations to meet section 501(r)(3).

(a) *Excise tax for failure to meet the section 501(r)(3) requirements*—(1) *In general.* If a hospital organization (as defined in § 1.501(r)–1(b)(18)) fails to meet the requirements of section 501(r)(3) separately with respect to a hospital facility it operates in any taxable year, there is imposed on the hospital organization a tax equal to $50,000. If a hospital organization operates multiple hospital facilities and fails to meet the requirements of section 501(r)(3) with respect to more than one facility it operates, the $50,000 tax is imposed on the hospital organization separately for each hospital facility's failure. The tax is imposed for each taxable year that a hospital facility fails to meet the requirements of section 501(r)(3).

(2) *Examples.* The following examples illustrate this paragraph (a):

Example 1. (i) U is a hospital organization that operates only one hospital facility, V. In Year 1, V conducts a community health needs assessment (CHNA) and adopts an implementation strategy to meet the health needs identified through the CHNA. In Years 2 and 3, V does not conduct a CHNA. V fails to conduct a CHNA by the last day of Year 4. Accordingly, U has failed to meet the requirements of section 501(r)(3) with respect to V in Year 4 because V has failed to conduct a CHNA in Years 2, 3, and 4. U is subject to a tax equal to $50,000 for Year 4.

(ii) V also fails to conduct a CHNA by the last day of Year 5. Accordingly, U has failed to meet the requirements of section 501(r)(3) with respect to V in Year 5 because V has failed to conduct a CHNA in Years 3, 4, and 5. U is subject to a tax equal to $50,000 for Year 5.

Example 2. P is a hospital organization that operates only one hospital facility, Q. In Year 1, Q conducts a CHNA and adopts an implementation strategy to meet the health needs identified through the CHNA. In Years 2 and 3, Q does not conduct a CHNA. In Year 4, Q conducts a CHNA but does not adopt an implementation strategy to meet the health needs identified through that CHNA by the 15th day of the fifth month of Year 5. Accordingly, P has failed to meet the requirements of section 501(r)(3) with respect to Q in Year 4 because Q has failed to adopt an implementation strategy by the 15th day of the fifth month after the end of the taxable year in which Q conducted its CHNA. P is subject to a tax equal to $50,000 for Year 4.

Example 3. R is a hospital organization that operates two hospital facilities, S and T. In Year 1, S and T each conduct a CHNA and adopt an implementation strategy to meet the health needs identified through the CHNA. In Years 2 and 3, S and T do not conduct a CHNA. S and T each fail to conduct a CHNA by the last day of Year 4. Accordingly, R has failed to meet the requirements of section 501(r)(3) with respect to both S and T in Year 4. R is subject to a tax equal to $100,000 ($50,000 for S's failure plus $50,000 for T's failure) for Year 4.

(b) *Interaction with other provisions*—(1) *Correction.* Unless a hospital organization's failure to meet the requirements of section 501(r)(3) involves an omission or error that is described in and corrected in accordance with § 1.501(r)–2(b) (and is thus not considered a failure), a failure to meet the requirements of section 501(r)(3) will result in a tax being imposed on the organization under this section, notwithstanding the organization's correction and disclosure of the failure in accordance with the guidance described in § 1.501(r)–2(c).

(2) *Interaction with other taxes.* The tax imposed by this section is in addition to any tax imposed by § 1.501(r)–2(d) or as a result of revocation of a hospital organization's section 501(c)(3) status.

(c) *Effective/applicability date.* Paragraph (a) of this section applies on and after December 29, 2014.

[T.D. 9708, 79 FR 79015, Dec. 31, 2014, as amended at 80 FR 12765, Mar. 11, 2015]

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[T.D. 9938, 86 FR 6219, Jan. 19, 2021; 86 FR 23865, May 5, 2021]

§ 53.4960–1 Scope and definitions.

(a) *Scope*. This section provides definitions for purposes of section 4960, this section, and §§ 53.4960–2 through 53.4960–6. Section 53.4960–2 provides definitions and rules for determining the amount of remuneration paid for a taxable year. Section 53.4960–3 provides definitions and rules for determining whether a parachute payment is paid. Section 53.4960–4 provides definitions and rules for calculating the amount of excess remuneration paid for a taxable year, excess parachute payments paid in a taxable year, and liability for the excise tax. Section 53.4960–5 is reserved for rules on the coordination of sections 4960 and 162(m). Section 53.4960–6 provides rules regarding the applicability date for the regulations in §§ 53.4960–1 through 53.4960–5. The rules and definitions provided in this section through § 53.4960–6 apply solely for purposes of section 4960 unless specified otherwise.

(b) *Applicable tax-exempt organization*—(1) *In general*. *Applicable tax-exempt organization* or *ATEO* means any organization that is one of the following types of organizations:

(i) *Section 501(a) organization*. The organization is exempt from taxation under section 501(a) (except as provided in paragraph (b)(2) or (b)(3) of this section);

(ii) *Section 521 farmers' cooperative*. The organization is a farmers' cooperative organization described in section 521(b)(1);

(iii) *Section 115(1) organization*. The organization has income excluded from taxation under section 115(1); or

(iv) *Section 527 political organization*. The organization is a political organization described in section 527(e)(1).

(2) *Certain foreign organizations*. Any foreign organization described in section 4948(b) that either is exempt from tax under section 501(a) or is a taxable private foundation (section 4948(b) organization) is not an ATEO. A foreign organization is an organization not created or organized in the United States or in any possession thereof, or under the law of the United States, any State, the District of Columbia, or any possession of the United States. See section 4948(b) and § 53.4948–1. For purposes of this paragraph (b)(2) and the application of section 4960 to a taxable year, an organization's status as a section 4948(b) organization is determined at the end of its taxable year.

(c) *Applicable year*—(1) *In general*. *Applicable year* means the calendar year ending with or within the ATEO's taxable year. See § 53.4960–4 regarding how an ATEO's applicable year affects the liability of related organizations.

(2) *Examples*. The following examples illustrate the rules of paragraph (c)(1) of this section.

(i) *Example 1 (Calendar year taxpayer)*—(A) *Facts*. ATEO 1 uses the calendar year as its taxable year and became an ATEO before 2022.

(B) *Conclusion*. ATEO 1's applicable year for its 2022 taxable year is the period from January 1, 2022, through December 31, 2022 (that is, the 2022 calendar year).

(ii) *Example 2 (Fiscal year taxpayer)*—(A) *Facts*. ATEO 2 uses a taxable year that starts July 1 and ends June 30 and became an ATEO before 2022.

(B) *Conclusion*. ATEO 2's applicable year for the taxable year beginning July 1, 2022, and ending June 30, 2023, is the 2022 calendar year.

(3) *Short applicable years*—(i) *In general*. An ATEO may have an applicable year that does not span the entire calendar year for the initial taxable year that the organization is an ATEO or for the taxable year in which the taxpayer ceases to be an ATEO. The beginning and end dates of the applicable year in the case of an ATEO's change in status

depend on when the change in status occurs.

(ii) *Initial year of ATEO status*. For the taxable year in which an ATEO first becomes an ATEO, *applicable year* means the period beginning on the date the ATEO first becomes an ATEO and ending on the last day of the calendar year ending with or within such taxable year (or, if earlier, the date of termination of ATEO status, as described in paragraph (c)(3)(ii)(A) of this section). If the taxable year in which an ATEO first becomes an ATEO ends before the end of the calendar year in which the ATEO first becomes an ATEO, then there is no applicable year for the ATEO's first taxable year; however, for the ATEO's next taxable year, *applicable year* means the period beginning on the date the ATEO first becomes an ATEO and ending on December 31 of the calendar year (or, if earlier, the date of termination of ATEO status, as described in paragraph (c)(3)(ii)(A) of this section).

(iii) *Year of termination of ATEO status*—(A) *Termination on or before the close of the calendar year ending with or within the taxable year of termination*. If an ATEO has a termination of ATEO status during the taxable year and the termination of ATEO status occurs on or before the close of the calendar year ending with or within such taxable year, then, for the taxable year of termination of ATEO status, applicable year means the period starting January 1 of the calendar year of the termination of ATEO status and ending on the date of the termination of ATEO status.

(B) *Termination after the close of the calendar year ending in the taxable year of termination*. If an ATEO has a termination of ATEO status during the taxable year and the termination of ATEO status occurs after the close of the calendar year ending within such taxable year, then, for the taxable year of the termination of ATEO status, *applicable year* means both the calendar year ending within such taxable year and the period beginning January 1 of the calendar year of the termination of ATEO status and ending on the date of the termination of ATEO status. Both such applicable years are treated as separate applicable years. See § 53.4960–4(b)(2)(ii) for rules regarding calculation of the tax in the event there are multiple applicable years associated with a taxable year.

(4) *Examples*. The following examples illustrate the rules of paragraph (c)(3) of this section. For purposes of these examples, assume any entity referred to as ''ATEO'' is an ATEO and any entity referred to as ''CORP'' is not an ATEO.

(i) *Example 1 (Taxable year of formation ending after December 31)*—(A) *Facts*. ATEO 1, ATEO 2, and CORP 1 are related organizations that all use a taxable year that starts July 1 and ends June 30. ATEO 1 is recognized as a section 501(c)(3) organization by the IRS on May 8, 2023, effective as of October 1, 2022. ATEO 2 became an ATEO in 2017.

(B) *Conclusion (ATEO 1)*. ATEO 1's applicable year for the taxable year beginning October 1, 2022, and ending June 30, 2023, is the period beginning October 1, 2022, and ending December 31, 2022. For purposes of determining the amount of remuneration paid by ATEO 1 and all related organizations for ATEO 1's taxable year beginning October 1, 2022, and ending June 30, 2023, (including for purposes of determining ATEO 1's covered employees), only remuneration paid between October 1, 2022, and December 31, 2022, is taken into account. Thus, any remuneration paid by ATEO 1, ATEO 2, and CORP 1 before October 1, 2022, is disregarded for purposes of ATEO 1's applicable year associated with its initial taxable year.

(C) *Conclusion (ATEO 2)*. ATEO 2's applicable year for its taxable year beginning July 1, 2022, and ending June 30, 2023, is the 2022 calendar year. Thus, any remuneration paid by ATEO 1, ATEO 2, and CORP 1 during the 2022 calendar year is taken into account for purposes of determining ATEO 2's covered employees and remuneration paid for ATEO 2's taxable year ending June 30, 2023.

(ii) *Example 2 (Taxable year of formation ending before December 31)*—(A) *Facts*. Assume the same facts as in paragraph (c)(4)(i)(A) of this section (Example 1), except that ATEO 1 is recognized as a section 501(c)(3) organization effective as of March 15, 2023.

(B) *Conclusion*. ATEO 1 has no applicable year for the taxable year starting March 15, 2023, and ending June 30, 2023, because no calendar year ends (or termination of ATEO status occurs) with or within the taxable year. ATEO 1's applicable year for the taxable year ending June 30, 2024, is the period beginning March 15, 2023, and ending December 31, 2023. For purposes of determining the amount of remuneration paid by ATEO 1 and all related organizations for ATEO 1's taxable year ending June 30, 2024 (including for purposes of determining ATEO 1's covered employees), only remuneration paid between March 15, 2023, and December 31, 2023, is taken into account. The conclusion for ATEO 2 is the same as in paragraph (c)(4)(i)(C) of this section (Example 1).

(iii) *Example 3 (Termination before the close of the calendar year ending in the taxable year of termination)*—(A) *Facts*. Assume the same facts as in paragraph (c)(4)(i)(A) of this section (Example 1). In addition, ATEO 1 has a termination of ATEO status on September 30, 2024.

(B) *Conclusion*. For ATEO 1's taxable year beginning July 1, 2024, and ending September 30, 2024, ATEO 1's applicable year is the period beginning January 1, 2024, and ending September 30, 2024.

(iv) *Example 4 (Termination after the close of the calendar year ending in the taxable year of termination)*—(A) *Facts*. Assume the same facts as in paragraph (c)(4)(i)(A) of this section (Example 1). In addition, ATEO 1 has a termination of ATEO status on March 31, 2025.

(B) *Conclusion*. For ATEO 1's taxable year beginning July 1, 2024, and ending March 31, 2025, ATEO 1 has two applicable years: the 2024 calendar year, and the period beginning on January 1, 2025, and ending on March 31, 2025.

(d) *Covered employee*—(1) *In general*. For each taxable year, *covered employee* means any individual who is one of the five highest-compensated employees of the ATEO for the taxable year or was a covered employee of the ATEO (or any predecessor) for any preceding taxable year beginning after December 31, 2016.

(2) *Five highest-compensated employees*—(i) *In general*. Except as otherwise provided in this paragraph (d)(2), an individual is one of an ATEO's five highest- compensated employees for the taxable year if the individual is among the five employees of the ATEO with the highest amount of remuneration paid during the applicable year, as determined under § 53.4960–2. However, remuneration for which the deduction is disallowed by reason of section 162(m) is taken into account for purposes of determining an ATEO's five highest-compensated employees. The five highest-compensated employees of an ATEO for the taxable year are identified on the basis of the total remuneration paid during the applicable year to the employee for services performed as an employee of the ATEO or any related organization. An ATEO may have fewer than five highest-compensated employees for a taxable year if it has fewer than five employees other than employees who are disregarded under paragraphs (d)(2)(ii) through (iv) of this section. For purposes of this paragraph (d)(2), a grant of a legally binding right (within the meaning of § 1.409A–1(b)) to vested remuneration is considered to be remuneration paid as of the date of grant, as described in § 53.4960–2(c)(2), and a person or governmental entity is considered to grant a legally binding right to nonvested remuneration if the person or governmental entity grants a legally binding right to remuneration that is not vested within the meaning of § 53.4960–2(c)(2). An employee is disregarded for purposes of determining an ATEO's five highest-compensated employees for a taxable year if, during the applicable year, neither the ATEO nor any related organization paid remuneration or granted a legally binding right to nonvested remuneration to the individual for services the individual performed as an employee of the ATEO or any related organization.

(ii) *Limited hours exception*—(A) *In general*. An individual is disregarded for purposes of determining an ATEO's five highest-compensated employees for a taxable year if all of the following requirements are met:

(*1*) *Remuneration requirement*. Neither the ATEO nor any related ATEO paid remuneration or granted a legally binding right to nonvested remuneration to the individual for services the individual performed as an employee of

the ATEO during the applicable year; and

(*2*) *Hours of service requirement*. The individual performed services as an employee of the ATEO and all related ATEOs for no more than 10 percent of the total hours the individual worked as an employee of the ATEO and any related organizations during the applicable year. An ATEO may instead make this determination based on the total days the individual worked as an employee of the ATEO and all related ATEOs as a percentage of the total days worked as an employee of the ATEO and all related organizations, provided that for purposes of the calculation, any day that the individual worked at least one hour as an employee of the ATEO or a related ATEO is treated as a day worked as an employee of the ATEO and not for any other organization.

(B) *Certain payments disregarded*. For purposes of paragraph (d)(2)(ii)(A)(*1*) of this section, a payment of remuneration made to the individual by a related organization that is an employer of the individual and for which the related organization is neither entitled to reimbursement by the ATEO nor entitled to any other consideration from the ATEO is not considered remuneration paid by the ATEO under § 53.4960–2(b)(1), and a payment of remuneration made to the individual by a related organization is not treated as remuneration paid by the ATEO under § 53.4960–2(b)(2).

(C) *Safe harbor*. For purposes of paragraph (d)(2)(ii)(A)(*2*) of this section, an individual is treated as having performed services as an employee of the ATEO and all related ATEOs for no more than 10 percent of the total hours the individual worked as an employee of the ATEO and all related organizations during the applicable year if the employee performed no more than 100 hours of service as an employee of the ATEO and all related ATEOs during the applicable year.

(iii) *Nonexempt funds exception*—(A) *In general*. An individual is disregarded for purposes of determining an ATEO's five highest-compensated employees for a taxable year if all the following requirements are met:

(*1*) *Remuneration requirement*. Neither the ATEO, nor any related ATEO, nor any taxable related organization controlled by the ATEO, or by one or more related ATEOs, either alone or together with the ATEO, paid remuneration or granted a legally binding right to nonvested remuneration to the individual for services the individual performed as an employee of an ATEO during the applicable year and the preceding applicable year. For this purpose, whether a taxable related organization is controlled by the ATEO (or one or more related ATEOs) is determined without regard to paragraph (i)(2)(vii)(B)(*2*) of this section and without regard to section 318(a)(3) for purposes of applying paragraph (i)(2)(vii)(A) of this section, so that an interest in a corporation or nonstock entity is not attributed downward in determining control of the corporation or nonstock entity;

(*2*) *Hours of service requirement*. The individual performed services as an employee of the ATEO and any related ATEOs for not more than 50 percent of the total hours worked as an employee of the ATEO and any related organizations during the applicable year and the preceding applicable year. An ATEO may instead make this determination based on the total days the individual worked as an employee of the ATEO and all related ATEOs as a percentage of the total days worked as an employee of the ATEO and all related organizations, provided that for purposes of the calculation, any day that the individual worked at least one hour as an employee of the ATEO or a related ATEO is treated as a day worked as an employee of the ATEO and not for any other organization; and

(*3*) *Related organizations requirement*. No related organization that paid remuneration or granted a legally binding right to nonvested remuneration to the individual during the applicable year and the preceding applicable year provided services for a fee to the ATEO, to any related ATEO, or to any taxable related organization controlled by the ATEO or by one or more related ATEOs, either alone or together with the ATEO, during the applicable year and the preceding applicable year. For purposes of this paragraph

(d)(2)(iii)(A)(*3*), whether a taxable related organization is controlled by the ATEO (or one or more related ATEOs) is determined without regard to paragraph (i)(2)(vii)(B)(*2*) of this section and without regard to section 318(a)(3) for purposes of applying paragraph (i)(2)(vii)(A) of this section, so that an interest in a corporation or nonstock entity is not attributed downward in determining control of the corporation or nonstock entity.

(B) *Certain payments disregarded*. For purposes of paragraph (d)(2)(iii)(A)(*1*) of this section, a payment of remuneration made to an individual by a related organization that is an employer of the individual and for which the related organization is neither entitled to reimbursement by the ATEO nor entitled to any other consideration from the ATEO is not considered remuneration paid by the ATEO under § 53.4960–2(b)(1) and a payment of remuneration made to the individual by a related organization is not treated as paid by the ATEO under § 53.4960–2(b)(2).

(iv) *Limited services exception*. An individual is disregarded for purposes of determining an ATEO's five highest-compensated employees for a taxable year even though the ATEO paid remuneration to the individual if, disregarding § 53.4960–2(b)(2), all of the following requirements are met:

(A) *Remuneration requirement*. The ATEO did not pay 10 percent or more of the individual's total remuneration for services performed as an employee of the ATEO and all related organizations during the applicable year; and

(B) *Related ATEO requirement*. The ATEO had at least one related ATEO during the applicable year and one of the following conditions applies:

(*1*) *Ten percent remuneration condition*. A related ATEO paid at least 10 percent of the remuneration paid by the ATEO and any related organizations during the applicable year; or

(*2*) *Less remuneration condition*. No related ATEO paid at least 10 percent of the total remuneration paid by the ATEO and any related organizations and the ATEO paid less remuneration to the individual than at least one related ATEO during the applicable year.

(3) *Examples*. The following examples illustrate the rules of this paragraph (d). For purposes of these examples, assume any entity referred to as ''ATEO'' is an ATEO, any entity referred to as ''CORP'' is not an ATEO and is not a publicly held company within the meaning of section 162(m)(2) unless otherwise stated, and each taxpayer uses the calendar year as its taxable year.

(i) *Example 1 (Employee of two related ATEOs)*—(A) *Facts*. ATEO 1 and ATEO 2 are related organizations and have no other related organizations. Both employ Employee A during calendar year 2022 and pay remuneration to Employee A for Employee A's services. During 2022, Employee A performed services for 1,000 hours as an employee of ATEO 1 and 1,000 hours as an employee of ATEO 2.

(B) *Conclusion*. Employee A may be a covered employee of both ATEO 1 and ATEO 2 as one of the five highest-compensated employees for taxable year 2022 under paragraph (d)(2)(i) of this section because the exceptions in paragraphs (d)(2)(ii) through (iv) of this section do not apply. Because they are related organizations, ATEO 1 and ATEO 2 must each include the remuneration paid to Employee A by the other during each of their applicable years in determining their respective five highest-compensated employees for taxable year 2022.

(ii) *Example 2 (Employee of an ATEO and a related non-ATEO)*—(A) *Facts*. Assume the same facts as in paragraph (d)(3)(i) of this section (*Example 1*), except that ATEO 1 is instead CORP 1.

(B) *Conclusion (CORP 1)*. For taxable year 2022, CORP 1 is not an ATEO and therefore does not need to identify covered employees.

(C) *Conclusion (ATEO 2)*. Employee A may be a covered employee of ATEO 2 as one of its five highest-compensated employees for taxable year 2022 under paragraph (d)(2)(i) of this section because no exception in paragraphs (d)(2)(ii) through (iv) of this section applies. ATEO 2 must include the remuneration paid to Employee A by CORP 1 during its applicable year in determining ATEO 2's five highest-compensated employees for taxable year 2022.

(iii) *Example 3 (Amounts for which a deduction is disallowed under section*

162(m) are taken into account for purposes of determining the five highest-compensated employees)—(A) *Facts*. CORP 2 is a publicly held corporation within the meaning of section 162(m)(2) and is a related organization of ATEO 3. ATEO 3 is a corporation that is part of CORP 2's affiliated group (as defined in section 1504, without regard to section 1504(b)) and has no other related organizations. Employee B is a covered employee (as defined in section 162(m)(3)) of CORP 2 and an employee of ATEO 3. In 2022, CORP 2 paid Employee B $8 million of remuneration for services provided as an employee of CORP 2 and ATEO 3 paid Employee B $500,000 of remuneration for services provided as an employee of ATEO 3. $7.5 million of the remuneration is compensation for which a deduction is disallowed pursuant to section 162(m)(1).

(B) *Conclusion*. The $7.5 million of remuneration for which a deduction is disallowed under section 162(m)(1) is taken into account for purposes of determining ATEO 3's five highest-compensated employees. Thus, ATEO 3 is treated as paying Employee B $8.5 million of remuneration for purposes of determining its five highest-compensated employees.

(iv) *Example 4 (Employee disregarded due to receiving no remuneration)*—(A) *Facts*. Employee C is an officer of ATEO 4 who performs more than minor services for ATEO 4. In 2022, neither ATEO 4 nor any related organization paid remuneration or granted a legally binding right to any nonvested remuneration to Employee C. ATEO 4 paid premiums for insurance for liability arising from Employee C's service with ATEO 4, which is properly treated as a working condition fringe benefit excluded from gross income under § 1.132–5.

(B) *Conclusion*. Even though Employee C is an employee of ATEO 4, Employee C is disregarded for purposes of determining ATEO 4's five highest-compensated employees for taxable year 2022 under paragraph (d)(2)(i) of this section because neither ATEO 4 nor any related organization paid Employee C any remuneration (nor did they grant a legally binding right to nonvested remuneration) in applicable year 2022. The working condition fringe benefit is not wages within the meaning of section 3401(a), as provided in section 3401(a)(19), and thus is not remuneration within the meaning of § 53.4960–2(a).

(v) *Example 5 (Limited hours exception)*—(A) *Facts*. ATEO 5 and CORP 3 are related organizations. ATEO 5 has no other related organizations. Employee D is an employee of CORP 3. As part of Employee D's duties at CORP 3, Employee D serves as an officer of ATEO 5. Only CORP 3 paid remuneration (or granted a legally binding right to nonvested remuneration) to Employee D and ATEO 5 did not reimburse CORP 3 for any portion of Employee D's remuneration in any manner. During 2022, Employee D provided services as an employee for 2,000 hours to CORP 3 and 200 hours to ATEO 5.

(B) *Conclusion*. Even though Employee D is an employee of ATEO 5 because Employee D provided more than minor services as an officer, Employee D is disregarded for purposes of determining ATEO 5's five highest-compensated employees for taxable year 2022. Employee D is disregarded under paragraph (d)(2)(ii) of this section because only CORP 3 paid Employee D any remuneration or granted a legally binding right to nonvested remuneration in applicable year 2022 and Employee D provided services as an employee of ATEO 5 for 200 hours, which is not more than ten percent of the 2,200 total hours (2,000 + 200 = 2,200) worked as an employee of ATEO 5 and all related organizations.

(vi) *Example 6 (Limited hours exception)*—(A) *Facts*. Assume the same facts as in paragraph (d)(3)(v) of this section (*Example 5*), except that ATEO 5 also provides a reasonable allowance for expenses incurred by Employee D in executing Employee D's duties as an officer of ATEO 5, which is properly excluded from gross income under an accountable plan described in § 1.62–2.

(B) *Conclusion*. The conclusion is the same as in paragraph (d)(3)(v)(B) of this section (*Example 5*). Specifically, even though Employee D is an employee of ATEO 5 because Employee D provided more than minor services for ATEO 5, Employee D is disregarded for purposes of determining ATEO 5's five highest-compensated employees for taxable

year 2022 under paragraph (d)(2)(ii) of this section because the expense allowance under the accountable plan is excluded from wages within the meaning of section 3401(a), as provided in § 31.3401(a)-4, and thus is not remuneration within the meaning of § 53.4960–2(a).

(vii) *Example 7 (No exception applies due to source of payment)*—(A) *Facts*. Assume the same facts as in paragraph (d)(3)(v) of this section (*Example 5*), except that ATEO 5 has a contractual arrangement with CORP 3 to reimburse CORP 3 for the hours of service Employee D provides to ATEO 5 during applicable year 2022 by paying an amount equal to the total remuneration received by Employee D from both ATEO 5 and CORP 3, multiplied by a fraction equal to the hours of service Employee D provided ATEO 5 over Employee D's total hours of service to both ATEO 5 and CORP 3.

(B) *Conclusion*. Employee D may be one of ATEO 5's five highest-compensated employees for taxable year 2022 under paragraph (d)(2)(i) of this section because the exceptions in paragraphs (d)(2)(ii) through (iv) of this section do not apply. Pursuant to the contractual arrangement between CORP 3 and ATEO 5, ATEO 5 reimburses CORP 3 for a portion of Employee D's remuneration during applicable year 2022; thus, the exceptions under paragraphs (d)(2)(ii) and (iii) of this section do not apply. Further, while ATEO 5 paid Employee D less than 10 percent of the total remuneration from ATEO 5 and all related organizations (200 hours of service to ATEO 5/2,200 hours of service to ATEO 5 and all related organizations = 9 percent), it had no related ATEO; thus, the limited services exception under paragraph (d)(2)(iv) of this section does not apply.

(viii) *Example 8 (Nonexempt funds exception for part-time services)*—(A) *Facts*. ATEO 6 and CORP 4 are related organizations. ATEO 6 has no other related organizations and does not control CORP 4. During applicable year 2022, Employee E provided 2,000 hours of services as an employee of CORP 4 and 0 hours of services as an employee of ATEO 6; during applicable year 2023, Employee E provided 1,100 hours of services as an employee of CORP 4 and 900 hours of services as an employee of ATEO 6; during applicable year 2024, Employee E provided 1,100 hours of services as an employee of CORP 4 and 900 hours of services as an employee of ATEO 6. ATEO 6 neither paid any remuneration to Employee E nor paid a fee for services to CORP 4 during any applicable year. No exception under paragraphs (d)(2)(i), (ii), or (iv) applies to Employee E.

(B) *Conclusion (2023)*. Employee E is disregarded for purposes of determining ATEO 6's five highest-compensated employees for taxable year 2023 under paragraph (d)(2)(iii) of this section because for applicable years 2022 and 2023, Employee E provided services as an employee of ATEO 6 for not more than 50 percent of the total hours Employee E provided services as an employee of ATEO 6 and CORP 4 (900 hours/4,000 hours), and ATEO 6 neither paid any remuneration to Employee E nor paid a fee for services to CORP 4 during applicable years 2022 and 2023.

(C) *Conclusion (2024)*. Employee E is disregarded for purposes of determining ATEO 6's five highest-compensated employees for taxable year 2024 under paragraph (d)(2)(iii) of this section because for applicable years 2023 and 2024, Employee E provided services as an employee of ATEO 6 for not more than 50 percent of the total hours Employee E provided services as an employee of ATEO 6 and CORP 4 (1,800 hours/4,000 hours), and ATEO 6 neither paid any remuneration to Employee E nor paid a fee for services to CORP 4 during applicable years 2023 and 2024.

(ix) *Example 9 (Nonexempt funds for full-time services in one applicable year)*—(A) *Facts*. Assume the same facts as in paragraph (d)(3)(viii) of this section (*Example 8)*, except that during applicable year 2022, Employee E provided services as an employee for 2,000 hours to CORP 4 and for 0 hours to ATEO 6; during applicable year 2023, Employee E provided services as an employee for 0 hours to CORP 4 and 2,000 hours to ATEO 6; and during applicable year 2024, Employee E resumes employment with CORP 4 so that Employee E provided services as an employee for 2,000 hours to CORP 4 and 0 hours to ATEO 6.

(B) *Conclusion (2023).* Employee E is disregarded for purposes of determining ATEO 6's five highest-compensated employees for taxable year 2023 under paragraph (d)(2)(iii) of this section because for applicable years 2022 and 2023, Employee E provided services as an employee of ATEO 6 for not more than 50 percent of the total hours Employee E provided services as an employee of ATEO 6 and CORP 4 (2,000 hours/4,000 hours), and ATEO 6 neither paid any remuneration to Employee E nor paid a fee for services to CORP 4 during applicable years 2022 and 2023.

(C) *Conclusion (2024).* Employee E is disregarded for purposes of determining ATEO 6's five highest-compensated employees for taxable year 2024 under paragraph (d)(2)(iii) of this section because for applicable years 2023 and 2024, Employee E provided services as an employee of ATEO 6 for not more than 50 percent of the total hours Employee E provided services as an employee of ATEO 6 and CORP 4 (2,000 hours/4,000 hours for ATEO 6 and CORP 4), and ATEO 6 neither paid any remuneration to Employee E nor paid a fee for services to CORP 4 during applicable years 2023 and 2024.

(x) *Example 10 (Nonexempt funds exception for full-time services across two applicable years)*—(A) *Facts.* Assume the same facts as in paragraph (d)(3)(viii)(A) of this section (*Example 8)*, except that during applicable year 2022, Employee E provided services as an employee for 2,000 hours to CORP 4 and for 0 hours to ATEO 6; during applicable year 2023, Employee E provided services as an employee for 600 hours to CORP 4 and for 1,400 hours to ATEO 6; and during applicable year 2024, Employee E provided services as an employee for 1,400 hours to CORP 4 and for 600 hours to ATEO 6.

(B) *Conclusion (2023).* Employee E is disregarded for purposes of determining ATEO 6's five highest-compensated employees for taxable year 2023 under paragraph (d)(2)(iii) of this section because for applicable years 2022 and 2023, Employee E provided services as an employee of ATEO 6 for not more than 50 percent of the total hours Employee E provided services as an employee of ATEO 6 and CORP 4 (1,400 hours/4,000 hours), and ATEO 6 neither paid any remuneration to Employee E, nor paid a fee for services to CORP 4 during applicable years 2022 and 2023.

(C) *Conclusion (2024).* Employee E is disregarded for purposes of determining ATEO 6's five highest-compensated employees for taxable year 2024 under paragraph (d)(2)(iii) of this section because for applicable years 2023 and 2024, Employee E provided services as an employee of ATEO 6 for not more than 50 percent of the total hours Employee E provided services as an employee of ATEO 6 and CORP 4 (2,000 hours/4,000 hours), and ATEO 6 neither paid any remuneration to Employee E, nor paid a fee for services to CORP 4 during applicable years 2023 and 2024.

(xi) *Example 11 (Failure under the nonexempt funds exception)*—(A) *Facts.* Assume the same facts as in paragraph (d)(3)(viii)(A) of this section (*Example 8)*, except that during applicable year 2022, Employee E provided services as an employee for 2,000 hours to CORP 4 and for 0 hours to ATEO 6; during applicable year 2023, Employee E provided services as an employee for 600 hours to CORP 4 and for 1,400 hours to ATEO 6; and during applicable year 2024, Employee E provided services as an employee for 1,300 hours to CORP 4 and for 700 hours to ATEO 6.

(B) *Conclusion (2023).* Employee E is disregarded for purposes of determining ATEO 6's five highest-compensated employees for taxable year 2023 under paragraph (d)(2)(iii) of this section because for applicable years 2022 and 2023, Employee E provided services as an employee of ATEO 6 for less than 50 percent of the total hours Employee E provided services as an employee of ATEO 6 and CORP 4 (1,400 hours/4,000 hours), and ATEO 6 neither paid any remuneration to Employee E, nor paid a fee for services to CORP 4 during applicable years 2022 and 2023.

(C) *Conclusion (2024).* Employee E may be a covered employee of ATEO 6 as one of its five highest-compensated employees for taxable year 2024 because the requirements under paragraph (d)(2)(iii) are not met and no other exception applies. For applicable years 2023 and 2024, Employee E provided services as an employee of ATEO 6 for more than 50 percent of the total hours Employee E provided services as an

employee of ATEO 6 and CORP 4 (2,100 hours/4,000 hours).

(xii) *Example 12 (Limited services exception)*—(A) *Facts*. ATEO 7, ATEO 8, ATEO 9, and ATEO 10 are a group of related organizations, none of which have any other related organizations. During 2022, Employee F is an employee of ATEO 7, ATEO 8, ATEO 9, and ATEO 10. During applicable year 2022, ATEO 7 paid 5 percent of Employee F's remuneration, ATEO 8 paid 10 percent of Employee F's remuneration, ATEO 9 paid 25 percent of Employee F's remuneration, and ATEO 10 paid 60 percent of Employee F's remuneration. No exception under paragraph (d)(2)(i), (ii), or (iii) applies to Employee F for any of ATEO 7, ATEO 8, ATEO 9, or ATEO 10.

(B) *Conclusion (ATEO 7)*. Employee F is disregarded for purposes of determining ATEO 7's five highest-compensated employees for taxable year 2022 under paragraph (d)(2)(iv) of this section because ATEO 7 paid less than 10 percent of Employee F's total remuneration from ATEO 7 and all related organizations during applicable year 2022, and another related ATEO paid at least 10 percent of that total remuneration.

(C) *Conclusion (ATEO 8, ATEO 9, and ATEO 10)*. Employee F may be a covered employee of ATEO 8, ATEO 9, and ATEO 10 as one of their respective five highest-compensated employees for their taxable years 2022 because each of those ATEOs paid 10 percent or more of Employee F's remuneration during the 2022 applicable year. Thus, the limited services exception under paragraph (d)(2)(iv) of this section does not apply.

(xiii) *Example 13 (Limited services exception if no ATEO paid at least 10 percent of remuneration)*—(A) *Facts*. Assume the same facts as in paragraph (d)(3)(xii) of this section (*Example 12*), except that for applicable year 2022, ATEO 7 paid 6 percent of F's remuneration, ATEO 8, ATEO 9, and ATEO 10 each paid 5 percent of Employee F's remuneration, and Employee F also works as an employee of CORP 5, a related organization of ATEO 7, ATEO 8, ATEO 9, and ATEO 10 that paid 79 percent of Employee F's remuneration for applicable year 2022.

(B) *Conclusion (ATEO 7)*. Employee F may be one of ATEO 7's five highest-compensated employees for taxable year 2022. Although ATEO 7 did not pay Employee F 10 percent or more of the total remuneration paid by ATEO 7 and all of its related organizations, no related ATEO paid more than 10 percent of Employee F's remuneration, and ATEO 7 did not pay less remuneration to Employee F than at least one related ATEO. Thus, the limited services exception under paragraph (d)(2)(iv) of this section does not apply, and Employee F may be one of ATEO 7's five highest-compensated employees because ATEO 7 paid Employee F more remuneration than any other related ATEO.

(C) *Conclusion (ATEO 8, ATEO 9, and ATEO 10)*. Employee F is disregarded for purposes of determining the five highest-compensated employees of ATEO 8, ATEO 9, and ATEO 10 for taxable year 2022 under paragraph (d)(2)(iv) of this section because none paid 10 percent or more of Employee F's total remuneration, each had no related ATEO that paid at least 10 percent of Employee F's total remuneration, and each paid less remuneration than at least one related ATEO (ATEO 7).

(e) *Employee*—(1) *In general*. *Employee* means an employee as defined in section 3401(c) and § 31.3401(c)–1. Section 31.3401(c)–1 generally defines an employee as any individual performing services if the relationship between the individual and the person for whom the individual performs services is the legal relationship of employer and employee. As set forth in § 31.3401(c)–1, this includes common law employees, as well as officers and employees of government entities, whether or not elected. An employee generally also includes an officer of a corporation, but an officer of a corporation who as such does not perform any services or performs only minor services and who neither receives, nor is entitled to receive, any remuneration is not considered to be an employee of the corporation solely due to the individual's status as an officer of the corporation. Whether an individual is an employee depends on the facts and circumstances.

(2) *Directors*. A director of a corporation (or an individual holding a substantially similar position in a corporation or other entity) in the individual's capacity as such is not an employee of the corporation. See § 31.3401(c)–1(f).

(3) *Trustees*. The principles of paragraph (e)(2) of this section apply by analogy to a trustee of any arrangement classified as a trust for Federal tax purposes in § 301.7701–4(a).

(f) *Employer*—(1) *In general*. *Employer* means an employer within the meaning of section 3401(d), without regard to section 3401(d)(1) or (2), meaning generally the person or governmental entity for whom the services were performed as an employee. Whether a person or governmental entity is the employer depends on the facts and circumstances, but a person does not cease to be the employer through use of a payroll agent under section 3504, a common paymaster under section 3121(s), a person described in section 3401(d)(1) or (2), a certified professional employer organization under section 7705, or any similar arrangement.

(2) *Disregarded entities*. In the case of a disregarded entity described in § 301.7701–3, § 301.7701–2(c)(2)(iv) does not apply; thus, the sole owner of the disregarded entity is treated as the employer of any individual performing services as an employee of the disregarded entity.

(g) *Medical services*—(1) *Medical and veterinary services*—(i) *In general*. *Medical services* means services directly performed by a licensed medical professional (as defined in paragraph (g)(2) of this section) for the diagnosis, cure, mitigation, treatment, or prevention of disease in humans or animals; services provided for the purpose of affecting any structure or function of the human or animal body; and other services integral to providing such medical services. For purposes of section 4960, teaching and research services are not medical services except to the extent that they involve the services performed to directly diagnose, cure, mitigate, treat, or prevent disease or affect a structure or function of the body. Administrative services may be integral to directly providing medical services. For example, documenting the care and condition of a patient is integral to providing medical services, as is accompanying another licensed professional as a supervisor while that medical professional provides medical services. However, managing an organization's operations, including scheduling, staffing, appraising employee performance, and other similar functions that may relate to a particular medical professional or professionals who perform medical services, is not integral to providing medical services. See § 53.4960–2(a)(2)(ii) for rules regarding allocating remuneration paid to a medical professional who performs both medical services and other services.

(ii) *Examples*. The following examples illustrate the rules of this paragraph (g):

(A) *Example 1 (Administrative tasks that are integral to providing medical services)*—(*1*) *Facts*. Employee A is a doctor who is licensed to practice medicine in the state in which Employee A's place of employment is located. In the course of Employee A's practice, Employee A treats patients and performs some closely-related administrative tasks, such as examining and updating patient records.

(*2*) *Conclusion*. Employee A's administrative tasks are integral to providing medical services and thus are medical services.

(B) *Example 2 (Administrative tasks that are not integral to providing medical services)*—(*1*) *Facts*. Assume the same facts as in paragraph (g)(1)(ii)(A)(*1*) of this section (Example 1), except that Employee A also performs additional administrative tasks such as analyzing the budget, authorizing capital expenditures, and managing human resources for the organization by which Employee A is employed.

(*2*) *Conclusion*. Employee A's additional administrative tasks are not integral to providing medical services and thus are not medical services.

(C) *Example 3 (Teaching duties that are and are not medical services)*—(*1*) *Facts*. Employee B is a medical doctor who is licensed to practice medicine in the state in which her place of employment, a university hospital, is located. Employee B's duties include overseeing and teaching a group of resident physicians who have restricted licenses to

practice medicine. Those duties include supervising and instructing the resident physicians while they treat patients and instruction in a classroom setting.

(*2*) *Conclusion*. Employee B's supervision and instruction of resident physicians during the course of patient treatment are necessary for the treatment, and thus are medical services. Employee B's classroom instruction is not necessary for patient treatment, and thus is not medical services.

(D) *Example 4 (Research services that are and are not medical services)*—(*1*) *Facts*. Employee C is a licensed medical doctor who is employed to work on a research trial. Employee C provides an experimental treatment to patients afflicted by a disease and performs certain closely-related administrative tasks that ordinarily are performed by a medical professional in a course of patient treatment. As part of the research trial, Employee C also compiles and analyzes patient results and prepares reports and articles that would not ordinarily be prepared by a medical professional in the course of patient treatment.

(*2*) *Conclusion*. Employee C's services that are ordinarily performed by a medical professional in a course of treatment, including closely-related administrative tasks, are medical services. Because the compilation and analysis of patient results and the formulation of reports and articles are neither services ordinarily performed by a medical professional in a course of treatment nor necessary for such treatment, these services are not medical services.

(2) *Definition of licensed medical professional*. *Licensed medical professional* means an individual who is licensed under applicable state or local law to perform medical services, including as a doctor, nurse, nurse practitioner, dentist, veterinarian, or other licensed medical professional.

(h) *Predecessor*—(1) *Asset acquisitions*. If an ATEO (acquiror) acquires at least 80 percent of the operating assets or total assets (determined by fair market value on the date of acquisition) of another ATEO (target), then the target is a predecessor of the acquiror. For an acquisition of assets that occurs over time, only assets acquired within a 12-month period are taken into account to determine whether at least 80 percent of the target's operating assets or total assets were acquired. However, this 12-month period is extended to include any continuous period that ends or begins on any day during which the acquiror has an arrangement to acquire directly or indirectly, assets of the target. Additions to the assets of target made as part of a plan or arrangement to avoid the application of this subsection to acquiror's purchase of target's assets are disregarded in applying this paragraph. This paragraph (h)(1) applies for purposes of determining whether an employee is a covered employee under paragraph (d)(1) of this section only with respect to a covered employee of the target who commences the performance of services for the acquiror (or a related organization with respect to the acquiror) within the period beginning 12 months before and ending 12 months after the date of the transaction as defined in paragraph (h)(7) of this section.

(2) *Corporate reorganizations*. A predecessor of an ATEO includes another separate ATEO the stock or assets of which are acquired in a corporate reorganization as defined in section 368(a)(1)(A), (C), (D), (E), (F), or (G) (including by reason of section 368(a)(2)).

(3) *Predecessor change of form or of place of organization*. An ATEO that restructured by changing its organizational form or place of organization (or both) is a predecessor of the restructured ATEO.

(4) *ATEO that becomes a non-ATEO*—(i) *General rule*. An organization is a predecessor of an ATEO if it ceases to be an ATEO and then again becomes an ATEO effective on or before the predecessor end date. The *predecessor end date* is the date that is 36 months following the date that the organization's Federal information return under section 6033 (or, for an ATEO described in paragraph (b)(1)(ii) or (iii) of this section, its Federal income tax return under section 6011(a)) is due (or would be due if the organization were required to file), excluding any extension, for the last taxable year for which the organization previously was an ATEO. If the organization becomes an

ATEO again effective after the predecessor end date, then the former ATEO is treated as a separate organization that is not a predecessor of the current ATEO.

(ii) *Intervening changes or entities.* If an ATEO that ceases to be an ATEO (former ATEO) would be treated as a predecessor to an organization that becomes an ATEO before the predecessor end date (successor ATEO), and if the former ATEO would be treated as a predecessor to each intervening entity (if such intervening entities had been ATEOs) under the rules of this paragraph (h), then the former ATEO is a predecessor of the successor ATEO. For example, if ATEO 1 loses its tax-exempt status and then merges into Corporation X, Corporation X then merges into Corporation Y, and Corporation Y becomes an ATEO before the predecessor end date, then ATEO 1 is a predecessor of Corporation Y.

(5) *Predecessor of a predecessor.* A reference to a predecessor includes any predecessor or predecessors of such predecessor, as determined under these rules.

(6) *Elections under sections 336(e) and 338.* For purposes of this paragraph (h), when an ATEO organized as a corporation makes an election to treat as an asset purchase either the sale, exchange, or distribution of stock pursuant to regulations under section 336(e) or the purchase of stock pursuant to regulations under section 338, the corporation that issued the stock is treated as the same corporation both before and after such transaction.

(7) *Date of transaction.* For purposes of this paragraph (h), the date that a transaction is treated as having occurred is the date on which all events necessary to complete the transaction described in the relevant provision have occurred.

(i) *Related organization*—(1) *In general. Related organization* means any person or governmental entity, domestic or foreign, that meets any of the following tests:

(i) *Controls or controlled by test.* The person or governmental entity controls, or is controlled by, the ATEO;

(ii) *Controlled by same persons test.* The person or governmental entity is controlled by one or more persons that control the ATEO;

(iii) *Supported organization test.* The person or governmental entity is a supported organization (as defined in section 509(f)(3)) with respect to the ATEO;

(iv) *Supporting organization test.* The person or governmental entity is a supporting organization described in section 509(a)(3) with respect to the ATEO; or

(v) *VEBA test.* With regard to an ATEO that is a voluntary employees' beneficiary association (VEBA) described in section 501(c)(9), the person or governmental entity establishes, maintains, or makes contributions to such VEBA.

(2) *Control*—(i) *In general.* Control may be direct or indirect. For rules concerning application of the principles of section 318 in applying this paragraph (i)(2), see paragraph (i)(2)(vii) of this section.

(ii) *Stock corporation.* A person or governmental entity controls a stock corporation if it owns (by vote or value) more than 50 percent of the stock in the stock corporation.

(iii) *Partnership.* A person or governmental entity controls a partnership if it owns more than 50 percent of the profits interests or capital interests in the partnership, determined in accordance with the rules and principles of §1.706–1(b)(4)(ii) for a partner's interest in the profits of a partnership and §1.706–1(b)(4)(iii) for a partner's interest in the capital of a partnership.

(iv) *Trust.* A person or governmental entity controls a trust if it owns more than 50 percent of the beneficial interests in the trust, determined by actuarial value.

(v) *Nonstock organization*—(A) *In general.* A person or governmental entity controls a nonstock organization if more than 50 percent of the trustees or directors of the nonstock organization are either representatives of, or directly or indirectly controlled by, the person or governmental entity. A *nonstock organization* is a nonprofit organization or other organization without owners and includes a governmental entity.

(B) *Control of a trustee or director of a nonstock organization.* A person or governmental entity controls a trustee or director of the nonstock organization if the person or governmental entity has the power (either at will or at regular intervals) to remove such trustee or director and designate a new one.

(C) *Representatives.* Trustees, directors, officers, employees, or agents of a person or governmental entity are deemed representatives of the person or governmental entity. However, an employee of a person or governmental entity (other than a trustee, director, or officer, or an employee who possesses at least the authority commonly exercised by an officer) who is a director or trustee of a nonstock organization (or acting in that capacity) will not be treated as a representative of the person or governmental entity if the employee does not act as a representative of the person or governmental entity and that fact is reported in the form and manner prescribed by the Commissioner in forms and instructions.

(vi) *Brother-sister related organizations.* Under paragraph (i)(1)(ii) of this section, an organization is a related organization with respect to an ATEO if one or more persons control both the ATEO and the other organization. In the case of control by multiple persons, the control tests described in this paragraph (i)(2) of this section apply to the persons as a group. For example, if 1,000 individuals who are members of both ATEO 1 and ATEO 2 elect a majority of the board members of each organization, then ATEO 1 and ATEO 2 are related to each other because the same group of 1,000 persons controls both ATEO 1 and ATEO 2.

(vii) *Section 318 principles*—(A) *In general.* Section 318 (relating to constructive ownership of stock) applies in determining ownership of stock in a corporation. The principles of section 318 also apply for purposes of determining ownership of interests in a partnership or in a trust with beneficial interests. For example, applying the principles of section 318(a)(1)(A), an individual is considered to own the partnership interest or trust interest owned, directly or indirectly, by or for the family members specified in such section.

(B) *Nonstock organizations*—(*1*) *Attribution of ownership interest from a nonstock organization to a controlling person.* If a person or governmental entity controls a nonstock organization, the person or governmental entity is treated as owning a percentage of the stock (or partnership interest or beneficial interest in a trust) owned by the nonstock organization in accordance with the percentage of trustees or directors of the nonstock organization that are representatives of, or directly or indirectly controlled by, the person or governmental entity.

(*2*) *Attribution of ownership interest from a controlling person to a nonstock organization.* If a person or governmental entity controls a nonstock organization, the nonstock organization is treated as owning a percentage of the stock (or partnership interest or beneficial interest in a trust) owned by the person or governmental entity in accordance with the percentage of trustees or directors of the nonstock organization that are representatives of, or directly or indirectly controlled by, the person or governmental entity.

(*3*) *Indirect control of a nonstock organization through another nonstock organization.* If a person or governmental entity controls one nonstock organization that controls a second nonstock organization, the person or governmental entity is treated as controlling the second nonstock organization if the product of the percentage of trustees or directors of the first nonstock organization that are representatives of, or directly or indirectly controlled by, the person or governmental entity, multiplied by the percentage of trustees or directors of the second nonstock organization that are representatives of, or directly or indirectly controlled by, the person or governmental entity or first nonstock organization, exceeds 50 percent. Similar principles apply to successive tiers of nonstock organizations.

(*4*) *Attribution of control of nonstock organization to family member.* An individual's control of a nonstock organization or of a trustee or director of a nonstock organization is attributed to the members of the individual's family (as set forth in section 318(a)(1) and the regulations thereunder), subject to the

limitation of section 318(a)(5)(B) and the regulations thereunder.

(3) *Examples*. The following examples illustrate the principles of this paragraph (i). For purposes of these examples, assume any entity referred to as ''ATEO'' is an ATEO and any entity referred to as ''CORP'' is not an ATEO.

(i) *Example 1 (Related through a chain of control)*—(A) *Facts*. ATEO 1, ATEO 2, and ATEO 3 are nonstock organizations. ATEO 3 owns 80 percent of the stock (by value) of corporation CORP 1. Eighty percent of ATEO 2's directors are representatives of ATEO 1. In addition, 80 percent of ATEO 3's directors are representatives of ATEO 1.

(B) *Conclusion*. ATEO 1 is a related organization with respect to ATEO 2 (and vice versa) because more than 50 percent of ATEO 2's directors are representatives of ATEO 1; thus, ATEO 1 controls ATEO 2. Based on the same analysis, ATEO 1 is also a related organization with respect to ATEO 3 (and vice versa). CORP 1 is a related organization with respect to ATEO 3 because, as the owner of more than 50 percent of CORP 1's stock, ATEO 3 controls CORP 1. Applying the principles of section 318, ATEO 1 is deemed to own 64 percent of the stock of CORP 1 (80 percent of ATEO 3's stock in CORP 1). Thus, CORP 1 is a related organization with respect to ATEO 1 because ATEO 1 controls CORP 1. ATEO 2 is a related organization with respect to ATEO 3, ATEO 3 is a related organization with respect to ATEO 2, and CORP 1 is a related organization with respect to ATEO 2 because ATEO 2, ATEO 3, and CORP 1 are all controlled by the same person (ATEO 1).

(ii) *Example 2 (Not related through a chain of control)*—(A) *Facts*. ATEO 4, ATEO 5, and ATEO 6 are nonstock organizations. Sixty percent of ATEO 5's directors are representatives of ATEO 4. In addition, 60 percent of ATEO 6's directors are representatives of ATEO 5, but none are representatives of ATEO 4.

(B) *Conclusion*. ATEO 4 is a related organization with respect to ATEO 5 (and vice versa) because more than 50 percent of ATEO 5's directors are representatives of ATEO 4; thus, ATEO 4 controls ATEO 5. Based on the same analysis, ATEO 6 is a related organization with respect to ATEO 5 (and vice versa). Applying the principles of section 318, ATEO 4 is deemed to control 36 percent of ATEO 6's directors (60 percent of ATEO 5's 60 percent control over ATEO 6). Because less than 50 percent of ATEO 6's directors are representatives of ATEO 4, and absent any facts suggesting that ATEO 4 directly or indirectly controls ATEO 6, ATEO 4 and ATEO 6 are not related organizations with respect to each other.

[T.D. 9938, 86 FR 6219, Jan. 19, 2021]

§ 53.4960–2 Determination of remuneration paid for a taxable year.

(a) *Remuneration*—(1) *In general*. For purposes of section 4960, *remuneration* means any amount that is wages as defined in section 3401(a), excluding any designated Roth contribution (as defined in section 402A(c)) and including any amount required to be included in gross income under section 457(f). Remuneration includes amounts includible in gross income as compensation for services as an employee pursuant to a below-market loan described in section 7872(c)(1)(B)(i) (compensation-related loans) but does not include amounts excepted by section 7872(c)(3) ($10,000 de minimis exception). For example, see § 1.7872–15(e)(1)(i). Director's fees paid by a corporation to a director of the corporation are not remuneration, provided that if the director is also an employee of the corporation, the director's fees are excluded from remuneration only to the extent that they do not exceed fees paid to a director who is not an employee of the corporation or any related organization or, if there is no such director, they do not exceed reasonable director's fees. Remuneration does not include any amount that vested or was paid by a taxpayer before the start of the taxpayer's first taxable year that began on or after January 1, 2018.

(2) *Exclusion of remuneration for medical services*—(i) *In general*. *Remuneration* does not include the portion of any remuneration paid to a licensed medical professional that is for the performance of medical services by such professional.

(ii) *Allocation of remuneration for medical services and non-medical services*. If, during an applicable year, an employer

pays a covered employee remuneration for providing both medical services and non-medical services, the employer must make a reasonable, good faith allocation between the remuneration for medical services and the remuneration for non-medical services. For example, if a medical doctor receives current remuneration (or vests in remuneration under a deferred compensation plan) for providing medical services and administrative or management services, the employer must make a reasonable, good faith allocation between the remuneration for the medical services and the remuneration for the administrative or management services. For this purpose, if an employment agreement or similar written arrangement sets forth the remuneration to be paid for particular services, that allocation of remuneration applies unless the facts and circumstances demonstrate that the amount allocated to medical services is unreasonable for those services or that the allocation was established for purposes of avoiding application of the excise tax under section 4960. If some or all of the remuneration is not reasonably allocated in an employment agreement or similar arrangement, an employer may use any reasonable allocation method. For example, an employer may use a representative sample of records, such as patient, insurance, and Medicare/Medicaid billing records or internal time reporting mechanisms to determine the time spent providing medical services, and then allocate remuneration to medical services in the proportion such time bears to the total hours the employee worked for the employer (and any related employer) for purposes of making a reasonable allocation of remuneration. Similarly, if some or all of the remuneration is not reasonably allocated in an employment agreement or other similar arrangement, an employer may use salaries or other remuneration paid by the employer or similarly situated employers for duties comparable to those the employee performs (for example, hospital administrator and physician) for purposes of making a reasonable allocation between remuneration for providing medical services and for providing non-medical services.

(iii) *Examples*. The following examples illustrate the rules of this paragraph (a)(2). For purposes of these examples, assume any entity referred to as ''ATEO'' is an ATEO.

(A) *Example 1 (Allocation based on employment agreement)—(1) Facts*. Employee A is a covered employee of ATEO 1. Employee A is a licensed medical professional who provides patient care services for ATEO 1 and also provides management and administrative services to ATEO 1 as the manager of a medical practice group within ATEO 1. The employment agreement between ATEO 1 and Employee A specifies that of Employee A's salary, 30 percent is allocable to Employee A's services as manager of the medical practice group and 70 percent is allocable to Employee A's services as a medical professional providing patient care services. The facts regarding Employee A's employment indicate the employment agreement provides a reasonable allocation and that the allocation was not established for purposes of avoiding application of the excise tax.

(*2*) *Conclusion*. Consistent with Employee A's employment agreement, ATEO 1 must allocate 30 percent of Employee A's salary to the provision of non-medical services and 70 percent of Employee A's salary to the provision of medical services. Accordingly, only the 30 percent portion of Employee A's salary allocated to the other, non-medical services is remuneration for purposes of paragraph (a) of this section.

(B) *Example 2 (Allocation based on billing records)—(1) Facts*. Assume the same facts as in paragraph (a)(2)(iii)(A) of this section (Example 1), except that the employment agreement does not allocate Employee A's salary between medical and non-medical services performed by Employee A. Based on a representative sample of insurance and Medicare billing records, as well as time reports that Employee A submits to ATEO 1, ATEO 1 determines that Employee A spends 50 percent of her work hours providing patient care and 50 percent of her work hours performing administrative and management services. ATEO 1 allocates 50 percent of Employee A's remuneration to medical services.

(*2*) *Conclusion*. ATEO 1's allocation of Employee A's salary is a reasonable, good faith allocation. Accordingly, only the 50 percent portion of Employee A's remuneration allocated to the non-medical services is remuneration for purposes of paragraph (a) of this section.

(b) *Source of payment*. For purposes of this section, the determination of the source of a payment of remuneration may involve the application of one or both of two separate rules described in this paragraph (b). Paragraph (b)(1) of this section addresses payments by a third party for services performed as an employee of a separate employer entity, while paragraph (b)(2) of this section addresses the application of section 4960(c)(4)(A) to treat certain remuneration paid by a related organization (after application of paragraph (b)(1) of this section, if applicable) as paid by the ATEO.

(1) *Remuneration paid by a third party for employment by an employer*. Remuneration paid (or a grant of a legally binding right to nonvested remuneration) by a third-party payor (whether a related organization, payroll agent, agent designated under section 3504, certified professional employer organization under section 7705, or other entity) during an applicable year for services performed as an employee of an employer is remuneration paid (or payable) by the employer, except as otherwise provided in § 53.4960–1(d)(2)(ii) and (iii).

(2) *Remuneration paid by a related organization for employment by the related organization*. Pursuant to section 4960(c)(4)(A), remuneration paid (or a grant of a legally binding right to nonvested remuneration) by a related organization to an ATEO's employee during an applicable year for services performed as an employee of the related organization is treated as remuneration paid (or payable) by the ATEO, except as otherwise provided in § 53.4960–1(d)(2)(ii) and (iii).

(c) *Applicable year in which remuneration is treated as paid*—(1) *In general*. Remuneration that is a regular wage within the meaning of § 31.3402(g)–1(a)(1)(ii) is treated as paid on the date it is actually or constructively paid and all other remuneration is treated as paid on the first date on which the remuneration is vested.

(2) *Vested remuneration*. Remuneration is *vested* if it is not subject to a substantial risk of forfeiture within the meaning of section 457(f)(3)(B) (regardless of whether the arrangement under which the remuneration is to be paid is deferred compensation described in section 457(f) or 409A). In general, an amount is subject to a substantial risk of forfeiture if entitlement to the amount is conditioned on the future performance of substantial services or upon the occurrence of a condition that is related to a purpose of the remuneration if the possibility of forfeiture is substantial. Except as provided in paragraph (c)(1) of this section, remuneration that is never subject to a substantial risk of forfeiture is considered paid on the first date the service provider has a legally binding right to the payment. For purposes of this section, a *plan* means a plan within the meaning of § 1.409A–1(c), an *account balance plan* means an account balance plan within the meaning of § 1.409A–1(c)(2)(i)(A), and a *nonaccount balance plan* means a nonaccount balance plan within the meaning of § 1.409A–1(c)(2)(i)(C). Net earnings on previously paid remuneration (described in paragraph (d)(2) of this section) that are not subject to a substantial risk of forfeiture are vested (and, thus, treated as paid) at the earlier of the date actually or constructively paid to the employee or the close of the applicable year in which they accrue. For example, the present value of a principal amount accrued to an employee's account under an account balance plan (under which the earnings and losses attributed to the account are based solely on a predetermined actual investment as determined under § 31.3121(v)(2)–1(d)(2)(i)(B) or a reasonable market interest rate) is treated as paid on the date vested, but the present value of any net earnings subsequently accrued on that amount (the increase in value due to the predetermined actual investment or a reasonable market interest rate) is treated as paid at the close of the applicable year in which they accrue. Similarly, while the present value of an amount accrued under a nonaccount balance (including

earnings that accrued while the amount was nonvested) is treated as paid on the date it is first vested, the present value of the net earnings on that amount (the increase in the present value) is treated as paid at the close of the applicable year in which they accrue.

(3) *Change in related status during the year*. If a taxpayer becomes or ceases to be a related organization with respect to an ATEO during an applicable year, then only the remuneration paid by the taxpayer to an employee with respect to services performed as an employee of the related organization during the portion of the applicable year during which the employer is a related organization is treated as paid by the ATEO. If an amount is treated as paid due to vesting in the year the taxpayer becomes or ceases to be a related organization with respect to the ATEO, then the amount is treated as paid by the ATEO only if the amount becomes vested during the portion of the applicable year that the taxpayer is a related organization with respect to the ATEO.

(d) *Amount of remuneration treated as paid*—(1) *In general*. For each applicable year, the amount of remuneration treated as paid by the employer to a covered employee is the sum of regular wages within the meaning of § 31.3402(g)–1(a)(1)(ii) actually or constructively paid during the applicable year and the present value (as determined under paragraph (e) of this section) of all other remuneration that vested during the applicable year. The amount of remuneration that vests during an applicable year is determined on an employer-by-employer basis with respect to each covered employee.

(2) *Earnings and losses on previously paid remuneration*—(i) *In general*. The amount of net earnings or losses on previously paid remuneration paid by an employer is determined on an employee-by-employee basis, such that amounts accrued with regard to one employee do not affect amounts accrued with regard to a different employee. Similarly, losses accrued on previously paid remuneration from one employer do not offset earnings accrued on previously paid remuneration from another employer. The amount of net earnings or losses on previously paid remuneration paid by the employer is determined on a net aggregate basis for all plans maintained by the employer in which the employee participates for each applicable year. For example, losses under an account balance plan may offset earnings under a nonaccount balance plan for the same applicable year maintained by the same employer for the same employee.

(ii) *Previously paid remuneration*—(A) *New covered employee*. For an individual who was not a covered employee for any prior applicable year, *previously paid remuneration* means, for the applicable year for which the individual becomes a covered employee, the present value of vested remuneration that was not actually or constructively paid or otherwise includible in the employee's gross income before the start of the applicable year plus any remuneration that vested during the applicable year but that is not actually or constructively paid or otherwise includible in the employee's gross income before the close of the applicable year.

(B) *Existing covered employee*. For an individual who was a covered employee for any prior applicable year, *previously paid remuneration* means, for each applicable year, the amount of remuneration that the employer treated as paid in the applicable year or for a prior applicable year but that is not actually or constructively paid or otherwise includible in the employee's gross income before the close of the applicable year. Actual or constructive payment or another event causing an amount of previously paid remuneration to be includible in the employee's gross income thus reduces the amount of previously paid remuneration.

(iii) *Earnings*. *Earnings* means any increase in the vested present value of previously paid remuneration as of the close of the applicable year, regardless of whether the plan denominates the increase as earnings. For example, an increase in the vested account balance of a nonqualified deferred compensation plan based solely on the investment return of a predetermined actual

investment (and disregarding any additional contributions) constitutes earnings. Similarly, an increase in the vested present value of a benefit under a nonqualified nonaccount balance plan due solely to the passage of time (and disregarding any additional benefit accruals) constitutes earnings. However, an increase in an account balance of a nonqualified deferred compensation plan due to a salary reduction contribution or an employer contribution does not constitute earnings (and therefore may not be offset with losses). Likewise, an increase in the benefit under a nonaccount balance plan due to an additional year of service or an increase in compensation that is reflected in a benefit formula does not constitute earnings.

(iv) *Losses. Losses* means any decrease in the vested present value of previously paid remuneration as of the close of the applicable year, regardless of whether the plan denominates that decrease as losses.

(v) *Net earnings. Net earnings* means, for each applicable year, the amount (if any) by which the earnings accrued for the applicable year on previously paid remuneration exceeds the sum of the losses accrued on previously paid remuneration for the applicable year and any net losses carried forward from a previous taxable year.

(vi) *Net losses. Net losses* means, for each applicable year, the amount (if any) by which the sum of the losses accrued on previously paid remuneration for the applicable year and any net losses carried forward from a previous taxable year exceed the earnings accrued for the applicable year on previously paid remuneration. Losses may only be used to offset earnings and thus do not reduce the remuneration treated as paid for an applicable year except to the extent of the earnings accrued for that applicable year. However, with regard to a covered employee, an employer may carry net losses forward to the next applicable year and offset vested earnings for purposes of determining net earnings or losses for that subsequent applicable year. For example, if a covered employee who participates in a nonaccount balance plan and an account balance plan vests in an amount of earnings under the nonaccount balance plan and has losses under the account balance plan that exceed the vested earnings treated as remuneration under the nonaccount balance plan, those excess losses are carried forward to the next applicable year and offset vested earnings for purposes of determining net earnings or losses for that applicable year. If, for the next applicable year, there are not sufficient earnings to offset the entire amount of losses carried forward from the previous year (and any additional losses), the offset process repeats for each subsequent applicable year until there are sufficient earnings for the applicable year to offset any remaining losses carried forward.

(3) *Remuneration paid for a taxable year before the employee becomes a covered employee*—(i) *In general.* In accordance with the payment timing rules of paragraph (c) of this section, any remuneration that is vested but is not actually or constructively paid or otherwise includible in an employee's gross income as of the close of the applicable year for the taxable year immediately preceding the taxable year in which the employee first becomes a covered employee of an ATEO is treated as previously paid remuneration for the taxable year in which the employee first becomes a covered employee. Net losses on this previously paid remuneration from any preceding applicable year do not carry forward to subsequent applicable years. However, net earnings and losses that vest on such previously paid remuneration in subsequent applicable years are treated as remuneration paid for a taxable year for which the employee is a covered employee.

(ii) *Examples.* The following examples illustrate the rules of this paragraph (d)(3). For purposes of these examples, assume any organization described as ''ATEO'' is an ATEO.

(A) *Example 1 (Earnings on pre-covered employee remuneration)*—(*1*) *Facts.* ATEO 1 uses a taxable year beginning July 1 and ending June 30. Employee A becomes a covered employee of ATEO 1 for the taxable year beginning July 1, 2023, and ending June 30, 2024. During the 2022 applicable year, Employee A

vests in $1 million of nonqualified deferred compensation. As of December 31, 2022, the present value of the amount deferred under the plan is $1.1 million. During the 2023 applicable year, ATEO 1 pays Employee A $1 million in regular wages. The present value as of December 31, 2023, of Employee A's nonqualified deferred compensation is $1.3 million.

(*2*) *Conclusion (Taxable year beginning July 1, 2022, and ending June 30, 2023).* ATEO 1 pays Employee A $1.1 million of remuneration in the 2022 applicable year. This is comprised of $1 million of vested nonqualified deferred compensation, and $100,000 of earnings, all of which is treated as paid for the taxable year beginning July 1, 2022, and ending June 30, 2023.

(*3*) *Conclusion (Taxable year beginning July 1, 2023, and ending June 30, 2024).* ATEO 1 pays Employee A $1.2 million of remuneration in the 2023 applicable year. This is comprised of $1 million regular wages and $200,000 of earnings ($1.3 million present value as of December 31, 2023, minus $1.1 million previously paid remuneration as of December 31, 2022).

(B) *Example 2 (Losses on pre-covered employee remuneration)*—(*1*) *Facts.* Assume the same facts as in paragraph (d)(3)(ii)(A) of this section (Example 1), except that the present value of the nonqualified deferred compensation as of December 31, 2022, is $900,000.

(*2*) *Conclusion (Taxable year beginning July 1, 2022, and ending June 30, 2023).* ATEO 1 pays Employee A $1 million of remuneration in the 2022 applicable year. This is comprised of $1 million of vested nonqualified deferred compensation. The present value of all vested deferred compensation as of December 31 of the 2022 applicable year ($900,000) is treated as previously paid remuneration for the next applicable year (as Employee A is a covered employee for the next taxable year). The $100,000 of losses accrued while Employee A was not a covered employee do not carry forward to the next applicable year.

(*3*) *Conclusion (Taxable year beginning July 1, 2023, and ending June 30, 2024).* ATEO 1 pays Employee A $1.4 million of remuneration in the 2023 applicable year. This is comprised of $1 million cash and $400,000 of earnings ($1.3 million present value as of December 31, 2023, minus $900,000 previously paid remuneration).

(e) *Calculation of present value*—(1) *In general.* The employer must determine present value using reasonable actuarial assumptions regarding the amount, time, and probability that a payment will be made. For this purpose, a discount for the probability that an employee will die before commencement of benefit payments is permitted, but only to the extent that benefits will be forfeited upon death. The present value may not be discounted for the probability that payments will not be made (or will be reduced) because of the unfunded status of the plan; the risk associated with any deemed or actual investment of amounts deferred under the plan; the risk that the employer, the trustee, or another party will be unwilling or unable to pay; the possibility of future plan amendments; the possibility of a future change in the law; or similar risks or contingencies. The present value of the right to future payments as of the vesting date includes any earnings that have accrued as of the vesting date that are not previously paid remuneration.

(2) *Treatment of future payment amount as present value for certain amounts.* For purposes of determining the present value of remuneration that is scheduled to be actually or constructively paid within 90 days of vesting, the employer may treat the future amount that is to be paid as the present value at vesting.

(f) *Examples.* The following examples illustrate the rules of this section. For purposes of these examples, assume any entity referred to as ''ATEO'' is an ATEO, anyentity referred to as ''CORP'' is not an ATEO, and all taxpayers use the calendar year as their taxable year.

(1) *Example 1 (Account balance plan)*—(i) *Facts.* Employee A is a covered employee of ATEO 1. Employee A participates in a nonqualified deferred compensation plan (the NQDC plan) in which the account balance is adjusted based on the investment returns on predetermined actual investments. On January 1, 2022, ATEO 1 credits $100,000 to Employee A's account under the

plan, subject to the requirement that Employee A remain employed through June 30, 2024. On June 30, 2024, the vested account balance is $110,000. Due to earnings or losses on the account balance, the closing account balance on each of the following dates is: $115,000 on December 31, 2024, $120,000 on December 31, 2025, $100,000 on December 31, 2026, and $110,000 on December 31, 2027. During 2028, Employee A defers an additional $10,000 under the plan, all of which is vested at the time of deferral. On December 31, 2028, the closing account balance is $125,000. In 2029, ATEO 1 pays $10,000 to Employee A under the plan. On December 31, 2029, the closing account balance is $135,000 due to earnings on the account balance.

(ii) *Conclusion (2022 and 2023 applicable years—nonvested amounts).* For 2022 and 2023, ATEO 1 is not treated as paying Employee A any remuneration attributable to Employee A's participation in the NQDC plan because the amount deferred under the plan remains subject to a substantial risk of forfeiture within the meaning of section 457(f)(3)(B).

(iii) *Conclusion (2024 applicable year—amounts in year of vesting).* For 2024, ATEO 1 is treated as paying Employee A $115,000 of remuneration attributable to Employee A's participation in the NQDC plan, including $110,000 of remuneration on June 30, 2024, when the amount becomes vested, and an additional $5,000 of remuneration on December 31, 2024, which is earnings on the previously paid remuneration ($110,000).

(iv) *Conclusion (2025 applicable year—earnings).* For 2025, ATEO 1 is treated as paying Employee A $5,000 of remuneration attributable to Employee A's participation in the NQDC plan, which is the additional earnings on the previously paid remuneration ($115,000) as of December 31, 2025.

(v) *Conclusion (2026 applicable year—losses).* For 2026, ATEO 1 is not treated as paying Employee A any remuneration attributable to Employee A's participation in the NQDC plan because the present value of the previously paid remuneration ($120,000) decreased to $100,000 as of December 31, 2026. The $20,000 loss for 2026 does not reduce any amount previously treated as remuneration but is available for carryover to subsequent taxable years to offset earnings.

(vi) *Conclusion (2027 applicable year—recovery of losses).* For 2027, ATEO 1 is not treated as paying Employee A any remuneration attributable to Employee A's participation in the NQDC plan because the present value of the previously paid remuneration ($120,000) was $110,000 as of December 31, 2027. Due to increases on the account balance, ATEO 1 recovers $10,000 of the $20,000 of losses carried over from 2026. The net losses as of December 31, 2027, are $10,000, and none of the $10,000 in earnings during 2027 is treated as remuneration paid in 2027.

(vii) *Conclusion (2028 applicable year—no recovery of losses against additional deferrals of compensation).* For 2028, ATEO 1 is treated as paying Employee A $10,000 of remuneration attributable to Employee A's participation in the NQDC plan. The additional $10,000 deferral is vested and thus is treated as remuneration paid on the date credited to Employee A's account. This credit increases the amount of previously paid remuneration from $120,000 to $130,000. Additionally, due to earnings, ATEO 1 recovers $5,000 of the $10,000 loss carried over from 2027, none of which was remuneration paid for 2026, so that as of December 31, 2028, the net loss available for carryover to 2029 is $5,000.

(viii) *Conclusion (2029 applicable year—distributions, recovery of remainder of losses through earnings and additional earnings).* For 2029, ATEO 1 is treated as paying Employee A $15,000 of remuneration attributable to Employee A's participation in the NQDC plan. The $10,000 payment reduces the amount of previously paid remuneration (from $130,000 to $120,000) and the account balance (from $125,000 to $115,000). The present value of the vested account balance increases by $20,000 (from $115,000 to $135,000) as of December 31, 2029. Therefore, due to earnings, ATEO 1 recovers the remaining $5,000 loss carried over from 2028 (the difference between the $120,000 previously paid remuneration before earnings and the

$115,000 account balance before earnings) and is treated as paying Employee A an additional $15,000 of remuneration as earnings (the difference between the $135,000 account balance after earnings and the $120,000 previously paid remuneration after loss recovery).

(2) *Example 2 (Nonaccount balance plan with earnings)*—(i) *Facts*. ATEO 2 and CORP 2 are related organizations. Employee B is a covered employee of ATEO 2 and is also employed by CORP 2. On January 1, 2022, CORP 2 and Employee B enter into an agreement under which CORP 2 will pay Employee B $100,000 on December 31, 2025, if B remains employed by CORP 2 through January 1, 2024. Employee B remains employed by CORP 2 through January 1, 2024. On January 1, 2024, the present value based on reasonable actuarial assumptions of the $100,000 to be paid on December 31, 2025, is $75,000. On December 31, 2024, the present value of the $100,000 future payment increases to $85,000 due solely to the passage of time. On December 31, 2025, CORP 2 pays Employee B $100,000.

(ii) *Conclusion (2022 and 2023 applicable years—nonvested amounts)*. For 2022 and 2023, CORP 2 is not treated as paying Employee B any remuneration attributable to the agreement because the amount deferred under the agreement remains subject to a substantial risk of forfeiture within the meaning of section 457(f)(3)(B).

(iii) *Conclusion (2024 applicable year—amounts in year of vesting)*. For 2024, CORP 2 is treated as paying Employee B $75,000 of remuneration attributable to the agreement on January 1, 2024, which is the present value on that date of the $100,000 payable on December 31, 2025. In addition, CORP 2 is treated as paying Employee B $10,000 of remuneration attributable to the agreement on December 31, 2024, which is earnings based on the increase in the present value of the previously paid remuneration (from $75,000 to $85,000) as of December 31, 2024.

(iv) *Conclusion (2025 applicable year—earnings and distribution of previously paid remuneration)*. For 2025, CORP 2 is treated as paying Employee B $15,000 in remuneration attributable to the agreement on December 31, 2025, which is earnings based on the increase in the present value of the previously paid remuneration (from $85,000 to $100,000) as of December 31, 2025. In addition, the $100,000 payment is treated as reducing the amount of previously paid remuneration ($100,000) to zero.

(3) *Example 3 (Treatment of amount payable as present value at vesting)*—(i) *Facts*. Employee C is a covered employee of ATEO 3. Under an agreement between ATEO 3 and Employee C, ATEO 3 agrees to pay Employee C $100,000 two months after the date Employee C meets a specified performance goal that is a substantial risk of forfeiture within the meaning of section 457(f)(3)(B). Employee C meets the performance goal on November 30, 2022, and ATEO 3 pays Employee C $100,000 on January 31, 2023. In accordance with § 53.4960–2(e)(2), because the payment is to be made within 90 days of vesting, ATEO 3 elects to treat the full payment amount as the amount of remuneration paid at vesting.

(ii) *Conclusion (2022 applicable year—election to treat amount payable within 90 days as paid at vesting)*. For taxable year 2022, ATEO 3 is treated as paying Employee C $100,000 of remuneration attributable to the agreement. Employee C vests in the $100,000 payment in 2022 upon meeting the performance goal. Under the general rule, ATEO 3 would be treated as paying for the taxable year 2022 the present value as of November 30, 2022, of $100,000 payable on January 31, 2023 (two months after the date of vesting), with adjustments to the present value as of the end of the year. However, because ATEO 3 elected to treat the full $100,000 amount payable within 90 days of vesting as the remuneration paid, the $100,000 payable to Employee C in 2023 is treated as remuneration paid in 2022 (and no additional amount related to the $100,000 paid on January 31, 2023, is treated as remuneration paid in 2023).

(4) *Example 4 (Aggregation of remuneration from related organizations)*—(i) *Facts*. Employee D is a covered employee of ATEO 4 and also an employee of CORP 4 and CORP 5. ATEO 4, CORP 4, and CORP 5 are related organizations. ATEO 4, CORP 4, and CORP 5 each pay Employee D $200,000 of salary during 2022 and 2023. On January 1,

2022, ATEO 4 promises to pay Employee D $120,000 on December 31, 2023, under a nonaccount balance plan, the right to which is vested and the present value of which is $100,000 on January 1, 2022. On January 1, 2022, CORP 4 and CORP 5 each contribute $100,000 on Employee D's behalf to account balance plans of CORP 4 and CORP 5, respectively, under which all amounts deferred are vested. On December 31, 2022, the present value of the amounts deferred under the ATEO 4 plan is $110,000, the present value of the amounts deferred under the CORP 4 plan is $120,000, and the present value of the amounts deferred under the CORP 5 plan maintained is $90,000. On December 31, 2023, the present value of the amounts deferred under the ATEO 4 plan is $120,000, the present value of the amounts deferred under the CORP 4 plan is $130,000, and the present value of the amounts deferred under the CORP 5 plan is $110,000.

(ii) *Conclusion (2022 applicable year).* For 2022, before aggregation of remuneration paid by related organizations, ATEO 4 is treated as paying Employee D $310,000 of remuneration ($200,000 salary + $100,000 upon vesting of deferred amounts + $10,000 net earnings on vested deferred amounts). CORP 4 is treated as paying Employee D $320,000 of remuneration ($200,000 salary + $100,000 upon vesting of deferred amounts + $20,000 net earnings on vested deferred amounts). CORP 5 is treated as paying Employee D $300,000 of remuneration ($200,000 salary + $100,000 upon vesting of deferred amounts) and has $10,000 of net losses on vested deferred amounts, which are carried forward to 2023. Thus, ATEO 4 is treated as paying $930,000 of remuneration to Employee D for the applicable year.

(iii) *Conclusion (2023 applicable year).* For 2023, before aggregation of remuneration paid by related organizations, ATEO 4 is treated as paying Employee D $210,000 of remuneration ($200,000 salary + $10,000 earnings on previously paid remuneration). CORP 4 is treated as paying Employee D $210,000 of remuneration ($200,000 salary + $10,000 net earnings on previously paid remuneration). CORP 5 is treated as paying Employee D $210,000 of remuneration ($200,000 salary + $10,000 net earnings on previously paid remuneration after taking into account the loss carryforward). Thus, ATEO 4 is treated as paying $630,000 of remuneration to Employee D for the applicable year.

(5) *Example 5 (Treatment of regular wages for a pay period spanning applicable years)*—(i) *Facts.* ATEO 5 pays its employees' salaries in accordance with a two-week payroll period that begins Sunday of the first week and ends Saturday of the second week. Payment occurs the Friday following the end of the payroll period. The last payroll period of 2023 ends on December 31, 2023. For the last payroll period, Employee E earns $8,000 of salary. In addition, ATEO 5 awards Employee E a $10,000 bonus that vests on December 31, 2023. ATEO 5 pays Employee E $18,000 on Friday, January 5, 2024, reflecting Employee E's salary for the last payroll period of 2023 and the bonus, the right to which vested on December 31, 2023.

(ii) *Conclusion (Regular wages).* The $8,000 of salary is regular wages within the meaning of § 31.3402(g)–1(a)(1)(ii) because it is an amount paid at a periodic rate for the current payroll period. Thus, $8,000 is treated as remuneration paid on January 5, 2024 (when it is actually or constructively paid), and, therefore, is treated as remuneration paid in ATEO 5's 2024 applicable year.

(iii) *Conclusion (Amounts other than regular wages).* The $10,000 bonus is not regular wages within the meaning of § 31.3402(g)–1(a)(1)(ii) because it is not an amountpaid at a periodic rate for the current payroll period. Thus, $10,000 is treatedas remuneration paid on December 31, 2023 (when it is vested) and, therefore, is treated as remuneration paid in ATEO 5's 2023 applicable year.

[T.D. 9938, 86 FR 6219, Jan. 19, 2021]

§ 53.4960–3 Determination of whether there is a parachute payment.

(a) *Parachute payment*—(1) *In general.* Except as otherwise provided in paragraph (a)(2) of this section (relating to payments excluded from the definition of a parachute payment), *parachute payment* means any payment in the nature of compensation made by an ATEO (or a predecessor of the ATEO) or a related organization to (or for the benefit of) a covered employee if the

payment is contingent on the employee's separation from employment with the employer, and the aggregate present value of the payments in the nature of compensation to (or for the benefit of) the individual that are contingent on the separation equals or exceeds an amount equal to 3-times the base amount.

(2) *Exclusions*. The following payments are not parachute payments:

(i) *Certain qualified plans*. A payment that is a contribution to or a distribution from a plan described in section 401(a) that includes a trust exempt from tax under section 501(a), an annuity plan described in section 403(a), a simplified employee pension (as defined in section 408(k)), or a simple retirement account described in section 408(p);

(ii) *Certain annuity contracts*. A payment made under or to an annuity contract described in section 403(b) or a plan described in section 457(b);

(iii) *Compensation for medical services*. A payment made to a licensed medical professional for the performance of medical services performed by such professional; and

(iv) *Payments to non-HCEs*. A payment made to an individual who is not a highly compensated employee (HCE) as defined in paragraph (a)(3) of this section.

(3) *Determination of HCEs for purposes of the exclusion from parachute payments*. For purposes of this section, *highly compensated employee* or *HCE* means, with regard to an ATEO that maintains a qualified retirement plan or other employee benefit plan described in §1.414(q)–1T, Q/A–1, any person who is a highly compensated employee within the meaning of section 414(q) and, with regard to an ATEO that does not maintain such a plan, any person who would be a highly compensated employee within the meaning of section 414(q) if the ATEO did maintain such a plan. For purposes of determining the group of highly compensated employees for a determination year, consistent with §1.414(q)–1T, Q/A–14(a)(1), the determination year calculation is made on the basis of the applicable plan year under §1.414(q)–1T, Q/A–14(a)(2) of the plan or other entity for which a determination is made, and the look-back year calculation is made on the basis of the 12-month period immediately preceding that year. For an ATEO that does not maintain a plan described in §1.414(q)–1T, Q/A–1, the rules are applied by analogy, substituting the calendar year for the plan year. Thus, for example, in 2022, an ATEO that does not maintain such a plan must use its employees' 2021 annual compensation (as defined in §1.414(q)–1T, Q/A–13, including any of the safe harbor definitions if applied consistently to all employees) to determine which employees are HCEs for 2022, if any, for purposes of section 4960. If an employee is an HCE at the time of separation from employment, then for purposes of section 4960 any parachute payment that is contingent on the separation from employment (as defined in paragraph (d) of this section) is treated as paid to an HCE so that the exception from the term parachute payment under paragraph (a)(2)(iv) of this section does not apply, even if the payment occurs during one or more later taxable years (that is, taxable years after the taxable year during which the employee separated from employment).

(b) *Payment in the nature of compensation*—(1) *In general*. Any payment—in whatever form—is a payment in the nature of compensation if the payment arises out of an employment relationship, including holding oneself out as available to perform services and refraining from performing services. Thus, for example, a payment made under a covenant not to compete or a similar arrangement is a payment in the nature of compensation. A payment in the nature of compensation includes (but is not limited to) wages and salary, bonuses, severance pay, fringe benefits, life insurance, pension benefits, and other deferred compensation (including any amount characterized by the parties as interest or earnings thereon). A payment in the nature of compensation also includes cash when paid, the value of the right to receive cash, the value of accelerated vesting, or a transfer of property. The vesting of an option, stock appreciation right, or similar form of compensation as a result of a covered employee's separation from employment is a payment in

the nature of compensation. However, a payment in the nature of compensation does not include attorney's fees or court costs paid or incurred in connection with the payment of any parachute payment or a reasonable rate of interest accrued on any amount during the period the parties contest whether a parachute payment will be made.

(2) *Consideration paid by covered employee.* Any payment in the nature of compensation is reduced by the amount of any money or the fair market value of any property (owned by the covered employee without restriction) that is (or will be) transferred by the covered employee in exchange for the payment.

(c) *When payment is considered to be made*—(1) *In general.* A payment in the nature of compensation is considered made in the taxable year in which it is includible in the covered employee's gross income or, in the case of fringe benefits and other benefits that are excludable from income, in the taxable year the benefits are received. In the case of taxable non-cash fringe benefits provided in a calendar year, payment is considered made on the date or dates the employer chooses, but no later than December 31 of the calendar year in which the benefits are provided, except that when the fringe benefit is the transfer of personal property (either tangible or intangible) of a kind normally held for investment or the transfer of real property, payment is considered made on the actual date of transfer. If the fringe benefit is neither a transfer of personal property nor a transfer of real property, the employer may, in its discretion, treat the value of the benefit actually provided during the last two months of the calendar year as paid during the subsequent calendar year. However, an employer that treats the value of a benefit paid during the last two months of a calendar year as paid during the subsequent calendar year under this rule must treat the value of that fringe benefit as paid during the subsequent calendar year with respect to all employees who receive it.

(2) *Transfers of section 83 property.* A transfer of property in connection with the performance of services that is subject to section 83 is considered a payment made in the taxable year in which the property is transferred or would be includible in the gross income of the covered employee under section 83, disregarding any election made by the employee under section 83(b) or (i). Thus, in general, such a payment is considered made at the later of the date the property is transferred (as defined in §1.83–3(a)) to the covered employee or the date the property becomes substantially vested (as defined in §1.83–3(b) and (j)). The amount of the payment is the compensation as determined under section 83, disregarding any amount includible in income pursuant to an election made by an employee under section 83(b).

(3) *Stock options.* An option (including an option to which section 421 applies) is treated as property that is transferred when the option becomes vested (regardless of whether the option has a readily ascertainable fair market value as defined in §1.83–7(b)). For purposes of determining the timing and amount of any payment related to the option, the principles of §1.280G–1, Q/A–13 and any method prescribed by the Commissioner in published guidance of general applicability under §601.601(d)(2) apply.

(d) *Payment contingent on an employee's separation from employment*—(1) *In general.* A payment is contingent on an employee's separation from employment if the facts and circumstances indicate that the employer would not make the payment in the absence of the employee's involuntary separation from employment. A payment generally would be made in the absence of the employee's involuntary separation from employment if it is substantially certain at the time of the involuntary separation from employment that the payment would be made whether or not the involuntary separation occurred. A payment the right to which is not subject to a substantial risk of forfeiture within the meaning of section 457(f)(3)(B) at the time of an involuntary separation from employment generally is a payment that would have been made in the absence of an involuntary separation from employment (and is therefore not contingent on a separation from employment), except

that the increased value of an accelerated payment of a vested amount described in paragraph (f)(3) of this section resulting from an involuntary separation from employment is not treated as a payment that would have been made in the absence of an involuntary separation from employment. A payment the right to which is no longer subject to a substantial risk of forfeiture within the meaning of section 457(f)(3)(B) as a result of an involuntary separation from employment, including a payment the vesting of which is accelerated due to the separation from employment as described in paragraph (f)(3) of this section, is not treated as a payment that would have been made in the absence of an involuntary separation from employment (and thus is contingent on a separation from employment). A payment does not fail to be contingent on a separation from employment merely because the payment is conditioned upon the execution of a release of claims, noncompetition or nondisclosure provisions, or other similar requirements. See paragraph (d)(3) of this section for the treatment of a payment made pursuant to a covenant not to compete. If, after an involuntary separation from employment, the former employee continues to provide certain services as a nonemployee, payments for services rendered as a nonemployee are not payments that are contingent on a separation from employment to the extent those payments are reasonable and are not made on account of the involuntary separation from employment. Whether services are performed as an employee or nonemployee depends upon all the facts and circumstances. See § 53.4960–1(e). For rules on determining whether payments are reasonable compensation for services, the rules of § 1.280G–1, Q/A–40 through Q/A–42 (excluding Q/A–40(b) and Q/A–42(b)), and Q/A–44 are applied by analogy (substituting involuntary separation from employment for change in ownership or control).

(2) *Employment agreements*—(i) *In general.* If a covered employee involuntarily separates from employment before the end of a contract term and is paid damages for breach of contract pursuant to an *employment agreement*, the payment of damages is treated as a payment that is contingent on a separation from employment. An *employment agreement* is an agreement between an employee and employer that describes, among other things, the amount of compensation or remuneration payable to the employee for services performed during the term of the agreement.

(ii) *Example.* The following example illustrates the rules of this paragraph (d)(2). For purposes of this example, assume any entity referred to as ''ATEO'' is an ATEO.

(A) *Example—(1) Facts.* Employee A, a covered employee, has a 3-year employment agreement with ATEO 1. Under the agreement, Employee A will receive a salary of $200,000 for the first year and, for each succeeding year, an annual salary that is $100,000 more than the previous year. The agreement provides that, in the event of A's involuntary separation from employment without cause, Employee A will receive the remaining salary due under the agreement. At the beginning of the second year of the agreement, ATEO 1 involuntarily terminates Employee A's employment without cause and pays Employee A $700,000 representing the remaining salary due under the employment agreement ($300,000 for the second year of the agreement plus $400,000 for the third year of the agreement).

(2) Conclusion. The $700,000 payment is treated as a payment that is contingent on a separation from employment.

(3) *Noncompetition agreements.* A payment under an agreement requiring a covered employee to refrain from performing services (for example, a covenant not to compete) is a payment that is contingent on a separation from employment if the payment would not have been made in the absence of an involuntary separation from employment. For example, a payment contingent on compliance in whole or in part with a covenant not to compete negotiated as part of a severance arrangement arising from an involuntary separation from employment is contingent on a separation from employment. Similarly, one or more payments contingent on compliance in whole or in part with a covenant not to compete not negotiated as part of a severance

arrangement arising from an involuntary separation from employment but that provides for a payment specific to an involuntary separation from employment (and not voluntary separation from employment) is contingent on a separation from employment. Payments made under an agreement requiring a covered employee to refrain from performing services that are contingent on separation from employment are not treated as paid in exchange for the performance of services and are not excluded from parachute payments.

(4) *Payment of amounts previously included in income or excess remuneration.* Actual or constructive payment of an amount that was previously included in gross income of the employee is not a payment contingent on a separation from employment. For example, payment of an amount included in income under section 457(f)(1)(A) due to the lapsing of a substantial risk of forfeiture on a date before the separation from employment generally is not a payment that is contingent on a separation from employment, even if the amount is paid in cash or otherwise to the employee because of the separation from employment. In addition, actual or constructive receipt of an amount treated as excess remuneration under § 53.4960–4(b)(1) is not a payment that is contingent on a separation from employment (and thus is not a parachute payment), even if the amount is paid to the employee because of the separation from employment.

(5) *Window programs.* A payment under a window program is contingent on a separation from employment. A *window program* is a program established by an employer in connection with an impending separation from employment to provide separation pay if the program is made available by the employer for a limited period of time (no longer than 12 months) to employees who separate from employment during that period or to employees who separate from service during that period under specified circumstances. A payment made under a window program is treated as a payment that is contingent on an employee's separation from employment notwithstanding that the employee may not have had an involuntary separation from employment.

(6) *Anti-abuse provision.* Notwithstanding paragraphs (d)(1) through (5) of this section, if the facts and circumstances demonstrate that either the vesting or the payment of an amount (whether before or after an employee's involuntary separation from employment) would not have occurred but for the involuntary nature of the separation from employment, the payment of the amount is contingent on a separation from employment. For example, an employer's exercise of discretion to accelerate vesting of an amount shortly before an involuntary separation from employment may indicate that the acceleration of vesting was due to the involuntary nature of the separation from employment and was therefore contingent on the employee's separation from employment. Similarly, payment of an amount in excess of an amount otherwise payable (for example, increased salary), shortly before or after an involuntary separation from employment, may indicate that the amount was paid because the separation was involuntary and was therefore contingent on the employee's separation from employment. If an ATEO becomes a predecessor as a result of a reorganization or other transaction described in § 53.4960–1(h), any payment to an employee by a successor organization that is contingent on the employee's separation from employment with the predecessor ATEO is treated as paid by the predecessor ATEO.

(e) *Involuntary separation from employment*—(1) *In general. Involuntary separation from employment* means a separation from employment due to the independent exercise of the employer's unilateral authority to terminate the employee's services, other than due to the employee's implicit or explicit request, if the employee was willing and able to continue performing services as an employee. An involuntary separation from employment may include an employer's failure to renew a contract at the time the contract expires, provided that the employee was willing and able to execute a new contract providing terms and conditions substantially

similar to those in the expiring contract and to continue providing services. The determination of whether a separation from employment is involuntary is based on all the facts and circumstances.

(2) *Separation from employment for good reason*—(i) *In general.* Notwithstanding paragraph (e)(1) of this section, an employee's voluntary separation from employment is treated as an involuntary separation from employment if the separation occurs under certain bona fide conditions (referred to herein as a separation from employment for good reason).

(ii) *Material negative change required.* A separation from employment for good reason is treated as an involuntary separation from employment if the relevant facts and circumstances demonstrate that it was the result of unilateral employer action that caused a material negative change to the employee's relationship with the employer. Factors that may provide evidence of such a material negative change include a material reduction in the duties to be performed, a material negative change in the conditions under which the duties are to be performed, or a material reduction in the compensation to be received for performing such services.

(iii) *Deemed material negative change.* An involuntary separation from employment due to a material negative change is deemed to occur if the separation from employment occurs within 2 years following the initial existence of one or more of the following conditions arising without the consent of the employee:

(A) *Material diminution of compensation.* A material diminution in the employee's base compensation;

(B) *Material diminution of responsibility.* A material diminution in the employee's authority, duties, or responsibilities;

(C) *Material diminution of authority of supervisor.* A material diminution in the authority, duties, or responsibilities of the supervisor to whom the employee is required to report, including a requirement that an employee report to a corporate officer or employee instead of reporting directly to the board of directors (or similar governing body) of an organization;

(D) *Material diminution of budget.* A material diminution in the budget over which the employee retains authority;

(E) *Material change of location.* A material change in the geographic location at which the employee must perform services; or

(F) *Other material breach.* Any other action or inaction that constitutes a material breach by the employer of the agreement under which the employee provides services.

(3) *Separation from employment.* Except as otherwise provided in this paragraph, separation from employment has the same meaning as separation from service as defined in § 1.409A–1(h). Pursuant to § 1.409A–1(h), an employee generally separates from employment with the employer if the employee dies, retires, or otherwise has a termination of employment with the employer or experiences a sufficient reduction in the level of services provided to the employer. For purposes of applying the rules regarding reductions in the level of services set forth in the definition of termination of employment in § 1.409A–1(h)(1)(ii), the rules are modified for purposes of this paragraph such that an employer may not set the level of the anticipated reduction in future services that will give rise to a separation from employment, meaning that the default percentages set forth in § 1.409A–1(h)(1)(ii) apply in all circumstances. Thus, an anticipated reduction of the level of service of less than 50 percent is not treated as a separation from employment, an anticipated reduction of more than 80 percent is treated as a separation from employment, and the treatment of an anticipated reduction between those two levels is determined based on the facts and circumstances. The measurement of the anticipated reduction of the level of service is based on the average level of service for the prior 36 months (or shorter period for an employee employed for less than 36 months). In addition, an employee's separation from employment is determined without regard to § 1.409A–1(h)(2) and (5) (application to independent contractors), since, for purposes of this section, only an employee may have a

separation from employment, and a change from bona fide employee status to bona fide independent contractor status is also a separation from employment. See § 53.4960–2(a)(1) regarding the treatment of an employee who also serves as a director of a corporation (or in a substantially similar position). The definition of separation from employment also incorporates the rules under § 1.409A–1(h)(1)(i) (addressing leaves of absence, including military leaves of absence), § 1.409A–1(h)(4) (addressing asset purchase transactions), and § 1.409A–1(h)(6) (addressing employees participating in collectively bargained plans covering multiple employers). The definition further incorporates the rules of § 1.409A–1(h)(3), under which an employee separates from employment only if the employee has a separation from employment with the employer and all employers that would be considered a single employer under section 414(b) and (c), except that the ''at least 80 percent'' rule under section 414(b) and (c) is used, rather than replacing it with ''at least 50 percent.'' However, for purposes of determining whether there has been a separation from employment, a purported ongoing employment relationship between a covered employee and an ATEO or a related organization is disregarded if the facts and circumstances demonstrate that the purported employment relationship is not bona fide, or the primary purpose of the establishment or continuation of the relationship is avoidance of the application of section 4960.

(f) *Accelerated payment or accelerated vesting resulting from an involuntary separation from employment*—(1) *In general.* If a payment or the lapse of a substantial risk of forfeiture is accelerated as a result of an involuntary separation from employment, generally only the value due to the acceleration of payment or vesting is treated as contingent on a separation from employment, as described in paragraphs (f)(3) and (4) of this section, except as otherwise provided in this paragraph (f). For purposes of this paragraph (f), the terms *vested* and *substantial risk of forfeiture* have the same meaning as provided in § 53.4960–2(c)(2).

(2) *Nonvested payments subject to a non-service vesting condition.* If (without regard to a separation from employment) vesting of a payment would depend on an event other than the performance of services, such as the attainment of a performance goal, and that vesting event does not occur prior to the employee's separation from employment and the payment vests due to the employee's involuntary separation from employment, the full amount of the payment is treated as contingent on the separation from employment.

(3) *Vested payments.* If an involuntary separation from employment accelerates actual or constructive payment of an amount that previously vested without regard to the separation, the portion of the payment, if any, that is contingent on the separation from employment is the amount by which the present value of the accelerated payment exceeds the present value of the payment absent the acceleration. The payment of an amount otherwise due upon a separation from employment (whether voluntary or involuntary) is not treated as an acceleration of the payment unless the payment timing was accelerated due to the involuntary nature of the separation from employment. If the value of the payment absent the acceleration is not reasonably ascertainable, and the acceleration of the payment does not significantly increase the present value of the payment absent the acceleration, the present value of the payment absent the acceleration is the amount of the accelerated payment (so the amount contingent on the separation from employment is zero). If the present value of the payment absent the acceleration is not reasonably ascertainable but the acceleration significantly increases the present value of the payment, the future value of the payment contingent on the separation from employment is treated as equal to the amount of the accelerated payment. For purposes of this paragraph (f)(3), the acceleration of a payment by 90 days or less is not treated as significantly increasing the present value of the payment. For rules on determining present value, see paragraph (f)(6) and paragraphs (h), (i) and (j) of this section.

(4) *Nonvested payments subject to a service vesting condition*—(i) *In general.* If an involuntary separation from employment accelerates vesting of a payment, the portion of the payment that is contingent on separation from employment is the amount described in paragraph (f)(3) of this section (if any) plus the value of the lapse of the obligation to continue to perform services described in paragraph (f)(4)(ii) of this section (but the amount cannot exceed the amount of the accelerated payment, or, if the payment is not accelerated, the present value of the payment), to the extent that all of the following conditions are satisfied with respect to the payment:

(A) *Vesting trigger.* The payment vests as a result of an involuntary separation from employment;

(B) *Vesting condition.* Disregarding the involuntary separation from employment, the vesting of the payment was contingent only on the continued performance of services for the employer for a specified period of time; and

(C) *Services condition.* The payment is attributable, at least in part, to the performance of services before the date the payment is made or becomes certain to be made.

(ii) *Value of the lapse of the obligation to continue to perform services.* The value of the lapse of the obligation to continue to perform services is one percent of the amount of the accelerated payment multiplied by the number of full months between the date that the employee's right to receive the payment is vested and the date that, absent the acceleration, the payment would have been vested. This paragraph (f)(4)(ii) applies to the accelerated vesting of a payment in the nature of compensation even if the time when the payment is made is not accelerated. In that case, the value of the lapse of the obligation to continue to perform services is one percent of the present value of the future payment multiplied by the number of full months between the date that the individual's right to receive the payment is vested and the date that, absent the acceleration, the payment would have been vested.

(iii) *Accelerated vesting of equity compensation.* For purposes of this paragraph (f)(4), the acceleration of the vesting of a stock option or stock appreciation right (or similar arrangement) or the lapse of a restriction on restricted stock or a restricted stock unit (or a similar arrangement) is considered to significantly increase the value of the payment.

(5) *Application to benefits under a nonqualified deferred compensation plan.* In the case of a payment of benefits under a nonqualified deferred compensation plan, paragraph (f)(3) of this section applies to the extent benefits under the plan are vested without regard to the involuntary separation from employment, but the payment of benefits is accelerated due to the involuntary separation from employment. Paragraph (f)(4) of this section applies to the extent benefits under the plan are subject to the conditions described in paragraph (f)(4)(i) of this section. For any other payment of benefits under a nonqualified deferred compensation plan (such as a contribution made due to the employee's involuntary separation from employment), the full amount of the payment is contingent on the employee's separation from employment.

(6) *Present value.* For purposes of this paragraph (f), the present value of a payment is determined based on the payment date absent the acceleration and the date on which the accelerated payment is scheduled to be made. The amount that is treated as contingent on the separation from employment is the amount by which the present value of the accelerated payment exceeds the present value of the payment absent the acceleration.

(7) *Examples.* See § 1.280G Q/A–24(f) for examples that may be applied by analogy to illustrate the rules of this paragraph (f).

(g) *Three-times-base-amount test for parachute payments*—(1) *In general.* To determine whether payments in the nature of compensation made to a covered employee that are contingent on the covered employee separating from employment with the ATEO are parachute payments, the aggregate present value of the payments must be compared to the individual's base amount. To do this, the aggregate present value of all payments in the nature of compensation that are made or to be made

to (or for the benefit of) the same covered employee by an ATEO (or any predecessor of the ATEO) or related organization and that are contingent on the separation from employment must be determined. If this aggregate present value equals or exceeds the amount equal to 3-times the individual's base amount, the payments are parachute payments. If this aggregate present value is less than the amount equal to 3-times the individual's base amount, the payments are not parachute payments. See paragraphs (f)(6), (h), (i), and (j) of this section for rules on determining present value.

(2) *Examples*. The following examples illustrate the rules of this paragraph (g). For purposes of these examples, assume any entity referred to as ''ATEO'' is an ATEO.

(i) *Example 1 (Parachute payment)*—(A) *Facts*. Employee A is a covered employee and an HCE of ATEO 1. Employee A's base amount is $200,000. Payments in the nature of compensation that are contingent on a separation from employment with ATEO 1 totaling $800,000 are made to Employee A on the date of Employee A's separation from employment.

(B) *Conclusion*. The payments are parachute payments because they have an aggregate present value at the time of the separation from employment of $800,000, which is at least equal to 3-times Employee A's base amount of $200,000 (3 × $200,000 = $600,000).

(ii) *Example 2 (No parachute payment)*—(A) *Facts*. Assume the same facts as in paragraph (g)(2)(i) of this section (Example 1), except that the payments contingent on Employee A's separation from employment total $580,000.

(B) *Conclusion*. Because the aggregate present value of the payments ($580,000) is not at least equal to 3-times Employee A's base amount ($600,000), the payments are not parachute payments.

(h) *Calculating present value*—(1) *In general*. Except as otherwise provided in this paragraph (h), for purposes of determining if a payment contingent on a separation from employment exceeds 3-times the base amount, the present value of a payment is determined as of the date of the separation from employment or, if the payment is made prior to that date, the date on which the payment is made.

(2) *Deferred payments*. For purposes of determining whether a payment is a parachute payment, if a payment in the nature of compensation is the right to receive payments in a year (or years) subsequent to the year of the separation from employment, the value of the payment is the present value of the payment (or payments) calculated on the basis of reasonable actuarial assumptions and using the applicable discount rate for the present value calculation that is determined in accordance with paragraph (i) of this section.

(3) *Health care*. If the payment in the nature of compensation is an obligation to provide health care (including an obligation to purchase or provide health insurance), then, for purposes of this paragraph (h) and for applying the 3-times-base-amount test under paragraph (g) of this section, the present value of the obligation is calculated in accordance with generally accepted accounting principles. For purposes of paragraph (g) of this section and this paragraph (h), the obligation to provide health care is permitted to be measured by projecting the cost of premiums for health care insurance, even if no health care insurance is actually purchased. If the obligation to provide health care is made in coordination with a health care plan that the employer makes available to a group, then the premiums used for purposes of this paragraph (h)(3) may be the allocable portion of group premiums.

(i) *Discount rate*. Present value generally is determined by using a discount rate equal to 120 percent of the applicable Federal rate (determined under section 1274(d) and the regulations in part 1 under section 1274(d)), compounded semiannually. The applicable Federal rate to be used is the Federal rate that is in effect on the date as of which the present value is determined, using the period until the payment is expected to be made as the term of the debt instrument under section 1274(d). See paragraph (h) of this section for rules with respect to the date as of which the present value is determined. However, for any payment, the employer and the covered employee may elect to use the applicable Federal

rate that is in effect on the date on which the parties entered into the contract that provides for the payment if that election is set forth in writing in the contract.

(j) *Present value of a payment to be made in the future that is contingent on an uncertain future event or condition*—(1) *Treatment based on the estimated probability of payment.* In certain cases, it may be necessary to apply the 3-times-base-amount test to a payment that is contingent on separation from employment at a time when the aggregate present value of all the payments is uncertain because the time, amount, or right to receive one or more of the payments is also contingent on the occurrence of an uncertain future event or condition. In that case, the employer must reasonably estimate whether it will make the payment. If the employer reasonably estimates there is a 50-percent or greater probability that it will make the payment, the full amount of the payment is considered for purposes of the 3-times-base-amount test and the allocation of the base amount. If the employer reasonably estimates there is a less than 50-percent probability that the payment will be made, the payment is not considered for either purpose.

(2) *Correction of incorrect estimates.* If an ATEO later determines that an estimate it made under paragraph (j)(1) of this section was incorrect, it must reapply the 3-times-base-amount test to reflect the actual time and amount of the payment. In reapplying the 3-times-base-amount test (and, if necessary, reallocating the base amount), the ATEO must determine the aggregate present value of payments paid or to be paid as of the date described in paragraph (h) of this section using the discount rate described in paragraph (i) of this section. This redetermination may affect the amount of any excess parachute payment for a prior taxable year. However, if, based on the application of the 3-times-base-amount test without regard to the payment described in this paragraph (j), an ATEO has determined it will pay an employee an excess parachute payment or payments, then the 3-times-base-amount test does not have to be reapplied when a payment described in this paragraph (j) is made (or becomes certain to be made) if no base amount is allocated to that payment under § 53.4960–4(d)(5).

(3) *Initial option value estimate.* To the extent provided in published guidance of general applicability under § 601.601(d)(2), an initial estimate of the value of an option subject to paragraph (c) of this section is permitted to be made, with the valuation subsequently redetermined and the 3-times-base-amount test reapplied. Until guidance is published under section 4960, published guidance of general applicability described in § 601.601(d)(2) that is issued under section 280G applies by analogy.

(4) *Examples.* See § 1.280G–1, Q/A–33(d) for examples that may be applied by analogy to illustrate the rules of this paragraph (j).

(k) *Base amount*—(1) *In general.* A covered employee's base amount is the average annual compensation for services performed as an employee of the ATEO (including compensation for services performed for a predecessor of the ATEO), and/or, if applicable, a related organization, with respect to which there has been a separation from employment, if the compensation was includible in the gross income of the individual for taxable years in the base period (including amounts that were excluded under section 911) or that would have been includible in the individual's gross income if the individual had been a United States citizen or resident. See paragraph (l) of this section for the definition of base period and for examples of base amount computations.

(2) *Short or incomplete taxable years.* If the base period of a covered employee includes a short taxable year or less than all of a taxable year of the employee, compensation for the short or incomplete taxable year must be annualized before determining the average annual compensation for the base period. In annualizing compensation, the frequency with which payments are expected to be made over an annual period must be taken into account. Thus, any amount of compensation for a short or incomplete taxable year that represents a payment that will not be made more often than once per year is not annualized.

(3) *Excludable fringe benefits.* Because the base amount includes only compensation that is includible in gross income, the base amount does not include certain items that may constitute parachute payments. For example, payments in the form of excludable fringe benefits or excludable health care benefits are not included in the base amount but may be treated as parachute payments.

(4) *Section 83(b) income.* The base amount includes the amount of compensation included in income under section 83(b) during the base period.

(l) *Base period*—(1) *In general.* The base period of a covered employee is the covered employee's 5 most-recent taxable years ending before the date on which the separation from employment occurs. However, if the covered employee was not an employee of the ATEO for this entire 5-year period, the individual's base period is the portion of the 5-year period during which the covered employee performed services for the ATEO, a predecessor, or a related organization.

(2) *Determination of base amount if employee separates from employment in the year hired.* If a covered employee commences services as an employee and experiences a separation from employment in the same taxable year, the covered employee's base amount is the annualized compensation for services performed for the ATEO (or a predecessor or related organization) that was not contingent on the separation from employment and either was includible in the employee's gross income for that portion of the employee's taxable year prior to the employee's separation from employment (including amounts that were excluded under section 911) or would have been includible in the employee's gross income if the employee had been a United States citizen or resident.

(3) *Examples.* The following examples illustrate the rules of paragraph (k) of this section and this paragraph (l). For purposes of these examples, assume any entity referred to as ''ATEO'' is an ATEO, any entity referred to as ''CORP'' is not an ATEO, and all employees are HCEs of their respective employers.

(i) *Example 1 (Calculation with salary deferrals)*—(A) *Facts.* Employee A, a covered employee of ATEO 1, receives an annual salary of $500,000 per year during the 5-year base period. Employee A defers $100,000 of salary each year under a nonqualified deferred compensation plan (none of which is includible in Employee A's income until paid in cash to Employee A).

(B) *Conclusion.* Employee A's base amount is $400,000 (($400,000 × 5)/5).

(ii) *Example 2 (Calculation for less-than-5-year base period)*—(A) *Facts.* Employee B, a covered employee of ATEO 1, was employed by ATEO 1 for 2 years and 4 months preceding the year in which Employee B separates from employment. Employee B's compensation includible in gross income was $100,000 for the 4-month period, $420,000 for the first full year, and $450,000 for the second full year.

(B) *Conclusion.* Employee B's base amount is $390,000 (((3 × $100,000) + $420,000 + $450,000)/3). Any compensation Employee B receives in the year of separation from employment is not included in the base amount calculation.

(iii) *Example 3 (Calculation for less-than-5-year base period with signing bonus)*—(A) *Facts.* Assume the same facts as in paragraph (l)(3)(ii)(A) of this section (Example 2), except that Employee B also received a $60,000 signing bonus when Employee B's employment with ATEO 1 commenced at the beginning of the 4-month period.

(B) *Conclusion.* Employee B's base amount is $410,000 (((($60,000 + (3 × $100,000)) + $420,000 + $450,000)/3). Pursuant to paragraph (k)(2) of this section, because the bonus is a payment that will not be paid more often than once per year, the bonus is not taken into account in annualizing Employee B's compensation for the 4-month period.

(iv) *Example 4 (Effect of non-employee compensation)*—(A) *Facts.* Employee C, a covered employee of ATEO 1, was not an employee of ATEO 1 for the full 5-year base period. In 2024 and 2025, Employee C is only a director of ATEO 1 and receives $30,000 per year for services as a director. On January 1, 2026, Employee C becomes an officer and covered employee of ATEO 1. Employee C's includible compensation for services as an officer of ATEO 1 is $250,000

for each of 2026 and 2027, and $300,000 for 2028. In 2028, Employee C separates from employment with ATEO 1.

(B) *Conclusion.* Employee C's base amount is $250,000 ((2 × $250,000)/2). The $30,000 of director's fees paid to Employee C in each of 2024 and 2025 is not included in Employee C's base amount calculation because it was not for services performed as an employee of ATEO 1.

[T.D. 9938, 86 FR 6219, Jan. 19, 2021]

§ 53.4960–4 Liability for tax on excess remuneration and excess parachute payments.

(a) *Liability, reporting, and payment of excise taxes*—(1) *Liability.* For each taxable year, with respect to each covered employee, the taxpayer is liable for tax at the rate imposed under section 11 on the sum of the excess remuneration allocated to the taxpayer under paragraph (c) of this section and, if the taxpayer is an ATEO, any excess parachute payment paid by the taxpayer or a predecessor during the taxable year.

(2) *Reporting and payment.* The excise tax imposed by section 4960 is reported as provided in §§ 53.6011–1(b) and 53.6071–1(i) and paid in the form and manner prescribed by the Commissioner.

(3) *Arrangements between an ATEO and a related organization.* Calculation of, and liability for, the excise tax imposed by section 4960 is separate from, and unaffected by, any arrangement that an ATEO and any related organization may have for bearing the cost of any liability for the excise tax imposed by section 4960.

(4) *Certain foreign related organizations.* A related organization that is a foreign organization described in section 4948(b) that either is exempt from tax under section 501(a) or is a taxable private foundation (section 4948(b) related organization) is not liable for the excise tax imposed by section 4960. A foreign organization is an organization not created or organized in the United States or in any possession thereof, or under the law of the United States, any State, the District of Columbia, or any possession of the United States. See section 4948(b) and § 53.4948–1. For purposes of this paragraph (a)(4) and the application of section 4960 to a taxable year, an organization's status as a section 4948(b) related organization is determined at the end of its taxable year. However, remuneration that the section 4948(b) related organization pays to a covered employee of an ATEO must be taken into account by the ATEO and other related organizations for purposes of section 4960 generally, including for purposes of determining the five highest-compensated employees and the total remuneration paid to a covered employee. For example, if an ATEO and its related organization that is a section 4948(b) related organization each paid $600,000 remuneration to a covered employee during the applicable year, then the related organization would not be liable for the tax that would otherwise be allocable to it, and the ATEO would be liable for tax on $100,000 (50 percent of the $200,000 excess remuneration paid to the employee).

(5) [Reserved]

(b) *Amounts subject to tax*—(1) *Excess remuneration*—(i) *In general. Excess remuneration* means the amount of remuneration paid by an ATEO to any covered employee during an applicable year in excess of $1 million, as determined under § 53.4960–2.

(ii) *Exclusion for excess parachute payments.* Excess remuneration does not include any amount that is an excess parachute payment as defined in paragraph (b)(2) of this section.

(2) *Excess parachute payment. Excess parachute payment* means an amount equal to the excess (if any) of the amount of any parachute payment paid by an ATEO, a predecessor of the ATEO, or a related organization, or on behalf of any such person, during the taxable year over the portion of the base amount allocated to such payment.

(c) *Calculation of liability for tax on excess remuneration*—(1) *In general.* For each taxable year, an employer is liable for the tax on excess remuneration paid in the applicable year ending with or within the employer's taxable year. If, for the taxable year, remuneration paid during an applicable year by an ATEO or one or more related organizations to a covered employee is taken into account in determining the tax imposed on excess remuneration for that taxable year, then each employer

is liable for the tax in an amount that bears the same ratio to the total tax determined under section 4960(a) as the amount of remuneration paid by the employer to the covered employee (including remuneration paid by the employer as described in § 53.4960–2(b)(1), but disregarding remuneration treated as paid by the employer under § 53.4960–2(b)(2)), bears to the total amount of remuneration paid by the ATEO under § 53.4960–2 (including remuneration treated as paid by the ATEO under § 53.4960–2(b)(2)).

(2) *Calculation if liability is allocated from more than one ATEO with regard to an individual.* If liability for the tax on excess remuneration is allocated to an employer from more than one ATEO in a taxable year with regard to an individual that is a covered employee of each ATEO, then the employer is liable for the tax only in the capacity in which it is liable for the greatest amount of the tax with respect to that individual for the taxable year. For example, assume ATEO 1 is a related organization to both ATEO 2 and ATEO 3 and pays excess remuneration to Employee D, and Employee D is a covered employee of ATEO 1, ATEO 2, and ATEO 3. In this case, ATEO 1's liability for the tax on excess remuneration to Employee D is the highest of its liability as an ATEO, as a related organization to ATEO 2, or as a related organization to ATEO 3.

(3) *Calculation if liability is allocated from an ATEO with a short applicable year.* If liability for the tax on excess remuneration paid to an individual is allocated to an employer from an ATEO with a short applicable year under § 53.4960–1(c)(3), then the liability with respect to the excess remuneration paid to that individual is allocated in accordance with the principles of this paragraph (c) adjusted as necessary to avoid, to the extent possible, duplication of application of the excise tax. The Commissioner may provide additional guidance of general applicability, published in the Internal Revenue Bulletin (see § 601.601(d)(2) of this chapter), on the application of this paragraph (c)(3) to particular circumstances, including circumstances involving an ATEO with a short applicable year that has one or more related organizations and the ATEO's short applicable year and the preceding applicable year both end with or within the related organization's taxable year, such that the ATEO and related organizations are liable for the tax for multiple applicable years ending with or within the employer's taxable year.

(4) *Examples.* The following examples illustrate the rules of this paragraph (c). For purposes of these examples, assume that the rate of excise tax under section 4960 is 21 percent, that any entity that is referred to as ''ATEO'' is an ATEO, that any entity referred to as ''CORP'' is not an ATEO and is not a publicly held corporation within the meaning of section 162(m)(2) or a covered health insurance provider within the meaning of section 162(m)(6)(C), that no related organization is a section 4948(b) related organization, all taxpayers use the calendar year as their taxable year unless otherwise stated, and that no parachute payments are made in any of the years at issue.

(i) *Example 1 (Remuneration from multiple employers)*—(A) *Facts.* ATEO 1 and CORP 1 are related organizations. Employee A is a covered employee of ATEO 1 and an employee of CORP 1. In the 2022 applicable year, ATEO 1 pays Employee A $1.2 million of remuneration, and CORP 1 pays A $800,000 of remuneration. Remuneration paid by each employer is for services performed by Employee A solely as an employee of that employer.

(B) *Conclusion.* For the 2022 taxable year, ATEO 1 is treated as paying Employee A $2 million of remuneration, $1 million of which is excess remuneration. The total excise tax is $210,000 (21 percent × $1 million). ATEO 1 paid ⅗ of Employee A's total remuneration ($1.2 million/$2 million); thus, ATEO 1 is liable for ⅗ of the excise tax, which is $126,000. CORP 1 paid ⅖ of Employee A's total remuneration ($800,000/$2 million); thus, CORP 1 is liable for ⅖ of the excise tax, which is $84,000.

(ii) *Example 2 (Application when taxpayers have different taxable years)*—(A) *Facts.* Assume the same facts as in paragraph (c)(4)(i) of this section (*Example 1*), except that CORP 2 uses a taxable year beginning July 1 and ending June 30.

(B) *Conclusion*. The conclusion is the same as the conclusion in paragraph (c)(4)(i) of this section (*Example 1*), except that ATEO 1 is liable for the tax for its taxable year starting January 1, 2022, and ending December 31, 2022, and CORP 1 is liable for the tax for its taxable year beginning July 1, 2022, and ending June 30, 2023 (the taxable year with or within which ATEO 1's 2022 applicable year ends).

(iii) *Example 3 (Multiple liabilities for same applicable year due to multiple ATEOs)*—(A) *Facts*. The following facts are all with respect to the 2023 applicable year: ATEO 5 owns 60 percent of the stock of CORP 2. Sixty percent of ATEO 4's directors are representatives of ATEO 3. In addition, 60 percent of ATEO 5's directors are representatives of ATEO 4, but none are representatives of ATEO 3. Employee B is a covered employee of ATEO 3, ATEO 4, and ATEO 5 and is an employee of CORP 2. ATEO 3, ATEO 4, ATEO 5, and CORP 2 each pay Employee B $1.2 million of remuneration in the applicable year. ATEO 4's related organizations are ATEO 3 and ATEO 5. ATEO 3's only related organization is ATEO 4. ATEO 5's related organizations are ATEO 4 and CORP 2.

(B) *Calculation (ATEO 3)*. Under ATEO 3's calculation as an ATEO for the 2023 applicable year, ATEO 3 is treated as paying Employee B a total of $2.4 million in remuneration ($1.2 million from ATEO 3 + $1.2 million from ATEO 4). The total excise tax is $294,000 (21 percent × $1.4 million). ATEO 3 and ATEO 4 each paid ½ of Employee B's total remuneration ($1.2 million/$2.4 million); thus, under ATEO 3's calculation, ATEO 3 and ATEO 4 each would be liable for ½ of the excise tax, which is $147,000.

(C) *Calculation (ATEO 4)*. Under ATEO 4's calculation as an ATEO for the 2023 applicable year, ATEO 4 is treated as paying Employee B a total of $3.6 million in remuneration for the 2022 applicable year ($1.2 million from ATEO 3 + $1.2 million from ATEO 4 + $1.2 million from ATEO 5). The total excise tax is $546,000 (21 percent × $2.6 million). ATEO 3, ATEO 4, and ATEO 5 each paid ⅓ of the total remuneration to Employee B ($1.2 million/$3.6 million); thus, under ATEO 4's calculation, ATEO 3, ATEO 4, and ATEO 5 each would be liable for ⅓ of the excise tax, which is $182,000.

(D) *Calculation (ATEO 5)*. Under ATEO 5's calculation as an ATEO for the 2023 applicable year, ATEO 5 is treated as paying Employee B a total of $3.6 million in remuneration ($1.2 million from ATEO 4 + $1.2 million from ATEO 5 + $1.2 million from CORP 2). The total excise tax is $546,000 (21 percent × $2.6 million). ATEO 4, ATEO 5, and CORP 2 each paid ⅓ of the total remuneration to Employee B ($1.2 million/$3.6 million); thus, under ATEO 5's calculation, ATEO 4, ATEO 5, and CORP 2 each would be liable for ⅓ of the excise tax, which is $182,000.

(E) *Conclusion (Liability of ATEO 3)*. For the 2023 applicable year, ATEO 3 is liable for $182,000 of excise tax as a related organization under ATEO 4's calculation, which is greater than the $147,000 of excise tax under ATEO 3's own calculation. Thus, ATEO 3's excise tax liability with respect to Employee B is $182,000 for its 2023 taxable year.

(F) *Conclusion (Liability of ATEO 4)*. For the 2023 applicable year, ATEO 4 is liable as a related organization for $147,000 of excise tax according to ATEO 3's calculation, for $182,000 according to ATEO 4's own calculation, and for $182,000 according to ATEO 5's calculation. Thus, ATEO 4's excise tax liability with respect to Employee B is $182,000 for its 2023 taxable year.

(G) *Conclusion (Liability of ATEO 5)*. For the 2023 applicable year, ATEO 5 is liable as a related organization for $182,000 of excise tax under ATEO 4's calculation, and is liable for $182,000 of excise tax under ATEO 5's own calculation. Thus, ATEO 5's excise tax liability with respect to Employee B is $182,000 for its 2023 taxable year.

(H) *Conclusion (Liability of CORP 2)*. For the 2023 applicable year, CORP 2 is liable as a related organization for $182,000 of excise tax according to ATEO 5's calculation only. Thus, CORP 2's excise tax liability with respect to Employee B is $182,000 for its 2023 taxable year.

(d) *Calculation of liability for excess parachute payments*—(1) *In general*. Except as provided in paragraph (d)(3) of this section, only excess parachute payments made by or on behalf of an

ATEO are subject to tax under this section. However, parachute payments made by related organizations that are not made by or on behalf of an ATEO are taken into account for purposes of determining the total amount of excess parachute payments.

(2) *Computation of excess parachute payments*—(i) *Calculation*. The amount of an excess parachute payment is the excess of the amount of any parachute payment made by an ATEO, a predecessor of the ATEO, or a related organization, or on behalf of any such person, over the portion of the covered employee's base amount that is allocated to the payment. The portion of the base amount allocated to any parachute payment is the amount that bears the same ratio to the base amount as the present value of the parachute payment bears to the aggregate present value of all parachute payments made or to be made to (or for the benefit of) the same covered employee. Thus, the portion of the base amount allocated to any parachute payment is determined by multiplying the base amount by a fraction, the numerator of which is the present value of the parachute payment and the denominator of which is the aggregate present value of all parachute payments.

(ii) *Examples*. The following examples illustrate the rules of this paragraph (d)(2). For purposes of these examples, assume any entity referred to as ''ATEO'' is an ATEO and all employees are HCEs of their respective employers.

(A) *Example 1 (Compensation from related organizations)*—(*1*) *Facts*. ATEO 1 and ATEO 2 are related organizations. Employee A is a covered employee of ATEO 1 and an employee of ATEO 2 who has an involuntary separation from employment with ATEO 1 and ATEO 2. Employee A's base amount is $200,000 with respect to ATEO 1 and $400,000 with respect to ATEO 2. A receives $1 million from ATEO 1 contingent upon Employee A's involuntary separation from employment from ATEO 1 and $1 million from ATEO 2 contingent upon Employee A's involuntary separation from employment from ATEO 2.

(*2*) *Conclusion*. Employee A has a base amount of $600,000 ($200,000 + $400,000). The two $1 million payments are parachute payments because their aggregate present value is at least 3-times Employee A's base amount (3 × $600,000 = $1.8 million). The portion of the base amount allocated to each parachute payment is $300,000 (($1 million/$2 million) × $600,000). Thus, the amount of each excess parachute payment is $700,000 ($1 million − $300,000).

(B) *Example 2 (Multiple parachute payments)*—(*1*) *Facts*. Employee B is a covered employee of ATEO 3 with a base amount of $200,000 who is entitled to receive two parachute payments: One of $200,000 and the other of $900,000. The $200,000 payment is made upon separation from employment, and the $900,000 payment is to be made on a date in a future taxable year. The present value of the $900,000 payment is $800,000 as of the date of the separation from employment.

(*2*) *Conclusion*. The portion of the base amount allocated to the first payment is $40,000 (($200,000 present value of the parachute payment/$1 million present value of all parachute payments) × $200,000 total base amount) and the portion of the base amount allocated to the second payment is $160,000 (($800,000 present value of the parachute payment/$1 million present value of all parachute payments) × $200,000 total base amount). Thus, the amount of the first excess parachute payment is $160,000 ($200,000 − $40,000) and that the amount of the second excess parachute payment is $740,000 ($900,000 − $160,000).

(3) *Reallocation when the payment is disproportionate to base amount*. In accordance with section 4960(d), the Commissioner may treat a parachute payment as paid by an ATEO if the facts and circumstances indicate that the ATEO and other payors of parachute payments structured the payments in a manner primarily to avoid liability under section 4960. For example, if an ATEO would otherwise be treated as paying a portion of an excess parachute payment in an amount that is materially lower in proportion to the total excess parachute payment than the proportion that the amount of average annual compensation paid by the ATEO (or any predecessor) during the base period bears to the total average

annual compensation paid by the ATEO (or any predecessor) and any related organization (or organizations), and the lower amount is offset by payments from a non-ATEO or an unrelated ATEO, this may indicate that that the parachute payments were structured in a manner primarily to avoid liability under section 4960.

(4) *Election to prepay tax.* An ATEO may prepay the excise tax under paragraph (a)(1) of this section on any excess parachute payment for the taxable year of the separation from employment or any later taxable year before the taxable year in which the parachute payment is actually or constructively paid. However, an employer may not prepay the excise tax on a payment to be made in cash if the present value of the payment is not reasonably ascertainable under § 31.3121(v)(2)–1(e)(4) or on a payment related to health coverage. Any prepayment must be based on the present value of the excise tax that would be due for the taxable year in which the employer will pay the excess parachute payment, and be calculated using the discount rate equal to 120 percent of the applicable Federal rate (determined under section 1274(d) and the regulations in part 1 under section 1274) and the tax rate in effect under section 11 for the year in which the excise tax is paid. For purposes of projecting the future value of a payment that provides for interest to be credited at a variable interest rate, the employer may make a reasonable assumption regarding the variable rate. An employer is not required to adjust the excise tax paid merely because the actual future interest rates are not the same as the rate used for purposes of projecting the future value of the payment.

(5) *Liability after a redetermination of total parachute payments.* If an ATEO determines that an estimate made under § 53.4960–3(j)(1) was incorrect, it must reapply the 3-times-base-amount test to reflect the actual time and amount of the payment. In reapplying the 3-times-base-amount test (and, if necessary, reallocating the base amount), the ATEO must determine the correct base amount allocable to any parachute payment paid in the taxable year. See § 1.280G–1, Q/A–33(d) for examples that may be applied by analogy to illustrate the rules of this paragraph (d)(5).

(6) *Examples.* The following examples illustrate the rules of this paragraph (d). For purposes of these examples, assume any entity referred to as ''ATEO'' is an ATEO, any entity referred to as ''CORP'' is not an ATEO, and all employees are HCEs of their respective employers.

(i) *Example 1 (Excess parachute payment paid by a non-ATEO)*—(A) *Facts.* ATEO 1 and CORP 1 are related organizations that are treated as the same employer for purposes of § 53.4960–3(e)(3) (defining separation from employment) and are both calendar year taxpayers. For 2022 through 2026, ATEO 1 and CORP 1 each pay Employee A $250,000 of compensation per year for services performed as an employee of each organization ($500,000 total per year). In 2027, ATEO 1 and CORP 1 each pay Employee A $1 million payment ($2 million total) that is contingent on Employee A's separation from employment with both ATEO 1 and CORP 1, all of which is remuneration, and no other compensation. Employee A is a covered employee of ATEO 1 in 2027.

(B) *Conclusion.* Employee A's base amount in 2027 is $500,000 (Employee A's average annual compensation from both ATEO 1 and CORP 1 for the previous 5 years). ATEO 1 makes a parachute payment of $2 million in 2027, the amount paid by both ATEO 1 and CORP 1 that is contingent on Employee A's separation from employment with ATEO 1 and all organizations that are treated as the same employer under § 53.4960–3(e)(3). Employee A's $2 million payment exceeds 3-times the base amount ($1.5 million). ATEO 1 makes a $1.5 million excess parachute payment (the amount by which $2 million exceeds the $500,000 base amount). However, ATEO 1 is liable for tax only on the excess parachute payment paid by ATEO 1 ($1 million parachute payment − $250,000 base amount = $750,000) that is subject to tax under § 53.4960–4(a). CORP 1 is not liable for tax under § 53.4960–4(a) in 2027.

(ii) *Example 2 (Election to prepay tax on excess parachute payments and effect on excess remuneration)*—(A) *Facts.* Employee B is a covered employee of

ATEO 2 with a base amount of $200,000 who is entitled to receive two parachute payments from ATEO 2, one of $200,000 and the other of $900,000. The $200,000 payment is made upon separation from employment, and the $900,000 payment is to be made on a date in a future taxable year. The present value of the $900,000 payment is $800,000 as of the date of the separation from employment. ATEO 2 elects to prepay the excise tax on the $900,000 future parachute payment (of which $740,000 is an excess parachute payment). The tax rate under section 11 is 21 percent for the taxable year the excise tax is paid and, using a discount rate determined under § 53.4960–3(i), the present value of the $155,400 ($740,000 × 21 percent) excise tax on the $740,000 future excess parachute payment is $140,000.

(B) *Conclusion*. The excess parachute payment is thus $800,000 ($200,000 plus $800,000 present value of the $900,000 future payment, less $200,000 base amount), with $40,000 of the base amount allocable to the $200,000 payment and $160,000 of the base amount allocable to the $900,000 payment. To prepay the excise tax on the $740,000 future excess parachute payment, the employer must satisfy its $140,000 obligation under section 4960 with respect to the future payment, in addition to the $33,600 excise tax ($160,000 × 21 percent) on the $160,000 excess parachute payment made upon separation from employment. For purposes of determining the amount of excess remuneration (if any) under section 4960(a)(1), the amount of remuneration paid by the employer to the covered employee for the taxable year of the separation from employment is reduced by the $900,000 of total excess parachute payments ($160,000 + $740,000).

[T.D. 9938, 86 FR 6219, Jan. 19, 2021]

§ 53.4960–5 [Reserved]

§ 53.4960–6 Applicability date.

(a) *General applicability date*. Sections 53.4960–0 through 53.4960–4 apply to taxable years beginning after December 31, 2021. Taxpayers may choose to apply §§ 53.4960–0 through 53.4960–4 to taxable years beginning after December 31, 2017, and on or before December 31, 2021, provided the taxpayer applies §§ 53.4960–0 through 53.4960–4 in their entirety and in a consistent manner.

(b) [Reserved]

[T.D. 9938, 86 FR 6219, Jan. 19, 2021]

§ 53.4961–1 Abatement of second tier taxes for correction within correction period.

If any taxable event is corrected during the correction period for the event, then any second tier tax imposed with respect to the event shall not be assessed. If the tax has been assessed, it shall be abated. If the tax has been collected, it shall be credited or refunded as an overpayment. For purposes of this section, the tax imposed includes interest, additions to the tax and additional amounts. For definitions of the terms *second tier tax*, *taxable event*, *correct*, and *correction period*, see § 53.4963–1.

§ 53.4961–2 Court proceedings to determine liability for second tier tax.

(a) *Introduction*. Under section 4961 (b) and (c), the period of limitations on collection may be suspended and assessment or collection of first or second tier tax may be prohibited during the pendency of administrative and judicial proceedings conducted to determine a taxpayer's liability for second tier tax. This section provides rules relating to the suspension of the limitations period and the prohibitions on assessment and collection. In addition, this section describes the administrative and judicial proceedings to which these rules apply.

(b) *Initial proceeding*—(1) *Defined*. For purposes of subpart K, an initial proceeding means a proceeding described in subparagraph (2) or (3).

(2) *Tax Court proceeding before assessment*. A proceeding is described in this subparagraph (2) if it is a proceeding with respect to the taxpayer's liability for second tier tax and is commenced in accordance with section 6213 (a).

(3) *Refund proceeding commenced before correction period ends*. A proceeding is described in this subparagraph (3) if it is a proceeding commenced under section 7422, in accordance with the provisions of § 53.4963–1(e) (4) and (5) (relating to prerequisites to extension of the correction period during certain refund proceedings), and with respect

to the taxpayer's liability for second tier tax.

(c) *Supplemental proceeding*—(1) *Jurisdiction*. If a determination in an initial proceeding that a taxpayer is liable for a second tier tax has become final, the court in which the initial proceeding was commenced shall have jurisdiction to conduct any necessary supplemental proceeding to determine whether the taxable event was corrected during the correction period.

(2) *Time for beginning proceeding*. The time for beginning a supplemental proceeding begins on the day after a determination in an initial proceeding becomes final and ends on the 90th day after the last day of the correction period.

(d) *Restriction on assessment during Tax Court proceeding*. If a supplemental proceeding described in section 4961 (b) and § 53.4961–2(c) is commenced in the Tax Court, the provisions of the second and third sentences of section 6213(a) and the first and third sentences of § 301.6213–1(a)(2) apply with respect to a deficiency in second tier tax until the decision of the Tax Court in the supplemental proceeding is final.

(e) *Suspension of period of collection for second tier tax*—(1) *Scope*. Except as provided in subparagraph (6), this paragraph (e) applies to the second tier tax assessed with respect to a taxable event if a claim described in subparagraph (2) is filed.

(2) *Claim for refund*. A claim for refund is described in this subparagraph (2) if, no later than 90 days after the day on which the second tier tax is assessed with respect to a taxable event, the taxpayer—

(i) Pays the full amount of first tier tax for the taxable period, and

(ii) Files a claim for refund of the amount paid.

(3) *Collection prohibited*. No levy or proceeding in court for the collection of the second tier tax shall be made, begun, or prosecuted until the end of the collection prohibition period described in subparagraph (5). Notwithstanding section 7421(a), the collection by levy or proceeding may be enjoined during the collection prohibition period by a proceeding in the proper court.

(4) *Suspension of running of period of limitations on collection*. With respect to a second tier tax to which this paragraph (e) applies, the running of the period of limitations provided in section 6502 (relating to collection of tax by levy or by a proceeding in court) shall be suspended for the collection prohibition period described in subparagraph (5).

(5) *Collection prohibition period*. The collection prohibition period begins on the day the second tier tax is assessed and ends on the latest of:

(i) The day a decision in a refund proceeding commenced before the 91st day after denial of the claim described in subparagraph (2) of this paragraph (including any supplemental proceeding under § 53.4961–2(c)) becomes final;

(ii) The 90th day after the claim referred to in subparagraph (2) is denied; or

(iii) The 90th day after the second tier tax is assessed.

(6) *Jeopardy collection*. If the Secretary makes a finding that the collection of the second tier tax is in jeopardy, nothing in this paragraph (e) shall prevent the immediate collection of such tax.

(f) *Finality*—(1) *Tax Court proceeding*. For purposes of this subpart K, section 7481 applies in determining when a decision in a Tax Court proceeding becomes final.

(2) *Refund proceeding*. For purposes of this subpart K, § 301.7422–1 applies in determining when a decision in a refund proceeding becomes final.

§ 53.4963–1 Definitions.

(a) *First tier tax*. For purposes of this subpart K, the term *first tier tax* means any tax imposed by subsection (a) of section 4941, 4942, 4943, 4944, 4945, 4951, 4952, 4955, 4958, 4966, 4967, 4971, or 4975. A first tier tax may also be referred to as an ''initial tax'' in parts 53 and 54.

(b) *Second tier tax*. For purposes of this subpart K, the term *second tier tax* means any tax imposed by subsection (b) of section 4941, 4942, 4943, 4944, 4945, 4951, 4952, 4955, 4958, 4971, or 4975. A second tier tax may also be referred to as an ''additional tax'' in parts 53 and 54.

(c) *Taxable event*. For purposes of this subpart K, the term *taxable event* means any act, or failure to act, giving

rise to liability for tax under section 4941, 4942, 4943, 4944, 4945, 4951, 4952, 4955, 4958, 4966, 4967, 4971, or 4975.

(d) *Correct*—(1) *In general*. Except as provided in subparagraph (2), the term *correct* has the same meaning for purposes of this subpart K as in the section which imposes the second tier tax or the regulations thereunder.

(2) *Special rules*. The term *correct* means—

(i) For a second tier tax imposed by section 4942(b), reducing the amount of the undistributed income to zero,

(ii) For a second tier tax imposed by section 4943(b), reducing the amount of the excess business holdings to zero, and

(iii) For a second tier tax imposed by section 4944(b), removing the investment from jeopardy.

(e) *Correction period*—(1) *In general*. The correction period with respect to any taxable event shall begin with the date on which the taxable event occurs and shall end 90 days after the date of mailing of a notice of deficiency under section 6212 with respect to the second tier tax imposed with respect to the taxable event.

(2) *Extensions of correction period*. The correction period referred to in subparagraph (1) of this paragraph shall be extended by any period in which a deficiency cannot be assessed under section 6213(a). In addition, the correction period referred to in subparagraph (1) of this paragraph (e) shall be extended in accordance with subparagraph (3), (4), and (5) of this paragraph except that subparagraph (4), or (5) shall not operate to extend a correction period with respect to which a taxpayer has filed a petition with the United States Tax Court for redetermination of a deficiency within the time prescribed by section 6213(a).

(3) *Extensions by Commissioner*. The correction period referred to in subparagraph (1) of this paragraph may be extended by any period which the Commissioner determines is reasonable and necessary to bring about correction (including, for taxes imposed by section 4975, equitable relief sought by the Secretary of Labor) of the taxable event. The Commissioner ordinarily will not extend the correction period unless the following factors are present.

(i) The taxpayer on whom the second tier tax is imposed, the Secretary of Labor (for taxes imposed by section 4975), or an appropriate State officer (as defined in section 6104(c)(2)) is actively seeking in good faith to correct the taxable event;

(ii) Adequate corrective action cannot reasonably be expected to result during the unextended correction period;

(iii) For taxes imposed by section 4975, the Secretary of Labor requests the extension because subdivision (ii) applies; and

(iv) For taxes imposed by chapter 42 (other than taxes imposed by section 4940), the taxable event appears to have been an isolated occurrence so that it appears unlikely that similar taxable events will occur in the future.

(4) *Extension for payment of first tier tax*. If, within the unexpected correction period, the taxpayer pays the full amount of the first tier tax imposed with respect to the taxable event the Commissioner shall extend the correction period to the later of—

(i) Ninety days after the payment of the first tier tax, or

(ii) The last day of the correction period determined without regard to this paragraph.

(5) *Extensions for filing claim for refund or refund suit*. If prior to the expiration of the correction period (including extensions) a claim for refund is filed with respect to payment of the full amount of the first tier tax imposed with respect to the taxable event, the Commissioner shall extend the correction period during the pendency of the claim plus an additional 90 days. If within that time a suit or proceeding referred to in section 7422(g) with respect to the claim is filed, the Commissioner shall extend the correction period until the determination in the suit for refund (determined without regard to a supplemental proceeding under section 4861(b)) is final, determined under § 301.7422–2(a).

(6) *End of correction period if waiver accepted*. If the notice of deficiency referred to in paragraph (1) is not mailed because there is a waiver of the restrictions on assessment and collection of

the deficiency or because the deficiency is paid, the correction period will end with the end of the collection prohibition period described in § 53.4961–2(e)(5).

(7) *Date on which taxable event occurs.* For purposes of subparagraph (1), the taxable event shall be treated as occurring—

(i) Under section 4942, on the first day of the taxable year for which there is undistributed income,

(ii) Under section 4943, on the first day on which there are excess business holdings,

(iii) Under section 4971, on the last day of the plan year in which there is an accumulated funding deficiency, and

(iv) In all other cases, the date on which the event occurred.

(f) *Effective date.* The provisions of this subpart K are effective with respect to second tier taxes assessed after December 24, 1980. The preceding sentence shall not be construed to permit the assessment of a tax in a case to which, on December 24, 1980, the doctrine of res judicata applied.

[T.D. 8084, 51 FR 16303, May 2, 1986; 51 FR 17732, May 15, 1986, as amended by T.D. 8628, 60 FR 62212, Dec. 5, 1995; T.D. 8920, 66 FR 2171, Jan. 10, 2001; T.D. 9855, 84 FR 14009, Apr. 9, 2019]

§ 53.4965–1 Overview.

(a) *Entity-level excise tax.* Section 4965 imposes two excise taxes with respect to certain tax shelter transactions to which tax-exempt entities are parties. Section 4965(a)(1) imposes an entity-level excise tax on certain tax-exempt entities that are parties to ''prohibited tax shelter transactions,'' as defined in section 4965(e). *See* § 53.4965–2 for the discussion of covered tax-exempt entities. *See* § 53.4965–3 for the definition of prohibited tax shelter transactions. *See* § 53.4965–4 for the definition of tax-exempt party to a prohibited tax shelter transaction. The entity-level excise tax under section 4965(a)(1) is imposed on a specified percentage of the entity's net income or proceeds that are attributable to the transaction for the relevant tax year (or a period within that tax year). The rate of tax depends on whether the entity knew or had reason to know that the transaction was a prohibited tax shelter transaction at the time the entity became a party to the transaction. *See* § 53.4965–7(a) for the discussion of the entity-level excise tax under section 4965(a)(1). *See* § 53.4965–6 for the discussion of ''knowing or having reason to know.'' *See* § 53.4965–8 for the definition of net income and proceeds and the standard for allocating net income and proceeds that are attributable to a prohibited tax shelter transaction to various periods.

(b) *Manager-level excise tax.* Section 4965(a)(2) imposes a manager-level excise tax on ''entity managers,'' as defined in section 4965(d), of tax-exempt entities who approve the entity as a party (or otherwise cause the entity to be a party) to a prohibited tax shelter transaction and know or have reason to know, at the time the tax-exempt entity enters into the transaction, that the transaction is a prohibited tax shelter transaction. *See* § 53.4965–5 for the definition of entity manager and the meaning of ''approving or otherwise causing,'' and § 53.4965–6 for the discussion of ''knowing or having reason to know.'' *See* § 53.4965–7(b) for the discussion of the manager-level excise tax under section 4965(a)(2).

(c) *Effective/applicability dates. See* § 53.4965–9 for the discussion of the relevant effective and applicability dates.

[T.D. 9492, 75 FR 38702, July 6, 2010]

§ 53.4965–2 Covered tax-exempt entities.

(a) *In general.* Under section 4965(c), the term ''tax-exempt entity'' refers to entities that are described in sections 501(c), 501(d), or 170(c) (other than the United States), Indian tribal governments (within the meaning of section 7701(a)(40)), and tax-qualified pension plans, individual retirement arrangements and similar tax-favored savings arrangements that are described in sections 4979(e)(1), (2) or (3), 529, 457(b), or 4973(a). The tax-exempt entities referred to in section 4965(c) are divided into two broad categories, non-plan entities and plan entities.

(b) *Non-plan entities.* Non-plan entities are—

(1) Entities described in section 501(c);

(2) Religious or apostolic associations or corporations described in section 501(d);

(3) Entities described in section 170(c), including states, possessions of the United States, the District of Columbia, political subdivisions of states and political subdivisions of possessions of the United States (but not including the United States); and

(4) Indian tribal governments within the meaning of section 7701(a)(40).

(c) *Plan entities.* Plan entities are—

(1) Entities described in section 4979(e)(1) (qualified plans under section 401(a), including qualified cash or deferred arrangements under section 401(k) (including a section 401(k) plan that allows designated Roth contributions));

(2) Entities described in section 4979(e)(2) (annuity plans described in section 403(a));

(3) Entities described in section 4979(e)(3) (annuity contracts described in section 403(b), including a section 403(b) arrangement that allows Roth contributions);

(4) Qualified tuition programs described in section 529;

(5) Eligible deferred compensation plans under section 457(b) that are maintained by a governmental employer as defined in section 457(e)(1)(A);

(6) Arrangements described in section 4973(a) which include—

(i) Individual retirement plans defined in section 408(a) and (b), including—

(A) Simplified employee pensions (SEPs) under section 408(k);

(B) Simple individual retirement accounts (SIMPLEs) under section 408(p);

(C) Deemed individual retirement accounts or annuities (IRAs) qualified under a qualified plan (deemed IRAs) under section 408(q); and

(D) Roth IRAs under section 408A.

(ii) Arrangements described in section 220(d) (Archer Medical Savings Accounts (MSAs));

(iii) Arrangements described in section 403(b)(7) (custodial accounts treated as annuity contracts);

(iv) Arrangements described in section 530 (Coverdell education savings accounts); and

(v) Arrangements described in section 223(d) (health savings accounts (HSAs)).

(d) *Effective/applicability dates.* See § 53.4965–9 for the discussion of the relevant effective and applicability dates.

[T.D. 9492, 75 FR 38702, July 6, 2010; 75 FR 46844, Aug. 4, 2010]

§ 53.4965–3 Prohibited tax shelter transactions.

(a) *In general.* Under section 4965(e), the term *prohibited tax shelter transaction* means—

(1) Listed transactions within the meaning of section 6707A(c)(2), including subsequently listed transactions described in paragraph (b) of this section; and

(2) Prohibited reportable transactions, which consist of the following reportable transactions within the meaning of section 6707A(c)(1)—

(i) Confidential transactions, as described in § 1.6011–4(b)(3) of this chapter; or

(ii) Transactions with contractual protection, as described in § 1.6011–4(b)(4) of this chapter.

(b) *Subsequently listed transactions.* A subsequently listed transaction for purposes of section 4965 is a transaction that is identified by the Secretary as a listed transaction after the tax-exempt entity has entered into the transaction and that was not a prohibited reportable transaction (within the meaning of section 4965(e)(1)(C) and paragraph (a)(2) of this section) at the time the entity entered into the transaction.

(c) *Cross-reference.* The determination of whether a transaction is a listed transaction or a prohibited reportable transaction for section 4965 purposes shall be made under the law applicable to section 6707A(c)(1) and (c)(2).

(d) *Effective/applicability dates.* See § 53.4965–9 for the discussion of the relevant effective and applicability dates.

[T.D. 9492, 75 FR 38702, July 6, 2010]

§ 53.4965–4 Definition of tax-exempt party to a prohibited tax shelter transaction.

(a) *In general.* For purposes of sections 4965 and 6033(a)(2), a tax-exempt entity is a party to a prohibited tax shelter transaction if the entity—

(1) Facilitates a prohibited tax shelter transaction by reason of its tax-exempt, tax indifferent or tax-favored status; or

(2) Is identified in published guidance, by type, class or role, as a party to a prohibited tax shelter transaction.

(b) Published guidance may identify which tax-exempt entities, by type, class or role, will not be treated as a party to a prohibited tax shelter transaction.

(c) *Example*. The following example illustrates the principle of paragraph (a)(1) of this section:

Example. A tax-exempt entity enters into a transaction (Transaction A) with an S corporation. Transaction A is the same as or substantially similar to the transaction identified by the Secretary as a listed transaction in Notice 2004–30 (2004–1 CB 828). The tax-exempt entity's role in Transaction A is similar to the role of the tax-exempt party, as described in Notice 2004–30. Under the terms of the transaction, as described in Notice 2004–30, the tax-exempt entity receives the S corporation stock and purports to aid the S corporation and its shareholders in avoiding taxable income. The tax-exempt entity facilitates Transaction A by reason of its tax-exempt, tax indifferent or tax-favored status. Accordingly, the tax-exempt entity is a party to Transaction A for purposes of sections 4965 and 6033(a)(2). *See* § 601.601(d)(2)(ii)(*b*) of this chapter.

(d) *Effective/applicability dates*. See § 53.4965–9 for the discussion of the relevant effective and applicability dates.

[T.D. 9492, 75 FR 38702, July 6, 2010]

§ 53.4965–5 Entity managers and related definitions.

(a) *Entity manager of a non-plan entity*—(1) *In general*. Under section 4965(d)(1), an *entity manager of a non-plan entity* is—

(i) A person with the authority or responsibility similar to that exercised by an officer, director, or trustee of an organization (that is, the non-plan entity); and

(ii) With respect to any act, the person who has final authority or responsibility (either individually or as a member of a collective body) with respect to such act.

(2) *Definition of officer*. For purposes of paragraph (a)(1)(i) of this section, a person is considered to be an officer of the non-plan entity (or to have similar authority or responsibility) if the person—

(i) Is specifically designated as such under the certificate of incorporation, by-laws, or other constitutive documents of the non-plan entity; or

(ii) Regularly exercises general authority to make administrative or policy decisions on behalf of the non-plan entity.

(3) *Exception for acts requiring approval by a superior*. With respect to any act, any person is not described in paragraph (a)(2)(ii) of this section if the person has authority merely to recommend particular administrative or policy decisions, but not to implement them without approval of a superior.

(4) *Delegation of authority*. A person is an entity manager of a non-plan entity within the meaning of paragraph (a)(1)(ii) of this section if, with respect to any prohibited tax shelter transaction, such person has been delegated final authority or responsibility with respect to such transaction (including by transaction type or dollar amount) by a person described in paragraph (a)(1)(i) of this section or the governing board of the entity. For example, an investment manager is an entity manager with respect to a prohibited tax shelter transaction if the non-plan entity's governing body delegated to the investment manager the final authority to make certain investment decisions and, in the exercise of that authority, the manager committed the entity to the transaction. To be considered an entity manager of a non-plan entity within the meaning of paragraph (a)(1)(ii) of this section, a person need not be an employee of the entity. A person is not described in paragraph (a)(1)(ii) of this section if the person is merely implementing a decision made by a superior.

(b) *Entity manager of a plan entity*—(1) *In general*. Under section 4965(d)(2), an *entity manager of a plan entity* is the person who approves or otherwise causes the entity to be a party to the prohibited tax shelter transaction.

(2) *Special rule for plan participants and beneficiaries who have investment elections*—(i) *Fully self-directed plans or arrangements*. In the case of a fully self-directed qualified plan, IRA, or other savings arrangement (including a case

where a plan participant or beneficiary is given a list of prohibited investments, such as collectibles), if the plan participant or beneficiary selected a certain investment and, therefore, approved the plan entity to become a party to a prohibited tax shelter transaction, the plan participant or the beneficiary is an entity manager.

(ii) *Plans or arrangements with limited investment options.* In the case of a qualified plan, IRA, or other savings arrangement where a plan participant or beneficiary is offered a limited number of investment options from which to choose, the person responsible for determining the pre-selected investment options is an entity manager and the plan participant or the beneficiary generally is not an entity manager.

(c) *Meaning of ''approves or otherwise causes''*—(1) *In general.* A person is treated as approving or otherwise causing a tax-exempt entity to become a party to a prohibited tax shelter transaction if the person has the authority to commit the entity to the transaction, either individually or as a member of a collective body, and the person exercises that authority.

(2) *Collective bodies.* If a person shares the authority described in paragraph (c)(1) of this section as a member of a collective body (for example, board of trustees or committee), the person will be considered to have exercised such authority if the person voted in favor of the entity becoming a party to the transaction. However, a member of the collective body will not be treated as having exercised the authority described in paragraph (c)(1) of this section if he or she voted against a resolution that constituted approval or an act that caused the tax-exempt entity to be a party to a prohibited tax shelter transaction, abstained from voting for such approval, or otherwise failed to vote in favor of such approval.

(3) *Exceptions*—(i) *Successor in interest.* If a tax-exempt entity that is a party to a prohibited tax shelter transaction is dissolved, liquidated, or merged into a successor entity, an entity manager of the successor entity will not, solely by reason of the reorganization, be treated as approving or otherwise causing the successor entity to become a party to a prohibited tax shelter transaction, provided that the reorganization of the tax-exempt entity does not result in a material change to the terms of the transaction. For purposes of this paragraph (c)(3)(i), a material change includes an extension or renewal of the agreement (other than an extension or renewal that results from another party to the transaction unilaterally exercising an option granted by the agreement) or a more than incidental change to any payment under the agreement. A change for the sole purpose of substituting the successor entity for the original tax-exempt party is not a material change.

(ii) *Exercise or nonexercise of options.* Nonexercise of an option pursuant to a transaction involving the tax-exempt entity generally will not constitute an act of approving or causing the entity to be a party to the transaction. If, pursuant to a transaction involving the tax-exempt entity, the entity manager exercises an option (such as a repurchase option), the entity manager will not be subject to the entity manager-level tax if the exercise of the option does not result in the tax-exempt entity becoming a party to a second transaction that is a prohibited tax shelter transaction.

(4) *Example.* The following example illustrates the principles of paragraph (c)(3)(ii) of this section:

Example. In a sale-in, lease-out (SILO) transaction described in Notice 2005–13 (2005–1 CB 630), X, which is a non-plan entity, has purported to sell property to Y, a taxable entity and lease it back for a term of years. At the end of the basic lease term, X has the option of ''repurchasing'' the property from Y for a predetermined purchase price, with funds that have been set aside at the inception of the transaction for that purpose. The entity manager, by deciding to exercise or not exercise the ''repurchase'' option is not approving or otherwise causing the non-plan entity to become a party to a second prohibited tax shelter transaction. See § 601.601(d)(2)(ii)(*b*) of this chapter.

(5) *Coordination with the reason-to-know standard.* The determination that an entity manager approved or caused a tax-exempt entity to be a party to a prohibited tax shelter transaction, by itself, does not establish liability for the section 4965(a)(2) tax. For rules on determining whether an entity manager knew or had reason to know that

the transaction was a prohibited tax shelter transaction, *see* § 53.4965–6(b).

(d) *Effective/applicability dates*. *See* § 53.4965–9 for the discussion of the relevant effective and applicability dates.

[T.D. 9492, 75 FR 38702, July 6, 2010; 75 FR 46844, Aug. 4, 2010]

§ 53.4965–6 Meaning of "knows or has reason to know".

(a) *Attribution to the entity*. An entity will be treated as knowing or having reason to know for section 4965 purposes if one or more of its entity managers knew or had reason to know that the transaction was a prohibited tax shelter transaction at the time the entity manager(s) approved the entity as (or otherwise caused the entity to be) a party to the transaction. The entity shall be attributed the knowledge or reason to know of any entity manager described in § 53.4965–5(a)(1)(i) even if that entity manager does not approve the entity as (or otherwise cause the entity to be) a party to the transaction.

(b) *Determining whether an entity manager knew or had reason to know*—(1) *In general*. Whether an entity manager knew or had reason to know that a transaction is a prohibited tax shelter transaction is based on all facts and circumstances. In order for an entity manager to know or have reason to know that a transaction is a prohibited tax shelter transaction, the entity manager must have knowledge of sufficient facts that would lead a reasonable person to conclude that the transaction is a prohibited tax shelter transaction. An entity manager will be considered to have ''reason to know'' if a reasonable person in the entity manager's circumstances would conclude that the transaction was a prohibited tax shelter transaction based on all the facts reasonably available to the manager at the time of approving the entity as (or otherwise causing the entity to be) a party to the transaction. Factors that will be considered in determining whether a reasonable person in the entity manager's circumstances would conclude that the transaction was a prohibited tax shelter transaction include, but are not limited to—

(i) The presence of tax shelter indicia (see paragraph (b)(2) of this section);

(ii) Whether the entity manager received a disclosure statement prior to the consummation of the transaction indicating that the transaction may be a prohibited tax shelter transaction (see paragraph (b)(3) of this section); and

(iii) Whether the entity manager made appropriate inquiries into the transaction (see paragraph (b)(4) of this section).

(2) *Tax-shelter indicia*. The presence of indicia that a transaction is a tax shelter will be treated as an indication that the entity manager knew or had reason to know that the transaction was a prohibited tax shelter transaction. Tax shelter indicia include but are not limited to—

(i) The transaction is extraordinary for the entity considering prior investment activity;

(ii) The transaction promises an economic return for the organization that is exceptional considering the amount invested by, the participation of, or the absence of risk to the organization; or

(iii) The transaction is of significant size relative to the receipts of the entity.

(3) *Effect of disclosure statements*. Receipt by an entity manager of a statement, including a statement described in section 6011(g), in advance of a transaction that the transaction may be a prohibited tax shelter transaction (or a statement that a partnership, hedge fund or other investment conduit may engage in a prohibited tax shelter transaction in the future) is a factor relevant in the determination of whether the entity manager knew or had reason to know that the transaction is a prohibited transaction. However, an entity manager will not be treated as knowing or having reason to know that the transaction was a prohibited tax shelter transaction solely because the entity manager receives such a disclosure.

(4) *Appropriate inquiries*. What inquiries are appropriate will be determined from the facts and circumstances of each case. For example, if one or more tax shelter indicia are present or if an entity manager receives a disclosure statement described in paragraph (b)(3) of this section, an entity manager has a responsibility to inquire further

whether the transaction is a prohibited tax shelter transaction.

(c) *Reliance on professional advice*—(1) *In general*. An entity manager is not required to obtain the advice of a professional tax advisor to establish that the entity manager made appropriate inquiries. Moreover, not seeking professional advice, by itself, shall not give rise to an inference that the entity manager had reason to know that a transaction is a prohibited tax shelter transaction.

(2) *Reliance on written opinion of professional tax advisor*. An entity manager may establish that he or she did not have a reason to know that a transaction was a prohibited tax shelter transaction at the time the tax-exempt entity entered into the transaction if the entity manager reasonably, and in good faith, relied on the written opinion of a professional tax advisor. Reliance on the written opinion of a professional tax advisor establishes that the entity manager did not have reason to know if, taking into account all the facts and circumstances, the reliance was reasonable and the entity manager acted in good faith. For example, the entity manager's education, sophistication, and business experience will be relevant in determining whether the reliance was reasonable and made in good faith. In no event will an entity manager be considered to have reasonably relied in good faith on an opinion unless the requirements of this paragraph (c)(2) are satisfied. The fact that these requirements are satisfied, however, will not necessarily establish that the entity manager reasonably relied on the opinion in good faith. For example, reliance may not be reasonable or in good faith if the entity manager knew, or reasonably should have known, that the advisor lacked knowledge in the relevant aspects of Federal tax law.

(i) *All facts and circumstances considered*. The advice must be based upon all pertinent facts and circumstances and the law as it relates to those facts and circumstances. The requirements of this paragraph (c)(2) are not satisfied if the entity manager fails to disclose a fact that it knows, or reasonably should know, is relevant to determining whether the transaction is a prohibited tax shelter transaction.

(ii) *No unreasonable assumptions*. The advice must not be based on unreasonable factual or legal assumptions (including assumptions as to future events) and must not unreasonably rely on the representations, statements, findings, or agreements of the entity manager or any other person (including another party to the transaction or a material advisor within the meaning of sections 6111 and 6112).

(iii) *''More likely than not'' opinion*. The written opinion of the professional tax advisor must apply the appropriate law to the facts and, based on this analysis, must conclude that the transaction was not a prohibited tax shelter transaction at a ''more likely than not'' level of certainty at the time the entity manager approved the entity (or otherwise caused the entity) to be a party to the transaction.

(3) *Special rule*. An entity manager's reliance on a written opinion of a professional tax advisor will not be considered reasonable if the advisor is, or is related to a person who is, a material advisor with respect to the transaction within the meaning of sections 6111 and 6112.

(d) *Subsequently listed transactions*. An entity manager will not be treated as knowing or having reason to know that a transaction (other than a prohibited reportable transaction as defined in section 4965(e)(1)(C) and § 53.4965–3(a)(2)) is a prohibited tax shelter transaction if the entity enters into the transaction before the date on which the transaction is identified by the Secretary as a listed transaction.

(e) *Effective/applicability dates*. See § 53.4965–9 for the discussion of the relevant effective and applicability dates.

[T.D. 9492, 75 FR 38702, July 6, 2010]

§ 53.4965–7 Taxes on prohibited tax shelter transactions.

(a) *Entity-level taxes*—(1) *In general*. Entity-level excise taxes apply to non-plan entities (as defined in § 53.4965–2(b)) that are parties to prohibited tax shelter transactions.

(i) *Prohibited tax shelter transactions other than subsequently listed transactions*—(A) *Amount of tax if the entity did not know and did not have reason to*

know. If the tax-exempt entity did not know and did not have reason to know that the transaction was a prohibited tax shelter transaction at the time the entity entered into the transaction, the tax is the highest rate of tax under section 11 multiplied by the greater of—

(*1*) The entity's net income with respect to the prohibited tax shelter transaction (after taking into account any tax imposed by Subtitle D, other than by this section, with respect to such transaction) for the taxable year; or

(*2*) 75 percent of the proceeds received by the entity for the taxable year that are attributable to such transaction.

(B) *Amount of tax if the entity knew or had reason to know*. If the tax-exempt entity knew or had reason to know that the transaction was a prohibited tax shelter transaction at the time the entity entered into the transaction, the tax is the greater of—

(*1*) 100 percent of the entity's net income with respect to the transaction (after taking into account any tax imposed by Subtitle D, other than by this section, with respect to such transaction) for the taxable year; or

(*2*) 75 percent of the proceeds received by the entity for the taxable year that are attributable to such transaction.

(ii) *Subsequently listed transactions*—(A) *In general*. In the case of a subsequently listed transaction (as defined in section 4965(e)(2) and § 53.4965–3(b)), the tax-exempt entity's income and proceeds attributable to the transaction are allocated between the period before the transaction became listed and the period beginning on the date the transaction became listed. See § 53.4965–8 for the standard for allocating net income or proceeds to various periods. The tax for each taxable year is the highest rate of tax under section 11 multiplied by the greater of—

(*1*) The entity's net income with respect to the subsequently listed transaction (after taking into account any tax imposed by Subtitle D, other than by this section, with respect to such transaction) for the taxable year that is allocable to the period beginning on the later of the date such transaction is identified by the Secretary as a listed transaction or the first day of the taxable year; or

(*2*) 75 percent of the proceeds received by the entity for the taxable year that are attributable to such transaction and allocable to the period beginning on the later of the date such transaction is identified by the Secretary as a listed transaction or the first day of the taxable year.

(B) *No increase in tax*. The 100 percent tax under section 4965(b)(1)(B) and § 53.4965–7(a)(1)(i)(B) does not apply to any subsequently listed transaction (as defined in section 4965(e)(2) and § 53.4965–3(b)) entered into by a tax-exempt entity before the date on which the transaction is identified by the Secretary as a listed transaction.

(2) *Taxable year*. The excise tax imposed under section 4965(a)(1) applies for the taxable year in which the entity becomes a party to the prohibited tax shelter transaction and any subsequent taxable year for which the entity has net income or proceeds attributable to the transaction. A taxable year for tax-exempt entities is the calendar year or fiscal year, as applicable, depending on the basis on which the tax-exempt entity keeps its books for Federal income tax purposes. If a tax-exempt entity has not established a taxable year for Federal income tax purposes, the entity's taxable year for the purpose of determining the amount and timing of net income and proceeds attributable to a prohibited tax shelter transaction will be deemed to be the annual period the entity uses in keeping its books and records.

(b) *Manager-level taxes*—(1) *Amount of tax*. If any entity manager approved or otherwise caused the tax-exempt entity to become a party to a prohibited tax shelter transaction and knew or had reason to know that the transaction was a prohibited tax shelter transaction, such entity manager is liable for the $20,000 tax. See § 53.4965–5(d) for the meaning of approved or otherwise caused. See § 53.4965–6 for the meaning of knew or had reason to know.

(2) *Timing of the entity manager tax*. If a tax-exempt entity enters into a prohibited tax shelter transaction during a taxable year of an entity manager, then the entity manager that approved

or otherwise caused the tax-exempt entity to become a party to the transaction is liable for the entity manager tax for that taxable year if the entity manager knew or had reason to know that the transaction was a prohibited tax shelter transaction.

(3) *Example*. The application of paragraph (b)(2) of this section is illustrated by the following example:

Example. The entity manager's taxable year is the calendar year. On December 1, 2006, the entity manager approved or otherwise caused the tax-exempt entity to become a party to a transaction that the entity manager knew or had reason to know was a prohibited tax shelter transaction. The tax-exempt entity entered into the transaction on January 31, 2007. The entity manager is liable for the entity manager level tax for the entity manager's 2007 taxable year, during which the tax-exempt entity entered into the prohibited tax shelter transaction.

(4) *Separate liability*. If more than one entity manager approved or caused a tax-exempt entity to become a party to a prohibited tax shelter transaction while knowing (or having reason to know) that the transaction was a prohibited tax shelter transaction, then each such entity manager is separately (that is, not jointly and severally) liable for the entity manager-level tax with respect to the transaction.

(c) *Effective/applicability dates*. *See* § 53.4965–9 for the discussion of the relevant effective and applicability dates.

[T.D. 9492, 75 FR 38702, July 6, 2010]

§ 53.4965–8 Definition of net income and proceeds and standard for allocating net income or proceeds to various periods.

(a) *In general*. For purposes of section 4965(a), the amount and the timing of the net income and proceeds attributable to the prohibited tax shelter transaction will be computed in a manner consistent with the substance of the transaction. In determining the substance of listed transactions, the IRS will look to, among other items, the listing guidance and any subsequent guidance published in the Internal Revenue Bulletin relating to the transaction.

(b) *Definition of net income and proceeds*—(1) *Net income*. A tax-exempt entity's net income attributable to a prohibited tax shelter transaction is its gross income derived from the transaction reduced by those deductions that are attributable to the transaction and that would be allowed by chapter 1 of the Internal Revenue Code if the tax-exempt entity were treated as a taxable entity for this purpose, and further reduced by taxes imposed by Subtitle D, other than by this section, with respect to the transaction.

(2) *Proceeds*—(i) *Tax-exempt entities that facilitate the transaction by reason of their tax-exempt, tax indifferent or tax-favored status*. Solely for purposes of section 4965, in the case of a tax-exempt entity that is a party to the transaction by reason of § 53.4965–4(a)(1) of this chapter, the term *proceeds* means the gross amount of the tax-exempt entity's consideration for facilitating the transaction, not reduced for any costs or expenses attributable to the transaction. Published guidance with respect to a particular prohibited tax shelter transaction may designate additional amounts as proceeds from the transaction for section 4965 purposes.

(ii) *Treatment of gifts and contributions*. To the extent not otherwise included in the definition of proceeds in paragraph (b)(2)(i) of this section, any amount that is a gift or a contribution to a tax-exempt entity and is attributable to a prohibited tax shelter transaction will be treated as proceeds for section 4965 purposes, unreduced by any associated expenses.

(c) *Allocation of net income and proceeds*—(1) *In general*. For purposes of section 4965(a), the net income and proceeds attributable to a prohibited tax shelter transaction must be allocated in a manner consistent with the tax-exempt entity's established method of accounting for Federal income tax purposes. If the tax-exempt entity has not established a method of accounting for Federal income tax purposes, solely for purposes of section 4965(a) the tax-exempt entity must use the cash receipts and disbursements method of accounting (cash method) provided for in section 446 of the Internal Revenue Code to determine the amount and timing of net income and proceeds attributable to a prohibited tax shelter transaction.

(2) *Special rule*. If a tax-exempt entity has established a method of accounting other than the cash method, the tax-exempt entity may nevertheless use the cash method of accounting to determine the amount of the net income and proceeds—

(i) Attributable to a prohibited tax shelter transaction entered into prior to the effective date of section 4965(a) tax and allocable to pre- and post-effective date periods; or

(ii) Attributable to a subsequently listed transaction and allocable to pre- and post-listing periods.

(d) *Transition year rules*. In the case of the taxable year that includes August 16, 2006 (the transition year), the IRS will treat the period beginning on the first day of the transition year and ending on August 15, 2006, and the period beginning on August 16, 2006, and ending on the last day of the transition year as short taxable years. This treatment is solely for purposes of allocating net income or proceeds under section 4965. The tax-exempt entity continues to file tax returns for the full taxable year, does not file tax returns with respect to these deemed short taxable years and does not otherwise take the short taxable years into account for Federal tax purposes. Accordingly, the net income or proceeds that are properly allocated to the transition year in accordance with this section will be treated as allocable to the period—

(1) Ending on or before August 15, 2006 (and accordingly not subject to tax under section 4965(a)) to the extent such net income or proceeds would have been properly taken into account in accordance with this section by the tax-exempt entity in the deemed short year ending on August 15, 2006; and

(2) Beginning after August 15, 2006 (and accordingly subject to tax under section 4965(a)) to the extent such income or proceeds would have been properly taken into account in accordance with this section by the tax-exempt entity in the short year beginning August 16, 2006.

(e) *Allocation to pre- and post-listing periods*. If a transaction other than a prohibited reportable transaction (as defined in section 4965(e)(1)(C) and § 53.4965–3(a)(2)) to which the tax-exempt entity is a party is subsequently identified in published guidance as a listed transaction during a taxable year of the entity (the listing year) in which it has net income or proceeds attributable to the transaction, the net income or proceeds are allocated between the pre- and post-listing periods. The IRS will treat the period beginning on the first day of the listing year and ending on the day immediately preceding the date of the listing, and the period beginning on the date of the listing and ending on the last day of the listing year as short taxable years. This treatment is solely for purposes of allocating net income or proceeds under section 4965. The tax-exempt entity continues to file tax returns for the full taxable year, does not file tax returns with respect to these deemed short taxable years and does not otherwise take the short taxable years into account for Federal tax purposes. Accordingly, the net income or proceeds that are properly allocated to the listing year in accordance with this section will be treated as allocable to the period—

(1) Ending before the date of the listing (and accordingly not subject to tax under section 4965(a)) to the extent such net income or proceeds would have been properly taken into account in accordance with this section by the tax-exempt entity in the deemed short year ending on the day immediately preceding the date of the listing; and

(2) Beginning on the date of the listing (and accordingly subject to tax under section 4965(a)) to the extent such income or proceeds would have been properly taken into account in accordance with this section by the tax-exempt entity in the short year beginning on the date of the listing.

(f) *Examples*. The following examples illustrate the allocation rules of this section:

Example 1. (i) In 1999, X, a calendar year non-plan entity using the cash method of accounting, entered into a lease-in/lease-out transaction (LILO) substantially similar to the transaction described in Notice 2000–15 (2000–1 CB 826) (describing Rev. Rul. 99–14 (1999–1 CB 835), superseded by Rev. Rul. 2002–69 (2002–2 CB 760)). In 1999, X purported to lease property to Y pursuant to a ''head lease,'' and Y purported to lease the property back to X pursuant to a ''sublease'' of a

shorter term. In form, X received $268M as an advance payment of head lease rent. Of this amount, $200M had been, in form, financed by a nonrecourse loan obtained by Y. X deposited the $200M with a ''debt payment undertaker.'' This served to defease both a portion of X's rent obligation under its sublease and Y's repayment obligation under the nonrecourse loan. Of the remainder of the $268M advance head lease rent payment, X deposited $54M with an ''equity payment undertaker.'' This served to defease the remainder of X's rent obligation under the sublease as well as the exercise price of X's end-of-sublease term purchase option. This amount inures to the benefit of Y and enables Y to recover its investment in the transaction and a return on that investment. In substance, the $54M is a loan from Y to X. X retained the remaining $14M of the advance head lease rent payment. In substance, this represents a fee for X's participation in the transaction. See § 601.601(d)(2)(ii)(*b*) of this chapter.

(ii) According to the substance of the transaction, the head lease, sublease and nonrecourse debt will be ignored for Federal income tax purposes. Therefore, any net income or proceeds resulting from these elements of the transaction will not be considered net income or proceeds attributable to the LILO transaction for purposes of section 4965(a). The $54M deemed loan from Y to X and the $14M fee are not ignored for Federal income tax purposes.

(iii) Under X's established cash basis method of accounting, any net income received in 1999 and attributable to the LILO transaction is allocated to X's December 31, 1999, tax year for purposes of section 4965. The $14M fee received in 1999, which constitutes proceeds of the transaction, is likewise allocated to that tax year. Because the 1999 tax year is before the effective date of the section 4965 tax, X will not be subject to any excise tax under section 4965 for the amounts received in 1999.

(iv) Any earnings on the amount deposited with the equity payment undertaker that constitute gross income to X will be reduced by X's original issue discount deductions with respect to the deemed loan from Y, in determining X's net income from the transaction.

Example 2. B, a non-plan entity using the cash method of accounting, has an annual accounting period that ends on December 31, 2006. B entered into a prohibited tax shelter transaction on March 15, 2006. On that date, B received a payment of $600,000 as a fee for its involvement in the transaction. B received no other proceeds or income attributable to this transaction in 2006. Under B's method of accounting, the payment received by B on March 15, 2006, is taken into account in the deemed short year ending on August 15, 2006. Accordingly, solely for purposes of section 4965, the payment is treated as allocable solely to the period ending on or before August 15, 2006, and is not subject to the excise tax imposed by section 4965(a).

Example 3. The facts are the same as in *Example 2*, except that B received an additional payment of $400,000 on September 30, 2006. Under B's method of accounting, the payment received by B on September 30, 2006, is taken into account in the deemed short year beginning on August 16, 2006. Accordingly, solely for purposes of section 4965, the $400,000 payment is treated as allocable to the period beginning after August 15, 2006, and is subject to the excise tax imposed by section 4965(a).

Example 4. C, a non-plan entity using the cash method of accounting, has an annual accounting period that ends on December 31. C entered into a prohibited tax shelter transaction on May 1, 2005. On March 15, 2007, C received a payment of $580,000 attributable to the transaction. On June 1, 2007, the transaction is identified by the IRS in published guidance as a listed transaction. On June 15, 2007, C received an additional payment of $400,000 attributable to the transaction. Under C's method of accounting, the payments received on March 15, 2007, and June 15, 2007, are taken into account in 2007. The IRS will treat the period beginning on January 1, 2007, and ending on May 31, 2007, and the period beginning on June 1, 2007, and ending on December 31, 2007, as short taxable years. The payment received by C on March 15, 2007, is taken into account in the deemed short year ending on May 31, 2007. Accordingly, solely for purposes of section 4965, the payment is treated as allocable solely to the pre-listing period, and is not subject to the excise tax imposed by section 4965(a). The payment received by C on June 15, 2007, is taken into account in the deemed short year beginning on June 1, 2007. Accordingly, solely for purposes of section 4965, the payment is treated as allocable to the post-listing period, and is subject to the excise tax imposed by section 4965(a).

(g) *Effective/applicability dates.* See § 53.4965–9 for the discussion of the relevant effective and applicability dates.

[T.D. 9492, 75 FR 38702, July 6, 2010; 75 FR 46844, Aug. 4, 2010]

§ 53.4965–9 Effective/applicability dates.

(a) *In general.* The taxes under section 4965(a) and § 53.4965–7 are effective for taxable years ending after May 17, 2006, with respect to transactions entered into before, on or after that date, except that no tax under section 4965(a) applies with respect to income or proceeds that are properly allocable to

any period ending on or before August 15, 2006.

(b) *Applicability of the regulations.* As of July 6, 2010, except as provided in paragraph (c) of this section, §§ 53.4965–1 through 53.4965–8 of this chapter will apply to taxable years ending after July 6, 2007. A tax-exempt entity may rely on the provisions of §§ 53.4965–1 through 53.4965–8 for taxable years ending on or before July 6, 2007.

(c) *Effective/applicability date with respect to certain knowing transactions*—(1) *Entity-level tax.* The 100 percent tax under section 4965(b)(1)(B) and § 53.4965–7(a)(1)(i)(B) does not apply to prohibited tax shelter transactions entered into by a tax-exempt entity on or before May 17, 2006.

(2) *Manager-level tax.* The IRS will not assert that an entity manager who approved or caused a tax-exempt entity to become a party to a prohibited tax shelter transaction is liable for the entity manager tax under section 4965(b)(2) and § 53.4965–7(b)(1) with respect to the transaction if the tax-exempt entity entered into such transaction prior to May 17, 2006.

[T.D. 9492, 75 FR 38702, July 6, 2010]

§ 53.4968–1 Excise tax based on investment income of certain private colleges and universities.

(a) *Excise tax on the investment income of certain private colleges and universities.* For taxable years beginning after December 31, 2017, section 4968 of the Internal Revenue Code (Code) imposes a tax equal to 1.4 percent of the net investment income (as defined in section 4968(c) and § 53.4968–2) of an applicable educational institution (as defined in section 4968(b)(1) and paragraph (b)(1) of this section).

(b) *Definitions.* The definitions in this paragraph (b) apply for purposes of section 4968 and §§ 53.4968–1 through 53.4968–4.

(1) *Applicable educational institution.* The term *applicable educational institution* means any eligible educational institution (as defined in section 25A(f)(2) of the Code and § 1.25A–2(b) of this chapter)—

(i) That had at least 500 tuition-paying students during the preceding taxable year;

(ii) More than 50 percent of whose tuition-paying students are located in the United States;

(iii) That is not described in the first sentence of section 511(a)(2)(B) of the Code (relating to state colleges and universities); and

(iv) The aggregate fair market value of the assets of which at the end of such preceding taxable year (other than those assets that are used directly in carrying out the institution's exempt purpose) is at least $500,000 per student.

(2) *Student.* The term *student* means a person who is enrolled and attending a course for academic credit from the institution and who is being charged tuition at a rate that is commensurate with the tuition rate charged to students enrolled for a degree. The number of students of an educational institution (including for purposes of determining the number of students at a particular location) is based on the daily average number of full-time students (with part-time students taken into account on a full-time student equivalent basis). The standards for determining part-time students, full-time students, full-time equivalents, and daily average are determined by each educational institution. However, the standards may not be lower than the minimum applicable standards established by the Department of Education under the Higher Education Act of 1965 (20 U.S.C. 1088), as amended.

(3) *Tuition-paying*—(i) *In general.* The term *tuition-paying* means the payment of any tuition or fees required for the enrollment or attendance of a student for a course of instruction at an educational institution. Tuition and fees do not include payment for supplies or equipment required during a specific course once a student is enrolled in and attending the course, or payment for room and board or other personal living expenses.

(ii) *Treatment of a comprehensive or bundled fee.* If a student is required to pay a fee (such as a comprehensive fee or a bundled fee) to an educational institution that combines charges for tuition with charges for personal expenses such as room and board, the student is a tuition-paying student.

(iii) *Scholarships, grants, and work study programs.* Whether a student is tuition-paying is determined after taking into account any scholarships and grants provided directly by the educational institution or by the Federal government or any state or local government, and after application of any work study programs operated directly by the institution. Scholarships and grants provided by non-governmental third parties, even if administered by the institution, are considered payments of tuition on behalf of the student. Accordingly, a student will be considered a tuition-paying student if payment of tuition or a fee is required for the enrollment or attendance of the student for courses of instruction after the application of any scholarships offered directly by the institution, any work study program operated directly by the institution, and any grants and scholarships provided by the Federal government or any state or local government.

(4) *Located in the United States.* A student is *located in the United States* if the student resided in the United States for at least a portion of the time the student attended the educational institution during the institution's preceding taxable year. Whether a student resided in the United States in any given year can be determined using any reasonable method, as long as that method is consistently applied.

(5) *Assets used directly in carrying out an institution's exempt purpose*—(i) *In general.* Except as provided in paragraph (b)(5)(iv) of this section, an asset is *used directly in carrying out an educational institution's exempt purpose* only if the asset is actually used directly by the institution in carrying out its exempt purpose. Whether an asset is used directly by the institution to carry out its exempt purpose is determined based on all the facts and circumstances. If property is used for an exempt purpose and for other purposes, and the exempt use represents 95 percent or more of the total use, the property is considered to be used exclusively for an exempt purpose. If the exempt use of such property represents less than 95 percent of the total use, the institution must make a reasonable allocation between such exempt and nonexempt uses.

(ii) *Illustrations.* Examples of assets that are used directly in carrying out an institution's exempt purpose include, but are not limited to, the following—

(A) Administrative assets, such as office equipment and supplies used by the institution directly in the administration of its exempt activities;

(B) Real estate or the portion of any building used by the institution directly in its exempt activities;

(C) Physical property such as paintings or other works of art owned by the institution that are on public display (or held for public display), fixtures and equipment in classrooms, research facilities and related equipment that under the facts and circumstances serve a useful purpose in the conduct of the institution's exempt activities;

(D) The reasonable cash balance, determined using any reasonable method, necessary to cover current operating and administrative expenses and other normal and current disbursements directly connected with the educational institution's exempt activities. For this purpose, a reasonable method would include calculating an amount equal to three months of operating expenses allocable to program services, calculated by dividing annual functional expenses allocable to program services by four. A larger amount may be a reasonable cash balance for this purpose if, under the facts and circumstances, a larger amount is established to be necessary to cover administrative expenses and other normal disbursements directly connected with the institution's exempt activity.

(E) Any property the educational institution leases to other persons at no cost (or at a nominal rent) to the lessee in furtherance of the institution's exempt purposes; and

(F) Patents, copyrights, and other intellectual property and intangible property to the extent that income from those assets is excluded from net investment income by §53.4968–2(b)(2)(iii).

(iii) *Assets not used directly.* The following assets are examples of assets not used directly in carrying out an institution's exempt purpose—

(A) Assets that are held for the production of income or for investment (for example, stocks, bonds, interest-bearing notes, endowment funds, or leased real estate not described in paragraph (b)(5)(ii)(E) of this section), even if the income from such assets is used to carry out such exempt purpose; and

(B) Property (such as offices and equipment) used for the purpose of managing the institution's endowment funds.

(iv) *Assets of related organizations.* An asset of a related organization that is treated as an asset of an educational institution by section 4968(d) and § 53.4968–3(c) and that is used directly in carrying out an educational institution's exempt purpose, or that is used directly in carrying out the exempt purpose of a related organization that is described in section 501(c)(3), is considered used directly by the educational institution in carrying out its exempt purpose.

(v) *Valuation of assets not used directly in carrying out an institution's exempt purpose*—(A) *In general.* The values of assets not used directly in carrying out an educational institution's exempt purpose are determined under the rules of section 4942(e) and § 53.4942(a)–2(c)(4), as modified by paragraph (b)(5)(v)(B) of this section.

(B) *Modifications.* In applying the rules of § 53.4942(a)–2(c)(4), an educational institution must—

(*1*) Substitute ''educational institution'' for ''private foundation'' or ''foundation'' every place they appear; and

(*2*) Make such adjustments as are reasonable and necessary to obtain the fair market value of any and all assets as of the last day of the preceding taxable year, rather than as of any other times permitted or required by § 53.4942(a)–2(c)(4).

[T.D 9917, 85 FR 65557, Oct. 15, 2020]

§ 53.4968–2 Net investment income.

(a) *Net investment income*—(1) *In general.* For taxable years beginning after December 31, 2017, section 4968(a) of the Internal Revenue Code (Code) imposes a 1.4 percent excise tax on the net investment income (as defined in section 4968(c) and this section) of an applicable educational institution and on certain amounts of net investment income of certain related organizations, as described in section 4968(d) and § 53.4968–3. For purposes of this section, net investment income is determined under rules similar to the rules of section 4940(c) of the Code. Thus, net investment income generally is the amount by which the sum of the gross investment income (as defined in paragraph (b) of this section) and the capital gain net income (as defined in paragraph (d) of this section) exceeds the deductions allowed by paragraph (c) of this section. Except to the extent inconsistent with the provisions of this section, net investment income is determined under the principles of subtitle A of the Code.

(2) *Tax-exempt income.* For purposes of this section, net investment income is determined by applying section 103 of the Code (relating to State and local bonds) and section 265 of the Code (relating to expenses and interest relating to tax-exempt income).

(b) *Gross investment income*—(1) *In general.* For purposes of this section and except as provided in paragraph (b)(2) of this section, the term *gross investment income* means the gross amounts of income from interest, dividends, rents, payments with respect to securities loans (as defined in section 512(a)(5) of the Code), and royalties, but not including any such income to the extent included in computing the tax imposed by section 511 of the Code. Such term also includes income from sources similar to those in the preceding sentence. In general, gross investment income includes the items of investment income described in § 1.512(b)–1(a) of this chapter.

(2) *Exceptions.* The following items of income are excluded from the definition of gross investment income:

(i) Interest income from a student loan that was made by the applicable educational institution or a related organization to a student of the applicable educational institution in connection with the student's attendance at the institution;

(ii) Rental income from the provision of housing by the applicable educational institution or a related organization to students of the applicable

educational institution and from housing for faculty and staff if the housing is provided contingent on their roles as faculty or staff of the applicable educational institution; and

(iii) Royalty income that is derived from patents, copyrights, and other intellectual property and intangible property to the extent those assets resulted from the work of student(s) or faculty member(s) in their capacities as such with the applicable educational institution. However, neither royalty income from trademarks on the institution's logo or name nor royalty income from intellectual property donated or sold to the institution is excluded from gross investment income under this rule.

(c) *Deductions*—(1) *In general*. For purposes of computing net investment income—

(i) There is allowed as a deduction from gross investment income all the ordinary and necessary expenses paid or incurred for the production or collection of gross investment income or for the management, conservation, or maintenance of property held for the production of such income, determined with the modifications set forth in paragraph (c)(2) of this section. Taxes paid or incurred under section 4968 are not paid or incurred for the production or collection of gross investment income. Allowable expenses include that portion of an applicable educational institution's operating expenses that is paid or incurred for the production or collection of gross investment income. An applicable educational institution's operating expenses include compensation of officers, other salaries and wages of employees, outside professional fees, interest, and rent and taxes on property used in the applicable educational institution's operations. Where an applicable educational institution's officers or employees engage in activities on behalf of the institution for both activities that generate net investment income and for activities that do not generate net investment income, compensation and salaries paid to such officers or employees must be allocated between the activities that generate net investment income and for activities that do not generate net investment income.

(ii) Where only a portion of property produces, or is held for the production of, income subject to the section 4968 excise tax, and the remainder of the property is used for other purposes, the deductions allowed by this paragraph must be apportioned between the taxable and other uses.

(iii) No amount is allowable as a deduction under this section to the extent it is paid or incurred for purposes other than those described in paragraph (c)(1)(i) of this section. Thus, for example, the charitable deductions prescribed under sections 170 and 642(c) of the Code; the net operating loss deduction prescribed under section 172; and the special deductions prescribed under part VIII of subchapter B of chapter 1 of the Code are not allowable.

(2) *Deduction modifications*. The following modifications must be made in determining deductions otherwise allowable under this paragraph (c):

(i) The depreciation deduction is allowed, but only on the basis of the straight-line method provided in section 168(b)(3) and without regard to section 168(b)(1) and (2).

(ii) The depletion deduction is allowed, but such deduction is determined without regard to sections 613 and 613A of the Code, relating to percentage depletion.

(iii) The basis to be used for purposes of the deduction allowed for depreciation or depletion is the basis determined under the rules of part II of subchapter O of chapter 1 of the Code (part II of subchapter O), subject to the modifications found in paragraphs (c)(2)(i) and (ii) of this section (relating to depreciation and depletion), and without regard to § 53.4968–2(d)(2) (relating to the basis for determining gain for property held on December 31, 2017, and continuously thereafter to the date of disposition), or section 362(c) of the Code (relating to certain special basis rules regarding contributions of capital to corporations). Thus, an applicable educational institution must reduce the cost or other substituted or transferred basis by an amount equal to the straight-line depreciation or cost depletion, without regard to whether the applicable educational institution deducted such depreciation or depletion

during the period prior to its first taxable year beginning after December 31, 2017. However, where an applicable educational institution has previously taken depreciation or depletion deductions in excess of the amount which would have been taken had the straight-line or cost method been employed, such excess depreciation or depletion also is taken into account to reduce basis. If the facts necessary to determine the basis of property in the hands of the donor or the last preceding owner by whom it was not acquired by gift are unknown to the applicable educational institution, then the original basis to the applicable educational institution of such property is determined under the rules of § 1.1015–1(a)(3) of this chapter.

(iv) The deduction for expenses paid or incurred in any taxable year for the production of gross investment income earned as an incident to a charitable function can be no greater than the income earned from such function which is includible as gross investment income for such year. For example, where rental income incidentally is realized in a year from historic buildings held open to the public, deductions for amounts paid or incurred in that year for the production of such income is limited to the amount of rental income includible as gross investment income for the year.

(d) *Capital gains and losses*—(1) *In general*. In determining capital gain net income for purposes of the tax imposed by section 4968—

(i) *Interaction with section 511*. No gain or loss from the sale or other disposition of property is taken into account to the extent that such gain or loss is taken into account for purposes of computing the tax imposed by section 511.

(ii) *Sales or other dispositions of exempt use property*. To the extent that property is used by the educational institution for its exempt purposes, capital gain from the sale or exchange of the portion of that property that is used by the educational institution for its exempt purposes is disregarded;

(iii) *Sales of donated property*—(A) *In general*. Any appreciation in the value of donated property that occurred prior to the date of its donation to the institution is disregarded.

(B) *Date of donation*. The date of donation is determined under the timing rules of § 1.170A–1(b) of this chapter.

(C) *Value on the date of donation*. The value of the donated property on the date of donation is determined under the valuation rules of § 1.170A–1(c) of this chapter; and

(iv) *Capital losses*. Net losses from sales or other dispositions of property by one related organization (or by the applicable educational institution) reduce (but not below zero) net gains from such sales or other dispositions by other related organizations (or by the applicable educational institution). Should overall net losses from sales or other dispositions of property exceed gains from sales or other dispositions of such property during the same taxable year, such excess may not be deducted from gross investment income in any taxable year, nor may such excess be used to reduce gains in prior taxable years. However, capital loss carryovers are allowed and may be deducted from capital gains in a future year.

(2) *Basis*—(i) *For purposes of calculating gain from the sale or other disposition of property other than a partnership interest*. Subject to the modifications of paragraphs (c)(2)(i) and (ii) of this section (referring to the modifications relating to deductions against gross investment income) and without regard to section 362(c), the basis for purposes of determining gain from the sale or other disposition of property (other than a partnership interest) for purposes of determining capital gain net income for purposes of the tax imposed by section 4968 is the greater of—

(A) Fair market value on December 31, 2017, plus or minus all adjustments after December 31, 2017, and before the date of disposition under the rules of part II of subchapter O, provided that the property was held by the applicable educational institution on December 31, 2017, and continuously thereafter to the date of disposition, or

(B) Basis as determined under the rules of part II of subchapter O.

(ii) *For purposes of determining a distributive share of gain from the sale or other disposition of a partnership asset*.

For purposes of determining an applicable educational institution's share of gain upon the sale or other disposition of a partnership asset, the applicable educational institution's basis in each such partnership asset generally is determined under the rules of subchapter K of chapter 1 of the Code (subchapter K). However, see paragraph (d)(3) of this section.

(iii) *For purposes of determining gain on the sale or other disposition of a partnership interest.* For purposes of determining an applicable educational institution's gain upon the sale or other disposition of all or a portion of a partnership interest, the applicable educational institution's basis in such partnership interest is generally determined under the rules of subchapter K, subject to the special rules in paragraph (d)(3) of this section.

(iv) *For purposes of calculating loss.* Subject to the modifications of paragraphs (c)(2)(i) and (ii) of this section (referring to the modifications relating to deductions against gross investment income) and without regard to section 362(c), basis as determined in paragraph (d)(2)(i)(B) of this section applies for purposes of determining loss. For purposes of determining loss from the sale or other disposition of a partnership interest, basis is determined under the rules of subchapter K.

(3) *Special rules regarding partnership interests and partnership assets*—(i) *Reduction of distributive share of capital gain net income from a partnership.* For purposes of computing net investment income, an applicable educational institution reduces the amount of its distributive share of capital gain net income from a partnership by the least of—

(A) The applicable educational institution's share of applicable capital gain (as defined in paragraph (d)(3)(iii)(A) of this section) from such partnership;

(B) One-third of the applicable educational institution's unadjusted step-up (as defined in paragraph (d)(3)(iii)(B) of this section) for such partnership; or

(C) The applicable educational institution's adjusted step-up (as defined in paragraph (d)(3)(iii)(C) of this section) for such partnership.

(ii) *Reduction of capital gain net income from a sale or other disposition of all or a portion of a partnership interest.* For purposes of computing net investment income, an applicable educational institution reduces the amount of its capital gain net income upon the sale or other disposition of all or a portion of a partnership interest by an amount that bears the same relation to the applicable educational institution's adjusted step-up (as defined in paragraph (d)(3)(iii)(C) of this section) for such partnership as the fair market value of the transferred portion of the interest bears to the fair market value of the applicable educational institution's entire interest in such partnership before the sale or other disposition.

(iii) *Definitions.* For purposes of this section—

(A) *Applicable capital gain.* For an applicable educational institution's first taxable year beginning after December 31, 2017, the term *applicable capital gain* means an applicable educational institution's share of both short-term and long-term capital gains and losses subject to section 4968 from a partnership. For subsequent taxable years, applicable capital gain does not include an applicable educational institution's share of short-term capital gains and losses subject to section 4968 from a partnership. For purposes of this paragraph, applicable capital gain is not less than zero.

(B) *Unadjusted step-up.* An applicable educational institution computes an *unadjusted step-up* for each partnership interest it held on December 31, 2017. The unadjusted step-up for a partnership interest equals the excess, if any, of the fair market value of such partnership interest on December 31, 2017, over the adjusted basis of such partnership interest on December 31, 2017.

(C) *Adjusted step-up.* An applicable educational institution computes an *adjusted step-up* for each partnership interest it held on December 31, 2017. The adjusted step-up for a partnership interest equals the unadjusted step-up for such partnership, reduced by the amount of any capital gain net income reduction pursuant to paragraphs (d)(3)(i) and (ii) of this section for such partnership.

(4) *Examples*. The following examples illustrate paragraph (d)(3) of this section. Unless stated otherwise in the examples, partners have no tax items other than those listed in the example. With respect to partnerships, all allocations are in accordance with section 704(b) and the regulations under section 704(b) in part 1 of this chapter (Income Tax Regulations).

(i) *Example 1*—(A) *Facts*. University (U), an applicable educational institution, is a partner in partnership PRS. On December 31, 2017, U's PRS interest had a fair market value of $130 and tax basis of $100. In 2018, U's share of capital gain net income from PRS is $5, which is comprised of $20 of gain from the sale of capital asset X and ($15) of loss from the sale of capital asset Y. Further, such $5 of capital gain net income is applicable capital gain (as defined in paragraph (d)(3)(iii)(A) of this section).

(B) *Analysis*. U has an unadjusted step-up (as defined in paragraph (d)(3)(iii)(B) of this section) for PRS of $30 ($130 fair market value − $100 tax basis on December 31, 2017). Pursuant to paragraph (d)(3)(i) of this section, for purposes of computing its net investment income, U reduces the amount of its capital gain net income from PRS by $5, which is the least of: U's share of applicable capital gain from PRS ($5); or one-third of U's unadjusted step-up for PRS ($10); or U's adjusted step-up for PRS ($30). Thus, U reduces its $5 of capital gain net income allocated from PRS by $5, resulting in U having $0 of capital gain net income in 2018 for purposes of section 4968. As a result, U's adjusted step-up for PRS for subsequent taxable years is reduced to $25 ($30 − $5) pursuant to paragraph (d)(4)(iii)(C) of this section. Pursuant to section 705, the $5 of gain allocated to U increases U's tax basis in its PRS interest to $105.

(ii) *Example 2*—(A) *Facts*. The facts are the same as in paragraph (d)(4)(i)(A) of this section (Example 1). In 2019, U sells its entire interest in PRS for $130, which, immediately prior to the sale, had a tax basis of $105. As a result, U has $25 of capital gain from the sale of its PRS interest.

(B) *Analysis*. Pursuant to paragraph (d)(3)(iii) of this section, for purposes of computing its net investment income, U reduces its capital gain net income resulting from the sale of its entire PRS interest by $25, which is the amount that bears the same relation to U's adjusted step-up for PRS ($25) as the fair market value of the transferred portion of PRS ($130) bears to the fair market value of the U's entire interest in PRS before the sale or other disposition ($130). Thus, U reduces its $25 of capital gain net income from the sale of its PRS interest by $25, resulting in U having $0 of capital gain net income in 2019 for purposes of section 4968.

(iii) *Example 3*—(A) *Facts*. The facts are the same as in paragraph (d)(4)(i)(A) of this section (Example 1). In 2019, U's share of capital gain net income from PRS is $15, which is comprised of $15 of gain from the sale of capital asset Z. Further, such $15 of capital gain net income is applicable capital gain (as defined in paragraph (d)(3)(iii)(A) of this section).

(B) *Analysis*. Pursuant to paragraph (d)(3)(i) of this section, for purposes of computing its net investment income, U reduces the amount of its capital gain net income from PRS by $10, which is the least of: U's share of applicable capital gain from PRS ($15); or one-third of U's unadjusted step-up for PRS ($10); or U's adjusted step-up for PRS ($25, computed as $30 of unadjusted step-up, less $5 of capital gain net income reduced in 2018 pursuant to paragraph (d)(3)(i) of this section). Thus, U reduces its $15 of capital gain net income allocated from PRS by $10, resulting in U having $5 of capital gain net income in 2019 for purposes of section 4968. As a result, U's adjusted step-up for PRS is reduced for subsequent taxable years to $15 ($25 − $10) pursuant to paragraph (d)(3)(iii)(C) of this section. Pursuant to section 705, the $15 of gain allocated to U increases U's tax basis in its PRS interest to $120.

[T.D 9917, 85 FR 65557, Oct. 15, 2020]

§ 53.4968–3 Related organizations.

(a) *Definition of related organization*—(1) *In general*. For purposes of section 4968(d) of the Internal Revenue Code (Code) and §§ 53.4968–1 through 53.4968–4, except as provided in paragraph (a)(2)

of this section, the term *related organization* means, with respect to an educational institution, any organization that—

(i) Controls such institution;

(ii) Is controlled by such institution;

(iii) Is controlled by one or more persons that also control such institution;

(iv) Is a supported organization (as defined in section 509(f)(3) of the Code) with respect to such institution during the taxable year; or

(v) Is a supporting organization (as described in section 509(a)(3)) with respect to such institution during the taxable year.

(2) *Organizations not considered related organizations.* For purposes of section 4968(d) and §§ 53.4968–1 through 53.4968–4, the term *related organization* does not include any organization that is—

(i) A taxable corporation;

(ii) A taxable trust, including a nongrantor charitable lead trust (except to the extent the trust is controlled by the educational institution as described in paragraph (b)(2)(ii) of this section);

(iii) A grantor charitable lead trust;

(iv) A charitable remainder trust;

(v) A partnership, S corporation (as defined in section 1361(a)(1) of the Code), or other pass-through entity that is generally not subject to Federal income tax, the income of which is taxable to its partners or other interest holders; or

(vi) A decedent's estate.

(3) *Employee benefit plans or arrangements.* A trust or similar funding vehicle of an employee benefit plan or arrangement, such as a section 501(a) trust funding a section 401(a) qualified retirement plan, or an annuity contract funding a section 403(b) plan, or a section 419(e) welfare benefit fund (including a voluntary employees' beneficiary association under section 501(c)(9)) funding a welfare benefit plan, will not be treated as a related organization and its assets will not be treated as the assets of the educational institution or of a related organization. A trust or other funding vehicle of an unfunded employee benefit plan of an educational institution or a related organization, such as a grantor trust described in section 671 *et seq.*, used in connection with a section 457(b) plan or an arrangement subject to section 457(f), will be treated as a related organization for purposes of section 4968(d) and its assets will be treated as the assets of the educational institution or of a related organization, but the assets are not considered ''used directly in carrying out the institution's exempt purpose'' for purposes of section 4968(b)(1)(D). For purposes of determining whether the employee benefit plan of an educational institution is funded or unfunded, the educational institution and all of its related organizations are treated as a single sponsor and payor of the benefits.

(b) *Control*—(1) *Controls such institution.* For purposes of section 4968(d) and §§ 53.4968–1 through 53.4968–4, an organization controls an educational institution if—

(i) The organization owns (by vote or value) more than 50 percent of the voting and non-voting stock or membership interest of the educational institution; or

(ii) The organization (or one or more of its managers, directors, officers, trustees, or employees, acting only in those capacities) can—

(A) Appoint or elect (which must include the power to remove and replace) more than 50 percent of the members of the educational institution's governing body (such as directors, officers, or trustees), or otherwise has the ongoing power to appoint or elect more than 50 percent of such members with reasonable frequency;

(B) Require the educational institution to make an expenditure (or prevent the educational institution from making an expenditure); or

(C) Require the educational institution to perform any act that significantly affects its operations (or prevent it from performing such an act).

(2) *Is controlled by such institution.* For purposes of section 4968(d) and §§ 53.4968–1 through 53.4968–4, an organization is controlled by an educational institution:

(i) *Tax-exempt corporation.* In the case of a corporation recognized as exempt from income tax under section 501(a), if the educational institution owns (by vote or value) more than 50 percent of the voting and nonvoting stock or

membership interest of the corporation.

(ii) *Trust*—(A) *In general.* In the case of a trust—

(*1*) If the educational institution is substantially the sole permissible trust beneficiary or appointee of both income and principal, whether or not the timing of the distribution is subject to the trustee's discretion;

(*2*) If the trust is a pooled income fund described in sections 642(c)(3) and 642(c)(5);

(*3*) If, but only to the extent that, the assets of the trust were contributed to the trust by the educational institution (or by a person controlled by the educational institution); or

(*4*) If, but only to the extent that, the educational institution (or person controlled by the educational institution) has the right to demand (or can otherwise cause) a distribution of principal from the trust to the educational institution (or a person controlled by the educational institution).

(B) *Person controlled by the educational organization.* For purposes of this paragraph (b)(2)(ii), a person is controlled by an educational institution if the educational institution has the power to remove and replace such person or otherwise controls the person under one of the tests described in § 53.4968–3(b)(2)(i), (ii), or (iii), with similar principles applying for purposes of determining control of any other form of entity.

(iii) *Nonstock organization.* In the case of a nonstock organization, if the educational institution (or one or more of its managers, directors, officers, trustees, or employees, acting only in those capacities) can—

(A) Appoint or elect (which must include the power to remove and replace) more than 50 percent of the members of the organization's governing body (such as directors, officers, or trustees), or otherwise has an ongoing power to appoint or elect more than 50 percent of such members with reasonable frequency);

(B) Require the organization to make an expenditure (or prevent the organization from making an expenditure); or

(C) Require the organization to perform any act that significantly affects its operations (or prevent it from performing such an act).

(3) *Is controlled by one or more persons that also control such institution.* For purposes of section 4968(d) and this section, an organization (other than one described in paragraph (a)(2) of this section) is controlled by one or more persons that also control the educational institution if more than 50 percent of the members of the governing body of the other organization are directly or indirectly controlled by persons that comprise more than 50 percent of the members of the governing body of the educational institution.

(4) *Constructive ownership.* The principles of section 318(a)(2) (relating to ownership attribution from partnerships, estates, trusts, and corporations) apply for purposes of determining ownership of stock in a corporation, and similar principles apply for purposes of determining ownership of an interest in any other entity.

(5) *Method of control.* Control includes control by aggregating votes or positions of authority (including by veto power), but applies regardless of the method by which the control is exercised or exercisable.

(c) *Organization described in section 509(a)(3) during the taxable year with respect to the educational institution.* A section 509(a)(3) organization is a supporting organization with respect to an educational institution only if the supporting organization meets the organizational, operational, and relationship tests of section 509(a)(3)(B) and § 1.509(a)–4 of this chapter with respect to the educational institution.

(d) *Assets and net investment income of related organizations*—(1) *In general.* A related organization's assets and net investment income are taken into account both in determining whether an institution is an applicable educational institution and in computing the net investment income of an applicable educational institution. For purposes of determining the aggregate fair market value of the assets and net investment income of an educational institution, the assets and net investment income of all related organizations are

treated as the assets and net investment income, respectively, of the institution, unless an exception provided in paragraph (d)(2) of this section or the exception provided in § 53.4968–1(b)(5)(iv) (relating to assets used directly in carrying out an exempt purpose) applies. In cases in which an organization is a related organization with respect to an educational institution under more than one definition of this § 53.4968–3, then the rule that attributes the largest amount of assets and net investment income of the related organization to the educational institution must be applied.

(2) *Exceptions*. For purposes of section 4968 and this paragraph (d)(2)—

(i) *No amount is taken into account with respect to more than one educational institution*. In determining the aggregate fair market value of the assets and net investment income of an educational institution, assets and net investment income of a related organization are not taken into account with respect to more than one educational institution. Thus, in any case in which an organization is a related organization with respect to more than one educational institution, the assets and net investment income of the related organization must be allocated between or among the educational institutions as to which the organization is a related organization, subject to paragraph (d)(2)(ii) of this section. The educational institution must make such allocation in a reasonable manner, taking into account all facts and circumstances, that is consistent across all related organizations.

(ii) *Assets and net investment income that are not intended or available for the use or benefit of the educational institution*—(A) *In general*. Unless a related organization is controlled by the educational institution or is a supporting organization described in section 509(a)(3) with respect to such institution for the taxable year, assets and net investment income of a related organization that are not intended or available for the use or benefit of the educational institution are not taken into account by that educational institution.

(B) *Determining whether assets and net investment income of a related organization are intended or available for the use or benefit of an educational institution*. If a related organization controls the educational institution, is controlled by one or more persons that also control such institution (but is not described in section 509(a)(3) with respect to the educational institution for the taxable year), or is a supported organization (as defined in section 509(f)(3)) during the taxable year with respect to the educational institution, then the related organization's assets and net investment income are taken into account as assets and net investment income of the educational institution only to the extent the assets and net investment income are intended or available for the use or benefit of that educational institution. Assets and net investment income of a related organization are intended or available for the use or benefit of an educational institution if such assets and net investment income are specifically earmarked or restricted for the benefit of, or otherwise are fairly attributable to, the educational institution. For example, assets are fairly attributable to the educational institution if they have been affirmatively designated or appropriated for the educational institution or made available for the educational institution to draw upon at will. Conversely, assets and net investment income of a related organization are not intended or available for the use or benefit of an educational institution if such assets and net investment income are specifically earmarked or restricted for another entity or for unrelated purposes or otherwise are not fairly attributable to the educational institution. The assets and net investment income of a related organization must be allocated between those intended or available for the use or benefit of an educational institution and those not intended or not available for the use or benefit of that same educational institution. The educational institution must make such allocation in a reasonable manner, taking into account all facts and circumstances, that is consistent across all related organizations.

(C) *Related organizations that are controlled by the educational institution or*

that are supporting organizations (as described in section 509(a)(3)) with respect to the educational institution during the taxable year—(1) In general. If a related organization is controlled, as defined in paragraph (b)(2) of this section, by an educational institution, or is a supporting organization with respect to the educational institution during the taxable year, as defined in paragraph (c) of this section, the assets and net investment income of the related organization are taken into account as assets and net investment income of the educational institution regardless of whether those assets and net investment income are earmarked or restricted for the benefit of, or otherwise are fairly attributable to, the educational institution and even if they are specifically earmarked or restricted for another entity or for unrelated purposes or otherwise are not fairly attributable to the educational institution, subject to paragraph (d)(2)(ii)(C)(*2*) of this section. However, see §§ 53.4968–1(b)(2)(ii)(A)(*3*) and (*4*) regarding trusts that are controlled related organizations only to the extent assets of the trust were contributed to the trust by the educational institution (or by a person controlled by the educational institution), or only to the extent the educational institution (or person controlled by the educational institution) has the right to demand (or can otherwise cause) a distribution of principal from the trust to the educational institution (or a person controlled by the educational institution). *See also* § 53.4968–1(b)(5)(iv) for rules relating to when assets of a related organization are deemed to be used directly in carrying out the institution's exempt purpose.

(*2*) *Special rule for Type III supporting organizations with respect to an educational institution as of December 31, 2017.* An educational institution with a related organization that was a Type III supporting organization with respect to the educational institution on December 31, 2017, takes into account only the assets and net investment income of such Type III supporting organization that are intended or available for the use or benefit of, or otherwise are fairly attributable to, the educational institution, as described in paragraph (d)(2)(ii)(B) of this section. An educational institution may determine whether the assets and net investment income of such a Type III supporting organization are intended or available for the use or benefit of, or otherwise are fairly attributable to, the educational institution using any reasonable method. A method that attributes to an educational institution assets and net investment income of a supporting organization that specifically are earmarked for the educational institution, are restricted for the benefit of the educational institution, or otherwise are fairly attributable to the educational institution (such as those that have been affirmatively designated or appropriated for the educational institution or made available for the educational institution to draw upon at will) will be deemed to be reasonable.

(3) *Determining assets of related organizations.* To determine which assets of a related organization are included by an educational institution under section 4968(b)(1)(D) for a particular year, an educational institution determines which organizations are related organizations, as defined in section 4968(d)(2) and § 53.4968–3, as of the end of the educational institution's preceding taxable year, and values the relevant assets on that date.

(4) *Determining net investment income of related organizations.* To determine the amount of net investment income of a related organization that is included by the applicable educational institution in calculating the tax imposed by section 4968(a) for a particular taxable year, an applicable educational institution determines which organizations are related organizations, as defined in section 4968(d)(2) and § 53.4968–3, as of the end of that taxable year of the applicable educational institution and includes the net investment income from each related organization's taxable year that ends with or within that same taxable year of the applicable educational institution. If an organization became a related organization after the beginning of the applicable educational institution's taxable year, then the applicable educational institution includes the organization's net investment income for the portion of

the year that the organization was a related organization, using any reasonable method.

[T.D 9917, 85 FR 65557, Oct. 15, 2020]

§ 53.4968–4 Applicability date.

The rules of §§ 53.4968–1 through 53.4968–3 apply to taxable years of an educational institution beginning after October 15, 2020.

[T.D 9917, 85 FR 65557, Oct. 15, 2020]

Subpart L—Procedure and Administration

SOURCE: T.D. 7368, 40 FR 29843, July 16, 1975, unless otherwise noted. Redesignated by T.D. 8084, 51 FR 16303, May 2, 1986.

§ 53.6001–1 Notice or regulations requiring records, statements, and special returns.

(a) *In general.* Any person subject to tax under Chapter 42, Subtitle D, of the Code shall keep such complete and detailed records as are sufficient to enable the district director to determine accurately the amount of liability under Chapter 42.

(b) *Notice by district director requiring returns, statements, or the keeping of records.* The district director may require any person, by notice served upon him, to make such returns, render such statements, or keep such specific records as will enable the district director to determine whether or not such person is liable for tax under Chapter 42.

(c) *Retention of records.* The records required by this section shall be kept at all times available for inspection by authorized internal revenue officers or employees, and shall be retained so long as the contents thereof may become material in the administration of any internal revenue law.

§ 53.6011–1 General requirement of return, statement or list.

(a) Every private foundation liable for tax under section 4940 or 4948(a) shall file an annual return with respect to such tax on the form prescribed by the Internal Revenue Service for such purpose and shall include therein the information required by such form and the instructions issued with respect thereto.

(b) Every person (including a governmental entity) liable for tax imposed by sections 4941(a), 4942(a), 4943(a), 4944(a), 4945(a), 4955(a), 4958(a), 4959, 4960(a), 4965(a), 4966(a), 4967(a), or 4968(a), and every private foundation and every trust described in section 4947(a)(2) which has engaged in an act of self-dealing (as defined in section 4941(d)) (other than an act giving rise to no tax under section 4941(a)) shall file an annual return on Form 4720,''Return of Certain Excise Taxes Under Chapters 41 and 42 of the Internal Revenue Code,'' and shall include therein the information required by such form and the instructions issued with respect thereto. In the case of any tax imposed by sections 4941(a), 4942(a), 4943(a), and 4944(a), the annual return shall be filed with respect to each act (or failure to act) for each year (or part thereof) in the taxable period (as defined in sections 4941 (e)(1), 4942(j)(1), 4943(d)(2), and 4944(e)(1)). In the case of a tax imposed by section 4945(a), 4955(a), 4958(a), 4960(a), 4965(a), 4966(a), or 4967(a), the annual return shall be filed with respect to each act for the year in which such act giving rise to liability occurred. In the case of a tax imposed by section 4959 on a hospital organization (as defined in § 1.501(r)–1(b)(18)), the annual return must include the required information for each of the organization's hospital facilities that failed to meet the requirements of section 501(r)(3) for the taxable year.

(c) If a Form 4720 is filed by a private foundation or trust described in section 4947(a)(2) with respect to a transaction to which other persons are required to file under paragraph (b) of this section, such persons may by their signature designate such organization's Form 4720 (to the extent applicable) as their return for purposes of compliance with such paragraph. However, this paragraph shall not apply to a person whose taxable year is other than the taxable year of the foundation or trust.

(d) For taxable years ending on or after December 31, 1975, every trust described in section 4947(a)(2) which is subject to any of the provisions of Chapter 42 as if it were a private foundation shall file an annual return on

Form 5227. For taxable years beginning after December 31, 1980, every trust described in section 4947(a)(1) which is a private foundation shall file an annual return on Form 990–PF.

(e) For taxable years beginning after December 31, 1977, every person liable for tax under section 4951, 4952, or 4953 (relating to taxes on self-dealing, taxable expenditures, and excess contributions involving black lung benefit trusts) shall file an annual return with respect to the tax on the form prescribed by the Internal Revenue Service for that purpose. The person liable for the tax shall include the information required by the form and its related instructions.

[T.D. 7368, 40 FR 29843, July 16, 1975, as amended by T.D. 7838, 47 FR 44249, Oct. 7, 1982; T.D. 8026, 50 FR 20757, May 20, 1985; T.D. 8628, 60 FR 62212, Dec. 5, 1995; T.D. 8705, 62 FR 26, Jan. 2, 1997; T.D. 9334, 72 FR 36872, July 6, 2007; T.D. 9629, 78 FR 49682, Aug. 15, 2013; T.D. 9708, 79 FR 79015, Dec. 31, 2014; T.D. 9855, 84 FR 14009, Apr. 9, 2019]

§ 53.6011–4 Requirement of statement disclosing participation in certain transactions by taxpayers.

(a) *In general.* If a transaction is identified as a *listed transaction* or a *transaction of interest* as defined in § 1.6011–4 of this chapter by the Commissioner in published guidance (see § 601.601(d)(2)(ii)(*b*) of this chapter), and the listed transaction or transaction of interest involves an excise tax under chapter 42 of subtitle D of the Internal Revenue Code (relating to private foundations and certain other tax-exempt organizations), the transaction must be disclosed in the manner stated in such published guidance.

(b) *Effective/applicability date.* This section applies to listed transactions entered into on or after January 1, 2003. This section applies to transactions of interest entered into on or after November 2, 2006.

[T.D. 9350, 72 FR 43154, Aug. 3, 2007]

§ 53.6060–1 Reporting requirements for tax return preparers.

(a) *In general.* A person that employs one or more tax return preparers to prepare a return or claim for refund of tax under Chapter 42 of the Internal Revenue Code, other than for the person, at any time during a return period, shall satisfy the record keeping and inspection requirements in the manner stated in § 1.6060–1 of this chapter.

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

[T.D. 9436, 73 FR 78457, Dec. 22, 2008]

§ 53.6061–1 Signing of returns and other documents.

Any return, statement, or other document required to be made with respect to a tax imposed by Chapter 42 or the regulations thereunder shall be signed by the person required to file such return, statement or document, or by such other persons required or duly authorized to sign in accordance with the regulations, forms or instructions prescribed with respect to such return, statement or other document. The person required or duly authorized to make the return may incur liability for penalties provided for erroneous, false or fraudulent returns. For criminal penalties see sections 7201, 7203, 7206, and 7207.

§ 53.6065–1 Verification of returns.

(a) *Penalties of perjury.* If a return, statement, or other document made under the provisions of Chapter 42 or Subtitle F of the Code or the regulations thereunder with respect to any tax imposed by Chapter 42 of the Code, or the form and instructions issued with respect to such return, statement, or other document, requires that it shall contain or be verified by a written declaration that it is made under the penalties of perjury, it must be so verified by the person or persons required to sign such return, statement, or other document. In addition, any other statement or document submitted under any provision of Chapter 42 or Subtitle F of the Code or regulations thereunder with respect to any tax imposed by Chapter 42 of the Code may be required to contain or be verified by a written declaration that it is made under the penalties of perjury.

(b) *Oath.* Any return, statement, or other document required to be submitted under Chapter 42 or Subtitle F

of the Code or regulations prescribed thereunder with respect to any tax imposed by Chapter 42 of the Code may be required to be verified by an oath.

§ 53.6071–1 Time for filing returns.

(a) *General rule*. Except as otherwise provided in this section, a return required by § 53.6011–1 shall be filed at the time the private foundation or trust described in section 4947(a)(2) is required to file its annual information or tax return under section 6033 or 6012 (as may be applicable).

(b) *Exception*. The Form 4720 of a person whose taxable year ends on a date other than that on which the taxable year of the foundation or trust ends shall be filed on or before the 15th day of the fifth month following the close of such person's taxable year.

(c) *Form 5227*. A Form 5227 required to be filed by paragraph (d) of § 53.6011–1 for a trust described in section 4947(a) shall be filed on or before the 15th day of the fourth month following the close of the trust's taxable year.

(d) *Taxes related to black lung benefit trusts*. Forms 990–BL and 6069 shall be filed on or before the 15th day of the fifth month following the close of the filer's taxable year.

(e) *Taxes related to political expenditures of organizations described in section 501(c)(3) of the Internal Revenue Code*. A Form 4720 required to be filed by § 53.6011–1(b) for an organization liable for tax imposed by section 4955(a) must be filed by the unextended due date for filing its annual information return under section 6033 or, if the organization is exempt from filing, the date the organization would be required to file an annual information return if it was not exempt from filing. The Form 4720 of a person whose taxable year ends on a date other than that on which the taxable year of the organization described in section 501(c)(3) ends must be filed on or before the 15th day of the fifth month following the close of the person's taxable year.

(f) *Taxes imposed on excess benefit transactions engaged in by organizations described in sections 501(c)(3) (except private foundations) and 501(c)(4)*—(1) *General rule*. A Form 4720 required by § 53.6011–1(b) for a disqualified person or organization manager liable for tax imposed by section 4958(a) shall be filed by that person on or before the 15th day of the fifth month following the close of such person's taxable year.

(2) *Special rule for taxable years ending after September 13, 1995, and on or before July 30, 1996*. A Form 4720 required by § 53.6011–1(b) for a disqualified person or organization manager liable for tax imposed by section 4958(a) on an excess benefit transaction occurring in such person's taxable year ending after September 13, 1995, and on or before July 30, 1996, is due on or before December 15, 1996.

(g) *Taxes imposed with respect to prohibited tax shelter transactions to which tax-exempt entities are parties*—(1) *Returns by certain tax-exempt entities*. A Form 4720, ''Return of Certain Excise Taxes Under Chapters 41 and 42 of the Internal Revenue Code,'' required by § 53.6011–1(b) for a tax-exempt entity described in section 4965(c)(1), (c)(2) or (c)(3) that is a party to a prohibited tax shelter transaction and is liable for tax imposed by section 4965(a)(1) shall be filed on or before the due date (not including extensions) for filing the tax-exempt entity's annual information return under section 6033(a)(1). If the tax-exempt entity is not required to file an annual information return under section 6033(a)(1), the Form 4720 shall be filed on or before the 15th day of the fifth month after the end of the tax-exempt entity's taxable year or, if the entity has not established a taxable year for Federal income tax purposes, the entity's annual accounting period.

(2) *Returns by entity managers of tax-exempt entities described in section 4965(c)(1), (c)(2) or (c)(3)*. A Form 4720, required by § 53.6011–1(b) for an entity manager of a tax-exempt entity described in section 4965(c)(1), (c)(2) or (c)(3) who is liable for tax imposed by section 4965(a)(2) shall be filed on or before the 15th day of the fifth month following the close of the entity manager's taxable year during which the entity entered into the prohibited tax shelter transaction.

(3) *Transition rule*. A Form 4720, for a section 4965 tax that was due on or before October 4, 2007, will be deemed to have been filed on the due date if it was filed by October 4, 2007, and if all section 4965 taxes required to be reported

on that Form 4720 were paid by October 4, 2007.

(h) *Taxes on failures by charitable hospital organizations to satisfy the community health needs assessment requirements of section 501(r)(3).* A hospital organization (as defined in § 1.501(r)–1(b)(18)) liable for tax imposed by section 4959 must file a Form 4720 as required by § 53.6011–1(b), on or before the 15th day of the fifth month after the end of the hospital organization's taxable year for which it failed to meet the requirements of section 501(r)(3).

(i) *Taxes under section 4960, 4966, 4967, or 4968.* A person (including a governmental entity) required by § 53.6011–1(b) to file a return for a tax imposed by section 4960(a), 4966(a), 4967(a), or 4968(a) in a taxable year must file the Form 4720 on or before the 15th day of the fifth month after the end of the person's taxable year (or, if the person has not established a taxable year for Federal income tax purposes, the person's annual accounting period).

(j) *Effective/applicability date*—(1) Paragraph (g) of this section applies on and after July 6, 2007.

(2) Paragraph (h) of this section applies on and after August 15, 2013.

(3) Paragraph (i) of this section applies on and after April 9, 2019.

[T.D. 7368, 40 FR 29843, July 16, 1975, as amended by T.D. 7407, 41 FR 9322, Mar. 4, 1976; T.D. 7838, 47 FR 44249, Oct. 7, 1982; T.D. 8628, 60 FR 62212, Dec. 5, 1995; T.D. 8736, 62 FR 52257, Oct. 7, 1997; T.D. 9334, 72 FR 36872, July 6, 2007; T.D. 9492, 75 FR 38708, July 6, 2010; 75 FR 46845, Aug. 4, 2010; T.D. 9629, 78 FR 49682, Aug. 15, 2013; T.D. 9708, 79 FR 79015, Dec. 31, 2014; T.D. 9855, 84 FR 14009, Apr. 9, 2019]

§ 53.6081–1 Automatic extension of time for filing the return to report taxes due under section 4951 for self-dealing with a nuclear decommissioning fund.

(a) *In general.* A ''disqualified person'' for purposes of section 4951(e)(4) who engaged in self-dealing with a Nuclear Decommissioning Fund, and must report tax due under section 4951 on Form 1120-ND, ''Return for Nuclear Decommissioning Funds and Certain Related Persons,'' will be allowed an automatic 6-month extension of time to file the return after the date prescribed for filing the return if the disqualified person files an application under this section in accordance with paragraph (b) of this section. For guidance on requesting an extension of time to file Form 1120-ND for purposes of reporting contributions received, income earned, administrative expenses of operating the fund, and the tax on modified gross income, see § 1.6081–3 of this chapter.

(b) *Requirements.* To satisfy this paragraph (b), a disqualified person must—

(1) Submit a complete application on Form 7004, ''Application for Automatic Extension of Time to File Certain Business Income Tax, Information, and Other Returns,'' or in any other manner prescribed by the Commissioner;

(2) File the application on or before the date prescribed for filing the return with the Internal Revenue Service office designated in the application's instructions; and

(3) Remit the amount of the properly estimated unpaid tax liability on or before the date prescribed for payment.

(c) *No extension of time for the payment of tax.* An automatic extension of time for filing a return granted under paragraph (a) of this section will not extend the time for payment of any tax due on such return.

(d) *Termination of automatic extension.* The Commissioner may terminate an automatic extension at any time by mailing to the disqualified person a notice of termination at least 10 days prior to the termination date designated in such notice. The Commissioner must mail the notice of termination to the address shown on the Form 7004 or to the disqualified person's last known address. For further guidance regarding the definition of last known address, see § 301.6212–2 of this chapter.

(e) *Penalties.* See section 6651 for failure to file or failure to pay the amount shown as tax on the return.

(f) *Effective/applicability dates.* This section is applicable for applications for an automatic extension of time to file a return to report taxes due under section 4951 for self-dealing with a Nuclear Decommissioning Fund filed after July 1, 2008.

[T.D. 9407, 73 FR 37369, July 1, 2008]

§ 53.6091–1 Place for filing chapter 42 tax returns.

Except as provided in § 53.6091–2 (relating to exceptional cases):

(a) *Persons other than corporations.* Chapter 42 tax returns of persons other than corporations shall be filed with any person assigned the responsibility to receive returns in the local Internal Revenue Service office that serves the legal residence or principal place of business of the person required to make the return.

(b) *Corporations.* Chapter 42 tax returns of corporations shall be filed with any person assigned the responsibility to receive returns in the local Internal Revenue Service office that serves the principal place of business or principal office or agency of the corporation.

(c) *Returns filed with service centers.* Notwithstanding paragraphs (a) and (b) of this section, unless a return is filed by hand carrying, whenever instructions applicable to Chapter 42 tax returns provide that the returns be filed with a service center, the returns must be so filed in accordance with the instructions. Returns which are filed by hand carrying shall be filed with any person assigned the responsibility to receive hand-carried returns in the local Internal Revenue Service office in accordance with paragraphs (a) or (b) of this section, whichever is applicable.

(d) *Returns of persons subject to a termination assessment.* Notwithstanding paragraph (c) of this section, income tax returns of persons with respect to whom a chapter 42 tax assessment was made under section 6852(a) with respect to the taxable year must be filed with any person assigned the responsibility to receive returns in the local Internal Revenue Service office as provided in paragraphs (a) and (b) of this section.

[T.D. 7368, 40 FR 29843, July 16, 1975, as amended by T.D. 7495, 42 FR 33727, July 1, 1977; T.D. 8628, 60 FR 62212, Dec. 5, 1995; T.D. 9156, 69 FR 55746, Sept. 16, 2004]

§ 53.6091–2 Exceptional cases.

Notwithstanding the provisions of § 53.6091–1, the Commissioner may permit the filing of any Chapter 42 tax return in any local Internal Revenue Service office.

[T.D. 7368, 40 FR 29843, July 16, 1975. Redesignated by T.D. 8084, 51 FR 16303, May 2, 1986, as amended by T.D. 9156, 69 FR 55746, Sept. 16, 2004]

§ 53.6107–1 Tax return preparer must furnish copy of return or claim for refund to taxpayer and must retain a copy or record.

(a) *In general.* A person who is a signing tax return preparer of any return or claim for refund of tax under Chapter 42 of the Internal Revenue Code shall furnish a completed copy of the return or claim for refund to the taxpayer and retain a completed copy or record in the manner stated in § 1.6107–1 of this chapter.

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

[T.D. 9436, 73 FR 78457, Dec. 22, 2008]

§ 53.6109–1 Tax return preparers furnishing identifying numbers for returns or claims for refund filed.

(a) *In general.* Each tax return or claim for refund under Chapter 42 of the Internal Revenue Code prepared by one or more signing tax return preparers must include the identifying number of the preparer required by § 1.6695–1(b) of this chapter to sign the return or claim for refund in the manner stated in § 1.6109–2 of this chapter.

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

[T.D. 9436, 73 FR 78457, Dec. 22, 2008]

§ 53.6151–1 Time and place for paying tax shown on returns.

The Chapter 42 tax shown on any return shall, without assessment or notice and demand, be paid to the internal revenue officer with whom the return is filed at the time and place for filing such return (determined without regard to any extension of time for filing the return). For provisions relating to the time and place for filing such return, see §§ 53.6071–1 and 53.6091–1. For provisions relating to the extension of time for paying the tax, see § 53.6161–1.

§ 53.6161–1 Extension of time for paying tax or deficiency.

(a) *In general*—(1) *Tax shown or required to be shown on return*. A reasonable extension of the time for payment of the amount of any tax imposed by Chapter 42 and shown or required to be shown on any return, may be granted by the district directors and directors of the service centers at the request of the taxpayer. The period of such extension shall not be in excess of 6 months from the date fixed for payment of such tax, except that if the taxpayer is abroad the period of the extension may be in excess of 6 months.

(2) *Deficiency*. The time for payment of any amount determined as a deficiency in respect of tax imposed by Chapter 42 may, at the request of the taxpayer, be extended by the internal revenue officer to whom the tax is required to be paid for a period not to exceed 18 months from the date fixed for payment of the deficiency, as shown on the notice and demand, and, in exceptional cases for a further period not in excess of 12 months. No extension of the time for payment of a deficiency shall be granted if the deficiency is due to negligence, to intentional disregard of rules and regulations, or to fraud with intent to evade tax.

(3) *Extension of time for filing distinguished*. The granting of an extension of time for filing a return does not operate to extend the time for the payment of the tax or any part thereof unless so specified in the extension.

(b) *Undue hardship required for extension*. An extension of the time for payment shall be granted only upon a satisfactory showing that payment on the due date of the amount with respect to which the extension is desired will result in an undue hardship. The extension will not be granted upon a general statement of hardship. The term ''undue hardship'' means more than an inconvenience to the taxpayer. It must appear that substantial financial loss, for example, loss due to the sale of property at a sacrifice price, will result to the taxpayer from making payment on the due date of the amount with respect to which the extension is desired. If a market exists, the sale of property at the current market price is not ordinarily considered as resulting in an undue hardship.

(c) *Application for extension*. An application for an extension of the time for payment of the tax shown or required to be shown on any return, or for the payment of any amount determined as a deficiency shall be made on Form 1127 and shall be accompanied by evidence showing the undue hardship that would result to the taxpayer if the extension were refused. Such application shall also be accompanied by a statement of the assets and liabilities of the taxpayer and an itemized statement showing all receipts and disbursements for each of the three months immediately preceding the due date of the amount to which the application relates. The application, with supporting documents, must be filed on or before the date prescribed for payment of the amount with respect to which the extension is desired with the internal revenue officer to whom the tax is to be paid. The application will be examined, and within 30 days, if possible, will be denied, granted, or tentatively granted subject to certain conditions of which the taxpayer will be notified. If an additional extension is desired, the request therefor must be made on or before the expiration of the period for which the prior extension is granted.

(d) *Payment pursuant to extension*. If an extension of time for payment is granted, the amount the time for payment of which is so extended shall be paid on or before the expiration of the period of the extension without the necessity of notice and demand. The granting of an extension of the time for payment of the tax or deficiency does not relieve the taxpayer from liability for the payment of interest thereon during the period of the extension. See section 6601 and § 301.6601–1 of this chapter (Regulations on Procedure and Administration).

§ 53.6165–1 Bonds where time to pay tax or deficiency has been extended.

If an extension of time for payment of tax or deficiency is granted under section 6161, the district director or the director of the service center may, if he deems it necessary, require a bond for the payment of the amount in respect

of which the extension is granted in accordance with the terms of the extension. However, such bond shall not exceed double the amount with respect to which the extension is granted. For provisions relating to form of bonds, see the regulations under section 7101 contained in part 301 of this chapter (Regulations on Procedure and Administration).

§ 53.6601–1 Interest on underpayment, nonpayment, or extensions of time for payment, of tax.

For regulations concerning interest on underpayment, nonpayment, or extensions of time for payment of tax, see § 301.6601–1 of this chapter (Regulations on Procedure and Administration).

§ 53.6651–1 Failure to file tax return or to pay tax.

(a) *General rules.* For general rules relating to the failure to file tax return or to pay tax, see the regulations under section 6651 contained in part 301 of this chapter (Regulations on Procedure and Administration).

(b) *Special rule where foundation files return.* (1) Except as provided in paragraph (b)(2) of this section, in the case of tax imposed by section 4941(a)(1) on any disqualified person, reasonable cause shall be presumed, for purposes of section 6651(a)(1), where the private foundation or trust described in section 4947(a)(2) files a return in good faith and such return indicates no tax liability with respect to such tax on the part of such disqualified person.

(2) Paragraph (b)(1) of this section shall not apply where the disqualified person knew of facts which, if known by the foundation, would have precluded the foundation from making the return, as filed, in good faith.

§ 53.6694–1 Section 6694 penalties applicable to tax return preparer.

(a) *In general.* For general definitions regarding section 6694 penalties applicable to preparers of tax returns or claims for refund under Chapter 42 of the Internal Revenue Code, see § 1.6694–1 of this chapter.

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

[T.D. 9436, 73 FR 78457, Dec. 22, 2008]

§ 53.6694–2 Penalties for understatement due to an unreasonable position.

(a) *In general.* A person who is a tax return preparer of any return or claim for refund of tax under Chapter 42 of the Internal Revenue Code (Code) shall be subject to penalties under section 6694(a) of the Code in the manner stated in § 1.6694–2 of this chapter.

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

[T.D. 9436, 73 FR 78457, Dec. 22, 2008]

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

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

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

[T.D. 9436, 73 FR 78457, Dec. 22, 2008]

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

(a) *In general.* For rules relating to the extension of period of collection when a tax return preparer who prepared a return or claim for refund of tax under Chapter 42 of the Internal Revenue Code pays 15 percent of a penalty for understatement of taxpayer's liability and procedural matters relating to the investigation, assessment and collection of the penalties under section 6694(a) and (b), the rules under § 1.6694–4 of this chapter will apply.

(b) *Effective/applicability date.* This section is applicable to returns and

claims for refund filed, and advice provided, after December 31, 2008.

[T.D. 9436, 73 FR 78458, Dec. 22, 2008]

§ 53.6695–1 Other assessable penalties with respect to the preparation of tax returns or claims for refund for other persons.

(a) *In general.* A person who is a tax return preparer of any return or claim for refund of tax under Chapter 42 of the Internal Revenue Code (Code) shall be subject to penalties for failure to furnish a copy to the taxpayer under section 6695(a) of the Code, failure to sign the return under section 6695(b) of the Code, failure to furnish an identification number under section 6695(c) of the Code, failure to retain a copy or list under section 6695(d) of the Code, failure to file a correct information return under section 6695(e) of the Code, and negotiation of a check under section 6695(f) of the Code, in the manner stated in § 1.6695–1 of this chapter.

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

[T.D. 9436, 73 FR 78458, Dec. 22, 2008]

§ 53.6696–1 Claims for credit or refund by tax return preparers.

(a) *In general.* For rules for claims for credit or refund by a tax return preparer who prepared a return or claim for refund for tax under Chapter 42 of the Internal Revenue Code, the rules under § 1.6696–1 of this chapter will apply.

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

[T.D. 9436, 73 FR 78458, Dec. 22, 2008]

§ 53.7101–1 Form of bonds.

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

§ 53.7701–1 Tax return preparer.

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

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

[T.D. 9436, 73 FR 78458, Dec. 22, 2008]

PART 54—PENSION EXCISE TAXES

Sec.

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54.9816–6T Methodology for calculating qualifying payment amount (temporary).
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Section 54.9815–2711T also issued under 26 U.S.C. 9833;
Section 54.9815–2712 also issued under 26 U.S.C. 9833;
Section 54.9815–2712T also issued under 26 U.S.C. 9833;
Section 54.9815–2713 also issued under 26 U.S.C. 9833;
Section 54.9815–2713T also issued under 26 U.S.C. 9833;
Section 54.9815–2714 also issued under 26 U.S.C. 9833;
Section 54.9815–2714T also issued under 26 U.S.C. 9833;
Section 54.9815–2715 also issued under 26 U.S.C. 9833;
Sections 54.9815–2715A1, 54.9815–2715A2, and 54.9815–2715A3 are also issued under 26 U.S.C. 9833;
Section 54.9815–2719 also issued under 26 U.S.C. 9833;
Section 54.9815–2719A also issued under 26 U.S.C. 9833;
Section 54.9815–2719AT also issued under 26 U.S.C. 9833;
Section 54.9815–2719T also issued under 26 U.S.C. 9833;
Section 54.9831–1 also issued under 26 U.S.C. 9833;
Section 54.9833–1 also issued under 26 U.S.C. 9833.

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

(a)–(b) [Reserved]

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

(d) [Reserved]

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

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

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

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

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

§ 54.4971(c)–1 Taxes on failure to meet minimum funding standards; definitions.

(a) *In general*. This section sets forth definitions that apply for purposes of applying the rules of section 4971.

(b) *Accumulated funding deficiency*—(1) *Multiemployer plans*. With respect to a multiemployer plan defined in section 414(f), the term *accumulated funding deficiency* has the meaning given to that term by section 431. A plan's accumulated funding deficiency for a plan year takes into account all charges and credits to the funding standard account under section 412 for plan years before the first plan year for which section 431 applies to the plan.

(2) *CSEC plans*. With respect to a CSEC plan (that is, a plan that fits within the definition of a CSEC plan in section 414(y) for plan years beginning on or after January 1, 2014 and for which the election under section 414(y)(3)(A) has not been made), the term *accumulated funding deficiency* means the CSEC accumulated funding deficiency determined under section 433. A plan's CSEC accumulated funding deficiency for a plan year takes into account all charges and credits to the funding standard account under section 412 for plan years before the first plan year for which section 433 applies to the plan.

(c) *Unpaid minimum required contribution*—(1) *In general*. The term *unpaid minimum required contribution* means, with respect to any plan year, the portion of the minimum required contribution under section 430 for the plan year for which contributions have not been made on or before the due date for the plan year under section 430(j)(1). The unpaid minimum required contribution is determined after taking into account the interest adjustment to contributions under § 1.430(j)–1(b)(4) and any offsets from use of the funding balances under § 1.430(f)–1(d).

(2) *Accumulated funding deficiency for pre-effective plan year*. For purposes of this section, a plan's accumulated funding deficiency under section 412 for the pre-effective plan year is treated as an unpaid minimum required contribution for that plan year until correction is made under the rules of paragraph (d)(2) of this section.

(d) *Correct*—(1) *Accumulated funding deficiency*. With respect to an accumulated funding deficiency for a plan year that is described in paragraph (b) of this section, the term *correct* means to contribute, to or under the plan, the amount necessary to reduce the accumulated funding deficiency as of the end of that plan year to zero. To reduce the deficiency to zero, the contribution must include interest at the plan's valuation interest rate for the period between the end of that plan year and the date of the contribution (determined taking into account the rules of section 431(c)(8) or section 433(c)(9), as applicable).

(2) *Unpaid minimum required contribution*—(i) *In general*. With respect to an unpaid minimum required contribution for a plan year, the term *correct* means to contribute, to or under the plan, an amount that, when discounted to the valuation date for the plan year for which the unpaid minimum required contribution is due at the appropriate rate of interest, equals or exceeds the unpaid minimum required contribution. For this purpose, the appropriate rate of interest is the plan's effective interest rate for the plan year for which the unpaid minimum required contribution is due except to the extent that the payments are subject to additional interest as provided under section 430(j)(3) or (4).

(ii) *Pre-PPA accumulated funding deficiency*. With respect to the accumulated funding deficiency under section 412 for the pre-effective plan year that is described in paragraph (c)(2) of this section, the term *correct* means to contribute, to or under the plan, the amount of that accumulated funding deficiency increased with interest from the end of the pre-effective plan year to the date of the contribution at the plan's valuation interest rate for the pre-effective plan year.

(iii) *Ordering rule*. For purposes of section 4971 and this section, a contribution is attributable first to the earliest plan year of any unpaid minimum required contribution for which correction has not yet been made.

(3) *Corrective action of certain retroactive plan amendments*. Certain retroactive plan amendments that meet the requirements of section 412(d)(2) may reduce the minimum required contribution for a plan year, which would reduce the accumulated funding deficiency or the amount of the unpaid minimum required contribution for a plan year.

(e) *Taxable period*—(1) *In general*. The term *taxable period* means the period beginning with the end of the plan year in which there is an accumulated funding deficiency or unpaid minimum required contribution, whichever is applicable, and ending on the earlier of:

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

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

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

(f) *Single-employer plan*. The term *single-employer plan* means a plan to which the minimum funding requirements of section 412 apply that is not a multiemployer plan as described in section

414(f). The term *single-employer plan* includes a multiple employer plan to which section 413(c) applies, other than a CSEC plan as described in paragraph (b)(2) of this section.

(g) *Examples*. The following examples illustrate the rules of this section.

Example 1. (i) Plan A, a single-employer defined benefit plan, has a calendar year plan year and a January 1 valuation date. The sponsor of Plan A has a calendar taxable year. Plan A has no funding shortfall as of January 1, 2008, and Plan A has no unpaid minimum required contributions for 2008 or any earlier plan year. The minimum required contribution for the 2009 plan year is $250,000. The plan sponsor makes one contribution for 2009 on July 1, 2009 in the amount of $200,000, and the sponsor does not make an election to use the prefunding balance or funding standard carryover balance to offset the minimum required contribution for 2009. The effective interest rate for Plan A for the 2009 plan year is 5.90%.

(ii) The contribution paid July 1, 2009 is discounted for 6 months (to the valuation date) at the effective interest rate ($200,000 ÷ $1.0590^{(6/12)}$ = $194,349). The unpaid minimum required contribution for the 2009 plan year is $250,000 minus $194,349, or $55,651. The excise tax due under section 4971(a) is 10% of the unpaid minimum required contribution, or $5,565.

Example 2. (i) The facts are the same as in *Example 1*. The plan sponsor makes an additional contribution of $175,000 on December 31, 2010.

(ii) Under the ordering rule in paragraph (d)(2)(iii) of this section, the contribution made on December 31, 2010 is applied first to correct the unpaid minimum required contribution for 2009. The portion of the contribution paid December 31, 2010 that is required to eliminate the unpaid minimum required contribution for 2009 (taking into account the 2009 effective interest rate for the 24 months between January 1, 2009 and the payment date of December 31, 2010), is $55,651 multiplied by $1.059^{(24/12)}$ or $62,412. The remaining payment of $112,588 ($175,000 minus $62,412) is applied to the contribution required for the 2010 plan year.

Example 3. (i) Plan B, a single-employer defined benefit plan, has a calendar year plan year. The sponsor of Plan B has a calendar taxable year. Plan B has an accumulated funding deficiency of $100,000 as of December 31, 2007, including additional interest due to late required installments during 2007. The valuation interest rate for the 2007 plan year is 7.5%.

(ii) In accordance with paragraph (c)(2) of this section, the accumulated funding deficiency under section 412 as of December 31, 2007 is considered an unpaid minimum required contribution until it is corrected. Pursuant to paragraph (d)(2)(ii) of this section, the amount needed to correct that accumulated funding deficiency is $100,000 plus interest at the valuation interest rate of 7.5% for the period between December 31, 2007 and the date of payment of the contribution.

(iii) The funding shortfall as of January 1, 2008 is calculated as the difference between the funding target and the value of assets as of that date. The assets are not adjusted by the amount of the accumulated funding deficiency. The fact that the contribution was not made for the 2007 plan year means that the January 1, 2008 funding shortfall is larger than it would have been otherwise.

Example 4. (i) The facts are the same as in *Example 3*. The minimum required contribution for the 2008 plan year is $125,000, but the plan sponsor does not make any required contributions for 2008.

(ii) The total unpaid minimum required contribution as of December 31, 2008 is the sum of the $100,000 accumulated funding deficiency under section 412 from 2007 and the $125,000 unpaid minimum required contribution for 2008, or $225,000. The section 4971(a) excise tax applies to the aggregate unpaid minimum required contributions for all plan years that remain unpaid as of the end of 2008. In this case, there is an unpaid minimum required contribution of $100,000 for the 2007 plan year and an unpaid minimum required contribution of $125,000 for the 2008 plan year. The section 4971(a) excise tax is 10% of the aggregate of those unpaid amounts, $22,500.

Example 5. (i) The facts are the same as in *Example 4*, except that the plan sponsor makes a contribution of $150,000 on December 31, 2008. No additional contributions are paid through September 15, 2009. Required installments of $25,000 each are due April 15, 2008, July 15, 2008, October 15, 2008, and January 15, 2009. Plan B's effective interest rate for the 2008 plan year is 5.75%.

(ii) In accordance with paragraph (c)(2) of this section, the accumulated funding deficiency under section 412 as of December 31, 2007 is treated as an unpaid minimum required contribution until it is corrected.

(iii) The December 31, 2008 contribution is first applied to the 2007 accumulated funding deficiency under section 412 that is treated as an unpaid minimum required contribution. Accordingly, the amount needed to correct the 2007 unpaid required minimum contribution ($100,000 multiplied by 1.075, or $107,500) is applied to eliminate this unpaid minimum required contribution for the 2007 plan year.

(iv) The remaining $42,500 December 31, 2008 contribution ($150,000 minus $107,500) is then applied to the 2008 minimum required contribution. This amount is first allocated to the required installment due April 15,

2008. In accordance with § 1.430(j)–1(b)(4)(ii) of this chapter, the adjustment for interest on late required installments is increased by 5 percentage points for the period of underpayment. Therefore, $25,000 of the remaining December 31, 2008 contribution is discounted using an interest rate of 10.75% for the 8½-month period between the payment date of December 31, 2008 and the required installment due date of April 15, 2008, and at the 5.75% effective interest rate for the 3½ months between April 15, 2008 and January 1, 2008. This portion of the December 31, 2008 contribution results in an adjusted amount of $22,880 (that is, $25,000 ÷ $1.1075^{(8.5/12)}$ ÷ $1.0575^{(3.5/12)}$) as of January 1, 2008.

(v) The remaining December 31, 2008 contribution is then applied to the required installment due July 15, 2008. The $17,500 balance of the December 31, 2008 contribution ($150,000 minus $107,500 minus $25,000) is paid after the due date for the second required installment. Accordingly, the remaining $17,500 contribution is adjusted using an interest rate of 10.75% for the 5½-month period between the payment date of December 31, 2008 and the required installment due date of July 15, 2008, and at the 5.75% effective interest rate for the 6½ months between July 15, 2008 and January 1, 2008. This portion of the December 31, 2008 contribution results in an adjusted amount of $16,202 (that is, $17,500 ÷ $1.1075^{(5.5/12)}$ ÷ $1.0575^{(6.5/12)}$) as of January 1, 2008.

(vi) The remaining unpaid minimum required contribution for 2008 is $125,000 minus the interest-adjusted amounts of $22,880 and $16,202 applied towards the 2008 minimum required contribution as determined in paragraphs (iv) and (v) of this *Example 5*. This results in an unpaid minimum required contribution of $85,918 for 2008. The section 4971(a) excise tax is 10% of the unpaid minimum required contribution, or $8,592.

Example 6. (i) Plan C, a single-employer defined benefit plan, has a calendar year plan year and a January 1 valuation date, and has no funding standard carryover balance or prefunding balance as of January 1, 2008. Plan C's sponsor has a calendar taxable year. The minimum required contributions for Plan C are $100,000 for the 2008 plan year, $110,000 for the 2009 plan year, $125,000 for the 2010 plan year, and $135,000 for the 2011 plan year. No contributions for these plan years are made until September 15, 2012, at which time the plan sponsor contributes $273,000 (which is exactly enough to correct the unpaid minimum required contributions for the 2008 and 2009 plan years).

(ii) The excise tax under section 4971(a) for the 2008 taxable year is 10% of the aggregate unpaid minimum required contributions for all plan years remaining unpaid as of the end of any plan year ending within the 2008 taxable year. Accordingly, the excise tax for the 2008 taxable year is $10,000 (that is, 10% of $100,000). The excise tax for the 2009 taxable year is $21,000 (that is, 10% of the sum of $100,000 and $110,000) and the excise tax for the 2010 taxable year is $33,500 (that is, 10% of the sum of $100,000, $110,000, and $125,000).

(iii) The contribution made on September 15, 2012 is applied to correct the unpaid minimum required contributions for the 2008 and 2009 plan years by the deadline for making contributions for the 2011 plan year. Therefore, the excise tax under section 4971(a) for the 2011 taxable year is based only on the remaining unpaid minimum required contributions for the 2010 and 2011 plan years, or $26,000 (that is, 10% of the sum of $125,000 and $135,000).

(iv) The plan sponsor may also be required to pay an excise tax of 100% under section 4971(b), if the unpaid minimum required contributions are not corrected by the end of the taxable period.

(h) *Effective/applicability dates and transition rules*—(1) *Statutory effective date*—(i) *In general*. In general, the amendments made to section 4971 by section 114 of the Pension Protection Act of 2006, Public Law 109–280, 120 Stat. 780 (2006), as amended (PPA '06), apply to taxable years beginning on or after January 1, 2008, but only with respect to a plan year that—

(A) Begins on or after January 1, 2008; and

(B) Ends with or within any such taxable year.

(ii) *Plans with delayed PPA '06 effective dates*. In the case of a plan for which the effective date of section 430 for purposes of determining the minimum required contribution is delayed in accordance with sections 104 through 106 of PPA '06, the amendments made to section 4971 by section 114 of PPA '06 apply to taxable years beginning on or after January 1, 2008, but only with respect to a plan year—

(A) To which section 430 applies to determine the minimum required contribution of the plan; and

(B) That ends with or within any such taxable year.

(2) *Effective date of regulations*. This section is effective for taxable years beginning on or after the statutory effective date described in paragraph (h)(1) of this section, but in no event does this section apply to taxable years ending before April 15, 2008.

(3) *Pre-effective plan year*. For purposes of this section, the pre-effective

plan year for a plan is the plan year described in § 1.430(a)–1(h)(5) of this chapter. Thus, except for plans with a delayed effective date under paragraph (h)(1)(ii) of this section, the pre-effective plan year for a plan is the last plan year beginning before January 1, 2008.

[T.D. 9732, 80 FR 54400, Sept. 9, 2015]

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

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

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

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

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

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

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

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

Example 3. Assume the same facts as in example (2) except that W dies in 1988. For 1988, 1989, and 1990, the amount required to be distributed under § 1.408–2(b)(6)(v) is zero. Thus, H would have no excise tax liability under section 4974 for these years. In 1991, the amount required to be distributed under § 1.408–2(b)(6)(v) is $855, determined by dividing $10,340 (the account balance as of January 1, 1991) by 12.1 years (the life expectancy of H as of January 1, 1991). Because the amount distributed from the account in 1991 ($608) is less than the amount required to be distributed from the account in 1991 ($855), H has an excise tax liability of $123.50 under section 4974 for 1991 [50% of ($855 − $608)].

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Section 403(b)(10) and § 1.403(b)–6(e) (in the case of an annuity contract, custodial account, or retirement income account described in section 403(b));

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

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

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

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

of the employee's death. For the calendar year which contains the date 5 years after the employee's death, the required minimum distribution amount required to be distributed to satisfy the applicable enumerated section is the payee's entire remaining interest in the qualified retirement plan.

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

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

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

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

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

(i) In the case of distributions commencing before the death of the employee, if there is a designated beneficiary under the impermissible annuity distribution option for purposes of section 401(a)(9), the permissible annuity distribution option is the joint and survivor annuity option under the plan for the lives of the employee and the designated beneficiary that provides for the greatest level amount payable to the employee determined on an annual basis. If the plan does not provide such an option or there is no designated beneficiary under the impermissible distribution option for purposes of section 401(a)(9), the permissible annuity distribution option is the life annuity option under the plan payable for the life of the employee in level amounts with no survivor benefit.

(ii) In the case of distributions commencing after the death of the employee, if there is a designated beneficiary under the impermissible annuity distribution option for purposes of section 401(a)(9), the permissible annuity distribution option is the life annuity option under the plan payable for the life of the designated beneficiary in level amounts. If there is no designated beneficiary, the 5-year rule in section 401(a)(9)(B)(ii) applies. See paragraph (b)(3) of this A–4. The determination of whether or not there is a designated beneficiary and the determination of which designated beneficiary's life is to

be used in the case of multiple beneficiaries will be made in accordance with § 1.401(a)(9)–4 and A–7 of § 1.401(a)(9)–5. If the defined benefit plan does not provide for distribution in the form of the applicable permissible distribution option, the required minimum distribution for each calendar year will be an amount as determined by the Commissioner.

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

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

(ii) In the case of a distribution commencing after the death of the employee, if there is a designated beneficiary under the impermissible annuity distribution option for purposes of section 401(a)(9), the annuity option is a life annuity for the life of the designated beneficiary which provides level annual payments and which would have been a permissible annuity distribution option. If there is no designated beneficiary, the 5-year rule in section 401(a)(9)(B)(ii) applies. See paragraph (b)(3) of this A–4. The amount of the payments under the annuity contract will be determined using the interest rate and actuarial tables prescribed under section 7520 determined using the date determined under A–3 of § 1.401(a)(9)–3 when distributions are required to commence and using the age of the beneficiary as of the beneficiary's birthday in the calendar year that contains that date. The determination of whether or not there is a designated beneficiary and the determination of which designated beneficiary's life is to be used in the case of multiple beneficiaries will be made in accordance with § 1.401(a)(9)–4 and A–7 of § 1.401(a)(9)–5.

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

(4) If the plan provides that the required beginning date for purposes of section 401(a)(9) for all employees is April 1 of the calendar year following the calendar year in which the employee attained age 70½ in accordance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 4975(d)(2) does not contain an exemption from other provisions of the Code, such as section 401, or other provisions of law which may impose requirements or restrictions relating to the transactions which are exempt under section 4975(d)(2). See, for example, the general fiduciary responsibility provisions of section 404 of the Employee Retirement Income Security Act of 1974 (the Act) (88 Stat. 877). The provisions of section 4975(d)(2) are further limited by the flush language at the end of section 4975(d) (relating to transactions with owner-employees and related persons).

(2) *Necessary service*. A service is necessary for the establishment or operation of a plan within the meaning of section 4975(d)(2) and § 54.4975–6(a)(1)(i) if the service is appropriate and helpful to the plan obtaining the service in carrying out the purposes for which the plan is established or maintained. A person providing such a service to a plan (or a person who is disqualified person solely by reason of a relationship to such a service provider described in section 4975(e)(2) (F), (G), (H), or (I)) may furnish goods which are necessary for the establishment or operation of the plan in the course of, and incidental to, the furnishing of such service to the plan.

(3) *Reasonable contract or arrangement.* No contract or arrangement is reasonable within the meaning of section 4975(d)(2) and § 54.4975–6(a)(1)(ii) if it does not permit termination by the plan without penalty to the plan on reasonably short notice under the circumstances to prevent the plan from becoming locked into an arrangement that has become disadvantageous. A long-term lease which may be terminated prior to its expiration (without penalty to the plan) on reasonably short notice under the circumstances is not generally an unreasonable arrangement merely because of its long term. A provision in a contract or other arrangement which reasonably compensates the service provider or lessor for loss upon early termination of the contract, arrangement or lease is not a penalty. For example, a minimal fee in a service contract which is charged to allow recoupment of reasonable start-up costs is not a penalty.

Similarly, a provision in a lease for a termination fee that covers reasonably foreseeable expenses related to the vacancy and reletting of the office space upon early termination of the lease is not a penalty. Such a provision does not reasonably compensate for loss if it provides for payments in excess of actual loss or if it fails to require mitigation of damages.

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

(5) *Transactions with fiduciaries*—(i) *In general.* If the furnishing of office space or a service involves an act described in section 4975(c)(1) (E) or (F) (relating to acts involving conflicts of interest by fiduciaries), such an act constitutes a separate transaction which is not exempt under section 4975(d)(2). The prohibitions of sections 4975(c)(1) (E) and (F) supplement the other prohibitions of section 4975(c)(1) by imposing on disqualified persons who are fiduciaries a duty of undivided loyalty to the plans for which they act. These prohibitions are imposed upon fiduciaries to deter them from exercising the authority, control, or responsibility which makes such persons fiduciaries when they have interests which may conflict with the interests of the plans for which they act. In such cases, the fiduciaries have interests in the transactions which may affect the exercise of their best judgment as fiduciaries. Thus, a fiduciary may not use the authority, control, or responsibility which makes such person a fiduciary to cause a plan to pay an additional fee to such fiduciary (or to a person in which such fiduciary has an interest which may affect the exercise of such fiduciary's best judgment as a fiduciary) to provide a service. Nor may a fiduciary use such authority, control, or responsibility to cause a plan to enter into a transaction involving plan assets whereby such fiduciary (or a person in which such fiduciary has an interest which may affect the exercise of such fiduciary's best judgment as a fiduciary) will receive consideration from a third party in connection with such transaction.

A person in which a fiduciary has an interest which may affect the exercise of such fiduciary's best judgment as a fiduciary includes, for example, a person who is a disqualified person by reason of a relationship to such fiduciary described in section 4975(e)(2) (E), (F), (G), (H), or (I).

(ii) *Transactions not described in section 4975(c)(1)(E).* A fiduciary does not engage in an act described in section 4975(c)(1)(E) if the fiduciary does not use any of the authority, control or responsibility which makes such person a fiduciary to cause a plan to pay additional fees for a service furnished by such fiduciary or to pay a fee for a service furnished by a person in which such fiduciary has an interest which may affect the exercise of such fiduciary's best judgment as a fiduciary. This may occur, for example, when one fiduciary is retained on behalf of a plan by a second fiduciary to provide a service for an additional fee. However, because the authority, control or responsibility which makes a person a fiduciary may be exercised ''in effect'' as well as in form, mere approval of the transaction by a second fiduciary does not mean that the first fiduciary has

not used any of the authority, control or responsibility which makes such person a fiduciary to cause the plan to pay the first fiduciary an additional fee for a service.

(iii) *Services without compensation.* If a fiduciary provides services to a plan without the receipt of compensation or other consideration (other than reimbursement of direct expenses properly and actually incurred in the performance of such services within the meaning of paragraph (e)(4) of this section), the provision of such services does not, in and of itself, constitute an act described in section 4975(c)(1) (E) or (F). The allowance of a deduction to an employer under section 162 or 212 for the expense incurred in furnishing office space or services to a plan established or maintained by such employer does not constitute compensation or other consideration.

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

Example 1. E, an employer whose employees are covered by plan P, is a fiduciary or P. I is a professional investment adviser in which E has no interest which may affect the exercise of E's best judgment as a fiduciary. E causes P to retain I to provide certain kinds of investment advisory services of a type which causes I to be a fiduciary of P under section 4975(e)(3)(B). Thereafter, I proposes to perform for additional fees portfolio evaluation services in addition to the services currently provided. The provision of such services is arranged by I and approved on behalf of the plan by E. I has not engaged in an act described in section 4975(c)(1)(E), because I did not use any of the authority, control or responsibility which makes I a fiduciary (the provision of investment advisory services) to cause the plan to pay I additional fees for the provision of the portfolio evaluation services. E has not engaged in an act which is described in section 4975(c)(1)(E). E, as the fiduciary who has the responsibility to be prudent in his selection and retention of I and the other investments advisers of the plan, has an interest in the purchase by the plan of portfolio evaluation services. However, such an interest is not an interest which may affect the exercise of E's best judgment as a fiduciary.

Example 2. D, a trustee of plan P with discretion over the management and disposition of plan assets, relies on the advice of C, a consultant to P, as to the investment of plan assets, thereby making C a fiduciary of the plan. On January 1, 1978, C recommends to D that the plan purchase an insurance policy from U, an insurance company which is not a disqualified person with respect to P. C thoroughly explains the reasons for the recommendation and makes a full disclosure concerning the fact that C will receive a commission from U upon the purchase of the policy by P. D considers the recommendation and approves the purchase of the policy by P. C receives a commission. Under such circumstances, C has engaged in an act described in section 4975(c)(1)(E) (as well as section 4975(c)(1)(F), because C is in fact exercising the authority, control or responsibility which makes C a fiduciary to cause the plan to purchase the policy. However, the transaction is exempt from the prohibited transaction provisions of section 4975(c)(1) if the requirements of Prohibited Transaction Exemption 77–9 are met.

Example 3. Assume the same facts as in Example (2) except that the nature of C's relationship with the plan is not such that C is a fiduciary of P. The purchase of the insurance policy does not involve an act described in section 4975(c)(1) (E) or (F), because such sections only apply to acts by fiduciaries.

Example 4. E, an employer whose employees are covered by plan P, is a fiduciary with respect to P. A, who is not a disqualified person with respect to P, persuades E that the plan needs the services of a professional investment adviser and that A should be hired to provide the investment advice. Accordingly, E causes P to hire A to provide investment advice of the type which makes A a fiduciary under § 54.4975–9(c)(1)(ii)(B). Prior to the expiration of A's first contract with P, A persuades E to cause P to renew A's contract with P to provide the same services for additional fees in view of the increased costs in providing such services. During the period of A's second contract, A provides additional investment advice services for which no additional charge is made. Prior to the expiration of A's second contract, A persuades E to cause P to renew his contract for additional fees in view of the additional services A is providing. A has not engaged in an act described in section 4975(c)(1)(E), because A has not used any of the authority, control or responsibility which makes A a fiduciary (the provision of investment advice) to cause the plan to pay additional fees for A's services.

Example 5. F, a trustee of plan P with discretion over the management and disposition of plan assets, retains C to provide administrative services to P of the type which makes C a fiduciary under section 4975(e)(3)(C). Thereafter, C retains F to provide, for additional fees, actuarial and various kinds of administrative services in addition to the services F is currently providing to P. Both F and C have engaged in an act described in section 4975(c)(1)(E). F, regardless of any intent which he may have had at the time he retained C, has engaged in such an act because F has, in effect, exercised the

authority, control or responsibility which makes F a fiduciary to cause the plan to pay F additional fees for the services. C, whose continued employment by P depends on F, has also engaged in such an act, because C has an interest in the transaction which might affect the exercise of C's best judgment as a fiduciary. As a result, C has dealt with plan assets in his own interest under section 4975(c)(1)(E).

Example 6. F, a fiduciary of plan P with discretionary authority respecting the management of P, retains S, the son of F, to provide for a fee various kinds of administrative services necessary for the operation of the plan. F has engaged in an act described in section 4975(c)(1)(E), because S is a person in whom F has an interest which may affect the exercise of F's best judgment as a fiduciary. Such act is not exempt under section 4975(d)(2) irrespective of whether the provision of the services by S is exempt.

Example 7. T, one of the trustees of plan P, is president of bank B. The bank proposes to provide administrative services to P for a fee. T physically absents himself from all consideration of B's proposal and does not otherwise exercise any of the authority, control or responsibility which makes T a fiduciary to cause the plan to retain B. The other trustees decide to retain B. T has not engaged in an act described in section 4975(c)(1)(E). Further, the other trustees have not engaged in an act described in section 4975(c)(1)(E) merely because T is on the board of trustees of P. This fact alone would not make them have an interest in the transaction which might affect the exercise of their best judgment as fiduciaries.

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

(2) *Plan covering own employees.* Such investment may be made if the plan is one which covers only the employees of the bank or similar financial institution, the employees of any of its affiliates, or the employees of both.

(3) *Other plans*—(i) *General rule.* Such investment may be made if the investment is expressly authorized by a provision of the plan or trust instrument or if the investment is expressly authorized (or made) by a fiduciary of the plan (other than the bank or similar financial institution or any of its affiliates) who has authority to make such investments, or to instruct the trustee or other fiduciary with respect to investments, and who has no interest in the transaction which may affect the exercise of such authorizing fiduciary's best judgment as a fiduciary so as to cause such authorization to constitute an act described in section 4975(c)(1) (E) or (F). Any authorization to make investments contained in a plan or trust instrument will satisfy the requirement of express authorization for investments made prior to November 1, 1977.

Effective November 1, 1977, in the case of a bank or similar financial institution that invests plan assets in deposits in itself or its affiliates under an authorization contained in a plan or trust instrument, such authorization

must name such bank or similar financial institution and must state that such bank or similar financial institution may make investments in deposits which bear a reasonable rate of interest in itself (or in an affiliate.)

(ii) *Example.* B, a bank, is the trustee of plan P's assets. The trust instruments give the trustee the right to invest plan assets in its discretion. B invests in the certificates of deposit of bank C, which is a fiduciary of the plan by virtue of performing certain custodial and administrative services. The authorization is sufficient for the plan to make such investment under section 4975(d)(4). Further, such authorization would suffice to allow B to make investments in deposits in itself prior to November 1, 1977. However, subsequent to October 31, 1977, B may not invest in deposits in itself, unless the plan or trust instrument specifically authorizes it to invest in deposits of B.

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

(ii) A person is an affiliate of a bank or similar financial institution if such person and such bank or similar financial institution would be treated as members of the same controlled group of corporations or as members of two or more trades or businesses under common control within the meaning of section 414 (b) or (c) and the regulations thereunder.

(iii) The term ''deposits'' includes any account, temporary or otherwise, upon which a reasonable rate of interest is paid, including a certificate of deposit issued by a bank or similar financial institution.

(c) *Exemption for ancillary bank services*—(1) *In general.* Section 4975(d)(6) exempts from the excise taxes imposed by section 4975 the provision of certain ancillary services by a bank or similar financial institution (as defined in § 54.4975–6(b)(4)(i)) supervised by the United States or a State to a plan for which it acts as a fiduciary if the conditions in § 54.4975–6(c)(2) are met. Such ancillary services include services which do not meet the requirements of section 4975(d)(2), because the provision of such services involves an act described in section 4975(c)(1)(E) (relating to fiduciaries dealing with the income or assets of plans in their own interest or for their own account) by the fiduciary bank or similar financial institution. Section 4975(d)(6) provides an exemption from section 4975(c)(1)(E), because section 4975 (d)(6) contemplates the provision of such ancillary services without the approval of a second fiduciary (as described in § 54.4975–6(a)(5)(ii)) if the conditions of § 54.4975–6(c)(2) are met. Thus, for example, plan assets held by a fiduciary bank which are reasonably expected to be needed to satisfy current plan expenses may be placed by the bank in a non-interest-bearing checking account in the bank if the conditions of § 54.4975–6(c)(2) are met, notwithstanding the provisions of section 4975(d)(4) (relating to investments in bank deposits). However, section 4975(d)(6) does not provide an exemption for an act described in section 4975(c)(1)(F) (relating to fiduciaries receiving consideration for their own personal account from any party dealing with a plan in connection with a transaction involving the income or assets of the plan). The receipt of such consideration is a separate transaction not described in section 4975(d)(6).

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

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

(i) At not more than reasonable compensation;

(ii) Under adequate internal safeguards which assure that the provision of such service is consistent with sound banking and financial practice, as determined by Federal or State supervisory authority; and

(iii) Only to the extent that such service is subject to specific guidelines issued by the bank or similar financial institution which meet the requirements of § 54.4975–6(c)(3).

(3) *Specific guidelines*. [Reserved]

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

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

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

(3) *Payments to certain fiduciaries*. Under sections 4975(d) (2) and (10), the term ''reasonable compensation'' does not include any compensation to a fiduciary who is already receiving full-time pay from an employer or association of employers (any of whose employees are participants in the plan) or from an employee organization (any of whose members are participants in the plan), except for the reimbursement of direct expenses properly and actually incurred and not otherwise reimbursed. The restrictions of this paragraph (e)(3) do not apply to a disqualified person who is not a fiduciary.

(4) *Certain expenses not direct expenses*. An expense is not a direct expense to the extent it would have been sustained had the service not been provided or if it represents an allocable portion of overhead costs.

(5) *Expense advances*. Under sections 4975(d) (2) and (10), the term ''reasonable compensation'', as applied to a fiduciary or an employee of a plan, includes an advance to such a fiduciary or employee by the plan to cover direct expenses to be properly and actually incurred by such person in the performance of such person's duties with the plan if:

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

(ii) The fiduciary or employee accounts to the plan at the end of the period covered by the advance for the expenses properly and actually incurred.

(6) *Excessive compensation*. Under sections 4975(d) (2) and (10), any compensation which would be considered excessive under § 1.162–7 (relating to compensation for personal services which constitutes an ordinary and necessary trade or business expense) will not be ''reasonable compensation''. Depending upon the facts and circumstances of the particular situation, compensation which is not excessive under § 1.162–7 may, nevertheless, not be ''reasonable compensation'' within the meaning of sections 4975(d) (2) and (10).

[T.D. 7491, 42 FR 32385, June 24, 1977; 42 FR 37810, July 25, 1977; 43 FR 4604, Feb. 3, 1978]

§ 54.4975–7 Other statutory exemptions.

(a) [Reserved]

(b) *Loans to employee stock ownership plans*—(1) *Definitions*. When used in this paragraph (b) and § 54.4975–11, the terms listed below have the following meanings:

(i) *ESOP*. The term ''ESOP'' refers to an employee stock ownership plan that meets the requirements of section 4975(e)(7) and § 54.4975–11. It is not synonymous with ''stock bonus plan.'' A stock bonus plan must, however, be an ESOP to engage in an exempt loan. The qualification of an ESOP under section 401(a) and § 54.4975–11 will not be adversely affected merely because it engages in a non-exempt loan.

(ii) *Loan*. The term ''loan'' refers to a loan made to an ESOP by a disqualified person or a loan to an ESOP which is guaranteed by a disqualified person. It includes a direct loan of cash, a purchase-money transaction, and an assumption of the obligation of an ESOP, ''Guarantee'' includes an unsecured guarantee and the use of assets of a disqualified person as collateral for a loan, even though the use of assets may not be a guarantee under applicable state law. An amendment of a loan in order to qualify as an exempt loan is not a refinancing of the loan or the making of another loan.

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

(iv) *Publicly traded*. The term ''publicly traded'' refers to a security that is listed on a national securities exchange registered under section 6 of the Securities Exchange Act of 1934 (15 U.S.C. 78f) or that is quoted on a system sponsored by a national securities association registered under section 15A(b) of the Securities Exchange Act (15 U.S.C. 78o).

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

(2) *Statutory exemption*—(i) *Scope*. Section 4975(d)(3) provides an exemption from the excise tax imposed under section 4975 (a) and (b) by reason of section 4975(c)(1) (A) through (E). Section 4975(d)(3) does not provide an exemption from the imposition of such tax by reason of section 4975(c)(1)(F), relating to fiduciaries receiving consideration for their own personal account from any party dealing with a plan in connection with a transaction involving the income or assets of the plan.

(ii) *Special scrutiny of transaction*. The exemption under section 4975(d)(3) includes within its scope certain transaction in which the potential for self-dealing by fiduciaries exists and in which the interests of fiduciaries may conflict with the interests of participants. To guard against those potential abuses, the Internal Revenue Service will subject these transactions to special scrutiny to ensure that they are primarily for the benefit of participants and their beneficiaries. Although the transactions need not be arranged and approved by an independent fiduciary, fiduciaries are cautioned to exercise scrupulously their discretion in approving them. For example, fiduciaries should be prepared to demonstrate compliance with the net effect test and the arm's-length standard under paragraph (b)(3)(ii) and (iii) of this section. Also, fiduciaries should determine that the transaction is truly arranged primarily in the interest of participants and their beneficiaries rather than, for example, in the interest of certain selling shareholders.

(3) *Primary benefit requirement*—(i) *In general*. An exempt loan must be primarily for the benefit of the ESOP participants and their beneficiaries. All the surrounding facts and circumstances, including those described in paragraph (b) (3) (ii) and (iii) of this section, will be considered in determining whether the loan satisfies this requirement. However, no loan will satisfy the requirement unless it satisfies the requirements of paragraph (b) (4), (5), and (6) of this section.

(ii) *Net effect on plan assets*. At the time that a loan is made, the interest rate for the loan and the price of securities to be acquired with the loan proceeds should not be such that plan assets might be drained off.

(iii) *Arm's-length standard*. The terms of a loan, whether or not between independent parties, must, at the same time the loan is made, be at least as favorable to the ESOP as the terms of a comparable loan resulting from arm's-length negotiations between independent parties.

(4) *Use of loan proceeds*. The proceeds of an exempt loan must be used within a reasonable time after their receipt by the borrowing ESOP only for any or all of the following purposes:

(i) To acquire qualifying employer securities.

(ii) To repay such loan.

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

Except as provided in paragraph (b) (9) and (10) of this section or as otherwise required by applicable law, no security acquired with the proceeds of an exempt loan may be subject to a put, call, or other option, or buy-sell or similar arrangement while held by and when distributed from a plan, whether or not the plan is then an ESOP.

(5) *Liability and collateral of ESOP for loan*. An exempt loan must be without recourse against the ESOP. Furthermore, the only assets of the ESOP that may be given as collateral on an exempt loan are qualifying employer securities of two classes: those acquired with the proceeds of the loan and those that were used as collateral on a prior

exempt loan repaid with the proceeds of the current exempt loan. No person entitled to payment under the exempt loan shall have any right to assets of the ESOP other than:

(i) Collateral given for the loan,

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

(iii) Earnings attributable to such collateral and the investment of such contributions.

The payments made with respect to an exempt loan by the ESOP during a plan year must not exceed an amount equal to the sum of such contributions and earnings received during or prior to the year less such payments in prior years. Such contributions and earnings must be accounted for separately in the books of account of the ESOP until the loan is repaid.

(6) *Default*. In the event of default upon an exempt loan, the value of plan assets transferred in satisfaction of the loan must not exceed the amount of default. If the lender is a disqualified person, a loan must provide for a transfer of plan assets upon default only upon and to the extent of the failure of the plan to meet the payment schedule of the loan. For purposes of this subparagraph (6), the making of a guarantee does not make a person a lender.

(7) *Reasonable rate of interest*. The interest rate of a loan must not be in excess of a reasonable rate of interest. All relevant factors will be considered in determining a reasonable rate of interest, including the amount and duration of the loan, the security and guarantee (if any) involved, the credit standing of the ESOP and the guarantor (if any), and the interest rate prevailing for comparable loans. When these factors are considered, a variable interest rate may be reasonable.

(8) *Release from encumbrance*—(i) *General rule*. In general, an exempt loan must provide for the release from encumbrance under this subdivision (i) of plan assets used as collateral for the loan. For each plan year during the duration of the loan, the number of securities released must equal the number of encumbered securities held immediately before release for the current plan year multiplied by a fraction. The numerator of the fraction is the amount of principal and interest paid for the year. The denominator of the fraction is the sum of the numerator plus the principal and interest to be paid for all future years. See § 54.4975–7(b) (8) (iv). The number of future years under the loan must be definitely ascertainable and must be determined without taking into account any possible extensions or renewal periods. If the interest rate under the loan is variable, the interest to be paid in future years must be computed by using the interest rate applicable as of the end of the plan year. If collateral includes more than one class of securities, the number of securities of each class to be released for a plan year must be determined by applying the same fraction to each class.

(ii) *Special rule*. A loan will not fail to be exempt merely because the number of securities to be released from encumbrance is determined solely with reference to principal payments. However, if release is determined with reference to principal payments only, the following three additional rules apply. The first rule is that the loan must provide for annual payments of principal and interest at a cumulative rate that is not less rapid at any time than level annual payments of such amounts for 10 years. The second rule is that interest included in any payment is disregarded only to the extent that it would be determined to be interest under standard loan amoritization tables. The third rule is that this subdivision, (ii) is not applicable from the time that, by reason of a renewal, extension, or refinancing, the sum of the expired duration of the exempt loan, the renewal period, the extension period, and the duration of a new exempt loan exceeds 10 years.

(iii) *Caution against plan disqualification*. Under an exempt loan, the number of securities released from encumbrance may vary from year to year. The release of securities depends upon certain employer contributions and earnings under the ESOP. Under § 54.4975–11(d)(2) actual allocations to participants' accounts are based upon assets withdrawn from the suspense account. Nevertheless, for purposes of applying the limitations under section

415 to these allocations, under § 54.4975–11(a)(8)(ii) contributions used by the ESOP to pay the loan are treated as annual additions to participants' accounts. Therefore, particular caution must be exercised to avoid exceeding the maximum annual additions under section 415. At the same time, release from encumbrance in annual varying numbers may reflect a failure on the part of the employer to make substantial and recurring contributions to the ESOP which will lead to loss of qualification under section 401(a). The Internal Revenue Service will observe closely the operation of ESOP's that release encumbered securities in varying annual amounts, particularly those that provide for the deferral of loan payments or for balloon payments.

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

Example. Corporation X establishes an ESOP that borrows $750,000 from a bank. X guarantees the loan, which is for 15 years at 5% interest and is payable in level annual amounts of $72,256.72. Total payments on the loan are $1,083,850.80. The ESOP uses the entire loan proceeds to acquire 15,000 shares of X stock which is used as collateral for the loan. The number of securities to be released for the first year is 1,000 shares, *i.e.*, 15,000 shares × $72,256.72/$1,083,850.80 = 15,000 shares × 1/15. The number of securities to be released for the second year is 1,000 shares, *i.e.*, 14,000 shares × $72,256.72/$1,011,594.08 = 14,000 shares × 1/14. If all loan payments are made as originally scheduled, the number of securities released in each succeeding year of the loan will also be 1,000.

(9) *Right of first refusal*. Qualifying employer securities acquired with proceeds of an exempt loan may, but need not, be subject to a right of first refusal. However, any such right must meet the requirements of this subparagraph (9). Securities subject to such right must be stock or an equity security, or a debt security convertible into stock or an equity security. Also, the securities must not be publicly traded at the time the right may be exercised. The right of first refusal must be in favor of the employer, the ESOP, or both in any order of priority. The selling price and other terms under the right must not be less favorable to the seller than the greater of the value of the security determined under § 54.4975–11(d)(5), or the purchase price and other terms offered by a buyer, other than the employer or the ESOP, making a good faith offer to purchase the security. The right of first refusal must lapse no later than 14 days after the security holder gives written notice to the holder of the right that an offer by a third party to purchase the security has been received.

(10) *Put option*. A qualifying employer security acquired with the proceeds of an exempt loan by an ESOP after September 30, 1976, must be subject to a put option if it is not publicly traded when distributed or if it is subject to a trading limitation when distributed. For purposes of subparagraph (10), a ''trading limitation'' on a security is a restriction under any Federal or state securities law, any regulation thereunder, or an agreement, not prohibited by this paragraph (b), affecting the security which would make the security not as freely tradable as one not subject to such restriction. The put option must be exercisable only by a participant, by the participant's donees, or by a person (including an estate or its distributee) to whom the security passes by reason of a participant's death. (Under this subparagraph (10), *participant* means a participant and beneficiaries of the participant under the ESOP.) The put option must permit a participant to put the security to the employer. Under no circumstances may the put option bind the ESOP. However, it may grant the ESOP an option to assume the rights and obligations of the employer at the time that the put option is exercised. If it is known at the time a loan is made that Federal or state law will be violated by the employer's honoring such put option, the put option must permit the security to be put, in a manner consistent with such law, to a third party (e.g., an affiliate of the employer or a shareholder other than the ESOP) that has substantial net worth at the time the loan is made and whose net worth is reasonably expected to remain substantial.

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

subject to the put option is distributed by the ESOP.

(ii) *Special rule*. In the case of a security that is publicly traded without restriction when distributed but ceases to be so traded within 15 months after distribution, the employer must notify each security holder in writing on or before the tenth day after the date the security ceases to be so traded that for the remainder of the 15-month period the security is subject to a put option. The number of days between such tenth day and the date on which notice is actually given, if later than the tenth day, must be added to the duration of the put option. The notice must inform distributees of the terms of the put options that they are to hold. Such terms must satisfy the requirements of paragraph (b) (10) through (12) of this section.

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

(ii) *Time excluded from duration of put option*. The period during which a put option is exercisable does not include any time when a distributee is unable to exercise it because the party bound by the put option is prohibited from honoring it by applicable Federal or state law.

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

(iv) *Payment terms*. The provisions for payment under a put option must be reasonable. The deferral of payment is reasonable if adequate security and a reasonable interest rate are provided for any credit extended and if the cumulative payments at any time are no less than the aggregate of reasonable periodic payments as of such time. Periodic payments are reasonable if annual installments, beginning with 30 days after the date the put option is 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.

(v) *Payment restrictions*. Payment under a put option may be restricted by the terms of a loan, including one used to acquire a security subject to a put option made before November 1, 1977. Otherwise, payment under a put option must not be restricted by the provisions of a loan or any other arrangement, including the terms of the employer's articles of incorporation, unless so required by applicable state law.

(13) *Other terms of loan*. An exempt loan must be for a specific term. Such loan may not be payable at the demand of any person, except in the case of default.

(14) *Status of plan as ESOP*. To be exempt, a loan must be made to a plan that is an ESOP at the time of such loan. However, a loan to a plan formally designated as an ESOP at the time of the loan that fails to be an ESOP because it does not comply with section 401(a) of the Code or § 54.4975–11 will be exempt as of the time of such loan if the plan is amended retroactively under section 401(b) or § 54.4975–11(a)(4).

(15) *Special rules for certain loans*—(i) *Loans made before January 1, 1976*. A loan made before January 1, 1976, or made afterwards under a binding agreement in effect on January 1, 1976 (or under renewals permitted by the terms of the agreement on that date) is exempt for the entire period of the loan if it otherwise satisfies the provisions of this paragraph (b) for such period, even though it does not satisfy the following provisions of this section: the last sentence of paragraph (b) (4) and all of paragraph (b) (5), (6), (8) (i) and (ii), and (9) through (13), inclusive.

(ii) *Loans made after December 31, 1975, but before November 1, 1977*. A loan made after December 31, 1975, but before November 1, 1977 or made afterwards under a binding agreement in effect on November 1, 1977 (or under renewals permitted by the terms of the agreement on that date) is exempt for the entire period of the loan if it otherwise satisfies the provisions of this paragraph (b) for such period even though it

does not satisfy the following provisions of this section: paragraph (b) (6) and (9) and the three additional rules listed in paragraph (b) (8) (ii).

(iii) *Release rule.* Notwithstanding paragraph (b) (15) (i) and (ii) of this section, if the proceeds of a loan are used to acquire securities after November 1, 1977, the loan must comply by such date with the provisions of paragraph (b) (8) of this section.

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

(v) *Put option rule.* With respect to a security distributed before November 1, 1977, the put option provisions of paragraph (b) (10), (11), and (12) of this section will be deemed satisfied as of the date the security is distributed if by December 31, 1977, the security is subject to a put option satisfying such provisions, the security is subject to a put option satisfying such provisions. For purposes of satisfying such provisions, the security will be deemed distributed on the date the put option is issued. However, the put option provisions need not be satisfied with respect to a security that is not owned on November 1, 1977, by a person in whose hands a put option must be exercisable.

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

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

§ 54.4975–9 Definition of "fiduciary".

(a)–(b) [Reserved]

(c) *Investment advice.* (1) A person shall be deemed to be rendering ''investment advice'' to an employee benefit plan, within the meaning of section 4975(e)(3)(B) and this paragraph, only if:

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

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

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

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

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

(i) Exempt such person from the provisions of section 405(a) of the Employee Retirement Income Security Act of 1974 concerning liability for fiduciary breaches by other fiduciaries with respect to any assets of the plan; or

(ii) Exclude such person from the definition of the term *disqualified person* (as set forth in section 4975(e)(2)) with respect to any assets of the plan.

(d) *Execution of securities transactions.* (1) A person who is a broker or dealer

registered under the Securities Exchange Act of 1934, a reporting dealer who makes primary markets in securities of the United States Government or of an agency of the United States Government and reports daily to the Federal Reserve Bank of New York its positions with respect to such securities and borrowings thereon, or a bank supervised by the United States or a State, shall not be deemed to be a fiduciary, within the meaning of section 4975(e)(3), with respect to an employee benefit plan solely because such person executes transactions for the purchase or sale of securities on behalf of such plan in the ordinary course of its business as a broker, dealer, or bank, pursuant to instructions of a fiduciary with respect to such plan, if:

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

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

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

(i) Exempt such broker-dealer, reporting dealer, or bank from the provisions of section 405(a) of the Employee Retirement Income Security Act of 1974 concerning liability for fiduciary breaches by other fiduciaries with respect to any assets of the plan; or

(ii) Exclude such broker-dealer, reporting dealer, or bank from the definition of the term *disqualified person* (as set forth in section 4975(e)(2)) with respect to any assets of the plan.

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

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

(ii) Any officer, director, partner, employee or relative (as defined in section 4975(e)(6)) of such person; and

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

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

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

§ 54.4975–11 "ESOP" requirements.

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

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

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

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

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

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

(4) *Retroactive amendment*. A plan meets the requirements of this section as of the date that it is designated as an ESOP if it is amended retroactively to meet, and in fact does meet, such requirements at any of the following times:

(i) 12 months after the date on which the plan is designated as an ESOP;

(ii) 90 days after a determination letter is issued with respect to the qualification of the plan as an ESOP under this section, but only if the determination is requested by the time in paragraph (a)(4)(i) of this section; or

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

(5) *Addition to other plan*. An ESOP may form a portion of a plan the balance of which includes a qualified pension, profit-sharing, or stock bonus plan which is not an ESOP. A reference to an ESOP includes an ESOP that forms a portion of another plan.

(6) *Conversion of existing plan to an ESOP*. If an existing pension, profit-sharing, or stock bonus plan is converted into an ESOP, the requirements of section 404 of the Employee Retirement Income Security Act of 1974 (ERISA) (88 Stat. 877), relating to fiduciary duties, and section 401(a) of the Code, relating to requirements for plans established for the exclusive benefit of employees, applying to such conversion. A conversion may constitute a termination of an existing plan. For definition of a termination, see the regulations under section 411(d)(3) of the Code and section 4041(f) of ERISA.

(7) *Certain arrangements barred*—(i) *Buy-sell agreements*. An arrangement involving an ESOP that creates a put option must not provide for the issuance of put options other than as provided under § 54.4975–7(b) (10), (11) and (12). Also, an ESOP must not otherwise obligate itself to acquire securities from a particular security holder at an indefinite time determined upon the happening of an event such as the death of the holder.

(ii) *Integrated plans*. A plan designated as an ESOP after November 1, 1977, must not be integrated directly or indirectly with contributions or benefits under title II of the Social Security Act or any other State or Federal law. ESOP's established and integrated before such date may remain integrated. However, such plans must not be

amended to increase the integration level or the integration percentage. Such plans may in operation continue to increase the level of integration if under the plan such increase is limited by reference to a criterion existing apart from the plan.

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

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

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

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

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

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

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

(iii) Paragraph (f)(3).

(b) *Plan designed to invest primarily in qualifying employer securities.* A plan constitutes an ESOP only if the plan specifically states that it is designed to invest primarily in qualifying employer securities. Thus, a stock bonus plan or a money purchase pension plan constituting an ESOP may invest part of its assets in other than qualifying employer securities. Such plan will be treated the same as other stock bonus plans or money purchase pension plans qualified under section 401a with respect to those investments.

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

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

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

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

(4) *Forfeitures.* If a portion of a participant's account is forfeited, qualifying employer securities allocated under paragraph (d)(2) of this section must be forfeited only after other assets. If interests in more than one class

of qualifying employer securities have been allocated to the participant's account, the participant must be treated as forfeiting the same proportion of each such class.

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

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

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

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

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

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

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

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

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

(2) *Exempt loan proceeds.* If securities acquired with the proceeds of an exempt loan available for distribution consist of more than one class, a distributee must receive substantially the same proportion of each such class. However, as indicated in paragraph (f)(1) of this section, benefits distributable from the portion of an ESOP consisting of a stock bonus plan are distributable only in stock of the employer.

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

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

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

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

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

(1) Stock or otherwise an equity security, or

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

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

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

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

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

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

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

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

(d) *Computation of section 4975 excise tax*. To the extent applicable, and solely for purposes associated with the payment of a section 4975 excise tax under the election referred to in this section, § 53.4941(e)–1 of this chapter (Foundation Excise Tax Regulations) is controlling.

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

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

§ 54.4975–15 Other transitional rules.

(a)–(c) [Reserved]

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

to the plan as an arm's-length transaction with an unrelated party would be.

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

(2) *Persons deemed to be June 30, 1974, service providers.* A disqualified person with respect to a plan which did not, on June 30, 1974, ordinarily and customarily furnish a particular service, will nevertheless be considered to have ordinarily and customarily furnished such service on June 30, 1974, for purposes of this section and section 2003(c)(2)(D) of the Act, if either of the following conditions are met:

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

(ii) Control, or the power to exercise a controlling influence over the management and policies of such disqualified person is possessed, directly or through one or more intermediaries, by the same person or persons who possessed directly or through one or more intermediaries control, or the power to exercise a controlling influence over the management and policies of a person who ordinarily and customarily furnished such service on June 30, 1974. For purposes of this paragraph (d)(2) a person shall be deemed to be an

''intermediary'' of another person if at least 50 percent of the outstanding beneficial interests of such person are owned by such other person, directly or indirectly, or if such other person controls or has the power to exercise a controlling influence over the management and policies of such person.

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

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

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

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

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

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

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

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

Q–1: What does section 4976 provide?

A–1: Section 4976 imposes a tax on employers who provide disqualified benefits through a welfare benefit fund. The tax imposed is equal to 100 percent of the disqualified benefit.

Q–2: What constitutes a disqualified benefit?

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

is provided and there is not (and there is not required to be) a separate account with an outstanding credit balance maintained for the key employee.

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

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

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

(c) In the case of a plan which is maintained pursuant to one or more collective bargaining agreements (1) between employee representatives and one or more employers and (2) which are in effect on July 1, 1985 (or ratified on or before that date), the provision does not apply to disqualified benefits provided in years beginning before the termination of the last of the collective bargaining agreements pursuant to which the plan is maintained (determined without regard to any extension of the contract agreed to after July 1, 1985). For purposes of the preceding sentence, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added under section 511 of the Tax Reform Act 1984 (*i.e.*, requirements under sections 419, 419A, 512(a)(3)(E), and 4976) shall not be treated as a termination of such collective bargaining agreement.

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

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

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

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

A–1: In general, section 4977 provides an elective grandfather rule that allows an employer under certain circumstances to treat employees of all lines of business which were in existence on January 1, 1984, as employees

of one of those lines of business for purposes of section 132(a) (1) and (2), but not for purposes of section 132(g)(2).

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

A–2: If:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q–6: When is a revocation effective?

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

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

A–7: No.

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

A–8: No.

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

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

Q–1: What does section 4978 provide?

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

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

(b) Such plan or cooperative disposes of any qualified securities during the 3-year period after the date on which any qualified securities were acquired in

the sale to which section 1042 applies; and

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

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

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

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

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

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

(1) The death of the employee;

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

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

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

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

(c) If restricted qualified securities held by an employee stock ownership plan or eligible worker-owned cooperative no longer meet the definition of qualified securities (''old restricted qualified securities'') as a result of a transaction changing (1) the status of a corporation as an employer, or as a member of a controlled group of corporations including the employer, or (2) the existence of employer securities

of the type described in section 409(l)(1), the disposition of such securities shall not be treated as a disposition of restricted qualified securities to which the tax under section 4978 is imposed if, within 90 days after such disposition, securities meeting the requirements of section 409(l) (''new restricted qualified securities'') that are of equal value to the old restricted qualfied securities (at the time of the disposition of the old restricted qualified securities) are substituted for such old restricted qualified securities. However, for purposes of determining the tax imposed under section 4978, old restricted qualified securities shall not be treated as if they retained their status as restricted qualified securities and new restricted qualified securities derived from the disposition of old restricted qualified securities pursuant to the preceding sentence shall be treated as restricted qualified securities for the remaining portion of the period during which the disposition of the old restricted qualified securities would have been subject to tax under section 4978.

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

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

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

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

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

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

This section contains the captions that appear in § 54.4979.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) *No tax when excess distributed within 2½ months of close of year or additional employer contributions made*—(1) *General rule*. No tax is imposed under this section on any excess contribution or excess aggregate contribution, as the case may be, to the extent the contribution (together with any income allocable thereto) is corrected before the close of the first 2½ months of the following plan year (6 months in the case of a plan that includes an eligible automatic contribution arrangement within the meaning of section 414(w)). The extension to 6 months applies to a distribution of excess contributions or excess aggregate contributions for a plan year beginning on or after January 1, 2010, only where all the eligible NHCEs and eligible HCEs (both as defined in §1.401(k)–6 of this Chapter) are covered employees under an eligible automatic contribution arrangement within the meaning of section 414(w) for the entire plan year (or the portion of the plan year that the eligible NHCEs and eligible HCEs are eligible employees under the plan)). Qualified nonelective contributions and qualified matching contributions taken into account under §1.401(k)–2(a)(6) of this Chapter or qualified nonelective contributions or elective contributions taken into account under §1.401(m)–2(a)(6) of this Chapter for a plan year may permit a plan to avoid excess contributions or excess aggregate contributions, respectively, even if made after the close of the 2½ month (or 6 month) period for

distributing excess contributions or excess aggregate contributions without the excise tax. See § 1.401(k)–2(b)(1)(i) and (5)(i) of this Chapter for methods to avoid excess contributions, and § 1.401(m)–2(b)(1)(i) of the Chapter for methods to avoid excess aggregate contributions.

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

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

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

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

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

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

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

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

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

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

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

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

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§ 54.4980B–10 Interaction of FMLA and COBRA.

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

§ 54.4980B–1 COBRA in general.

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

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

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

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

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

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

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

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

§ 54.4980B–2 Plans that must comply.

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

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

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

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

(c) Whether a benefit provided to employees constitutes health care is not affected by whether the benefit is excludable from income under section 132 (relating to certain fringe benefits). For example, if a department store provides its employees discounted prices on all merchandise, including health care items such as drugs or eyeglasses, the mere fact that the discounted prices also apply to health care items will not cause the program to be a plan providing health care, so long as the

discount program would normally be accessible to and used by employees without regard to health needs or physical condition. If, however, the employer maintaining the discount program is a health clinic, so that the program is used exclusively by employees with health or medical needs, the program is considered to be a plan providing health care and so is considered to be a group health plan.

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

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

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

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

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

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

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

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

(1) A person for whom services are performed;

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

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

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

Q–3: What is a multiemployer plan?

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

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

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

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

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

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

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

(c) The COBRA continuation coverage requirements generally do not apply to group health plans that are excepted from COBRA. However, a small-employer plan otherwise excepted from COBRA is nonetheless subject to COBRA with respect to qualified beneficiaries who experience a qualifying event during a period when

the plan is not a small-employer plan (see paragraph (g) of Q&A–5 of this section).

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

Q–5: What is a small-employer plan?

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

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

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

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

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

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

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

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

(d) In determining the number of the employees of an employer, each full-time employee is counted as one employee and each part-time employee is counted as a fraction of an employee, determined in accordance with paragraph (e) of this Q&A–5.

(e) An employer may determine the number of its employees on a daily basis or a pay period basis. The basis used by the employer must be used with respect to all employees of the employer and must be used for the entire year for which the number of employees is being determined. If an employer determines the number of its employees on a daily basis, it must determine the actual number of full-time employees on each typical business day and the actual number of part-time employees and the hours worked by each of those part-time employees on each typical business day. Each full-time employee counts as one employee on each typical business day and each part-time employee counts as a fraction, with the numerator of the fraction equal to the number of hours worked by that employee and the denominator equal to the number of

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

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

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

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

Example 2. The facts are the same as in *Example 1*. The employer continues to employ 19 employees throughout 2003 and 2004 and consequently the plan continues to be excepted from COBRA during 2004 and 2005. Spouse *S* is covered under the plan because *S* is married to one of the employer's employees. On April 1, 2002, *S* is divorced from that employee and ceases to be eligible for coverage under the plan. The plan is subject to COBRA during 2002 because *X* normally employed 20 employees during 2001. *S* timely notifies the plan administrator of the divorce and timely elects and pays for COBRA continuation coverage. Even though the plan is generally excepted from COBRA during 2003, 2004, and 2005, it must nevertheless continue to make COBRA continuation coverage available to *S* during those years until the obligation to make COBRA continuation coverage available ceases under the rules of § 54.4980B–7. The obligation could continue until April 1, 2005, the date that is 36 months after the date of *S*'s qualifying event.

Example 3. The facts are the same as in *Example 2*. *C* is a dependent child of one of the employer's employees and is covered under the plan. A dependent child is no longer eligible for coverage under the plan upon the attainment of age 23. *C* attains age 23 on November 16, 2005. The plan is excepted from COBRA with respect to *C* during 2005 because the employer normally employed fewer than

20 employees during 2004. Consequently, the plan is not obligated to make COBRA continuation coverage available to *C* (and would not be obligated to make COBRA continuation coverage available to *C* even if the plan later became subject to COBRA again).

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

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

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

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

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

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

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

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

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

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

Q–7: What is the plan year?

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

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

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

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

(3) If the plan does not impose deductibles or limits on an annual basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, then the plan year is the employer's taxable year.

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

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

A–8: (a)(1) The provision of health care benefits does not fail to be a group health plan merely because those benefits are offered under a cafeteria plan (as defined in section 125) or under any other arrangement under which an employee is offered a choice between health care benefits and other taxable or nontaxable benefits. However, the

COBRA continuation coverage requirements apply only to the type and level of coverage under the cafeteria plan or other flexible benefit arrangement that a qualified beneficiary is actually receiving on the day before the qualifying event. See paragraphs (b) through (e) of this Q&A–8 for rules limiting the obligations of certain health flexible spending arrangements.

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

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

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

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

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

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

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

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

(e) If the conditions in paragraph (c) of this Q&A–8 are satisfied for a plan year, the health FSA is not obligated to make COBRA continuation coverage available for that plan year to any qualified beneficiary who experiences a qualifying event during that plan year unless, as of the date of the qualifying event, the qualified beneficiary can become entitled to receive during the remainder of the plan year a benefit that exceeds the maximum amount that the health FSA is permitted to require to be paid for COBRA continuation coverage for the remainder of the plan year. In determining the amount of the benefit that a qualified beneficiary can become entitled to receive during the remainder of the plan year, the health FSA may deduct from the maximum benefit available to that qualified beneficiary for the year (based on the election made under the health FSA for that qualified beneficiary before the date of the qualifying event) any reimbursable claims submitted to the health FSA for that plan year before the date of the qualifying event.

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

Example. (i) An employer maintains a group health plan providing major medical benefits and a group health plan that is a

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

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

(iii) Whether the health FSA is obligated to make COBRA continuation coverage available in 2002 to a qualified beneficiary with respect to a qualifying event that occurs in 2002 depends upon the maximum benefit that would be available to the qualified beneficiary under COBRA continuation coverage for that plan year. *Case 1:* Employee *B* has elected to reduce *B*'s salary by $1200 for 2002. Thus, the maximum benefit that *B* can become entitled to receive under the health FSA during the entire year is $2400. *B* experiences a qualifying event that is the termination of *B*'s employment on May 31, 2002. As of that date, *B* had submitted $300 of reimbursable expenses under the health FSA. Thus, the maximum benefit that *B* could become entitled to receive for the remainder of 2002 is $2100. The maximum amount that the health FSA can require to be paid for COBRA continuation coverage for the remainder of 2002 is 102 percent times 1/12 of the applicable premium for 2002 times the number of months remaining in 2002 after the date of the qualifying event. In *B*'s case, the maximum amount that the health FSA can require to be paid for COBRA continuation coverage for 2002 is 2.04 times $1200, or $2448. One-twelfth of $2448 is $204. Because seven months remain in the plan year, the maximum amount that the health FSA can require to be paid for *B*'s coverage for the remainder of the year is seven times $204, or $1428. Because $1428 is less than the maximum benefit that *B* could become entitled to receive for the remainder of the year ($2100), the health FSA is required to make COBRA continuation coverage available to *B* for the remainder of 2002 (but not for any subsequent year).

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

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

A–9: Under section 4980B(a), if a group health plan subject to COBRA fails to comply with section 4980B(f), an excise tax is imposed. Moreover,

non-tax remedies may be available if the plan fails to comply with the parallel requirements in ERISA, which are administered by the Department of Labor.

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

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

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

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

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

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

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

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

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

§ 54.4980B–3 Qualified beneficiaries.

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

Q–1: Who is a qualified beneficiary?

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

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

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

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

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

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

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

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

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

(e) An individual is not a qualified beneficiary if the individual's status as a covered employee is attributable to a period in which the individual was a nonresident alien who received from the individual's employer no earned income (within the meaning of section 911(d)(2)) that constituted income from sources within the United States (within the meaning of section 861(a)(3)). If, pursuant to the preceding sentence, an individual is not a qualified beneficiary, then a spouse or dependent child of the individual is not considered a qualified beneficiary by virtue of the relationship to the individual.

(f) A qualified beneficiary who does not elect COBRA continuation coverage in connection with a qualifying event ceases to be a qualified beneficiary at the end of the election period (see Q&A–1 of § 54.4980B–6). Thus, for example, if such a former qualified beneficiary is later added to a covered employee's coverage (e.g., during an open enrollment period) and then another qualifying event occurs with respect to the covered employee, the former qualified beneficiary does not become a qualified beneficiary by reason of the second qualifying event. If a covered employee who is a qualified beneficiary

does not elect COBRA continuation coverage during the election period, then any child born to or placed for adoption with the covered employee on or after the date of the qualifying event is not a qualified beneficiary. Once a plan's obligation to make COBRA continuation coverage available to an individual who has been a qualified beneficiary ceases under the rules of § 54.4980B–7, the individual ceases to be a qualified beneficiary.

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

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

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

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

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

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

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

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

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

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

Example 5. (i) The facts are the same as in *Example 4*, except that, under the terms of the plan, the divorce or death does not cause *E* to lose coverage so that *E* continues to be covered for the balance of the original 12-month period.

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

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

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

Q&A–5 in § 54.4980B–2), the following individuals are employees if their relationship to the employer maintaining the plan makes them eligible to be covered under the plan—

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

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

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

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

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

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

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

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

§ 54.4980B–4 Qualifying events.

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

Q–1: What is a qualifying event?

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

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

(1) The death of a covered employee;

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

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

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

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

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

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

(d) An event satisfies this paragraph (d) if it occurs while the plan is subject to COBRA. Thus, an event will not satisfy this paragraph (d) if it occurs while the plan is excepted from COBRA (see Q&A–4 of § 54.4980B–2). Even if the plan later becomes subject to COBRA, it is not required to make COBRA continuation coverage available to anyone whose coverage ends as a result of an event during a year in which the plan is excepted from COBRA. For example, if a group health plan is excepted from COBRA as a small-employer plan during the year 2001 (see Q&A–5 of § 54.4980B–2) and an employee terminates employment on December 31, 2001, the termination is not a qualifying event and the plan is not required to permit the employee to elect COBRA continuation coverage. This is the case even if the plan ceases to be a small-employer plan as of January 1, 2002. Also, the same result will follow even if the employee is given three months of coverage beyond December 31 (that is, through March of 2002), because there will be no qualifying event as of the termination of coverage in March. However, if the employee's spouse is initially provided with the three-month coverage through March 2002, but the spouse divorces the employee before the end of the three months and loses coverage as a result of the divorce, the divorce will constitute a qualifying event during 2002 and so entitle the spouse to elect COBRA continuation coverage. See Q&A–7 of § 54.4980B–7 regarding the maximum coverage period in such a case.

(e) A reduction of hours of a covered employee's employment occurs whenever there is a decrease in the hours

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

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

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

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

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

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

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

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

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

Example 4. (i) *F* is a covered employee who is married to *G*, and both are covered under a group health plan maintained by *F*'s employer. *F* and *G* are divorced. Under the terms of the plan, the divorce causes *G* to lose coverage. The divorce is a qualifying event, and *G* elects COBRA continuation coverage, remarries during the period of COBRA continuation coverage, and *G*'s new spouse becomes covered under the plan. (See Q&A–5 in § 54.4980B–5, paragraph (c) in Q&A–4 of § 54.4980B–5, and section 9801(f)(2).) *G* dies. Under the terms of the plan, the death causes *G*'s new spouse to lose coverage under the plan.

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

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

(ii) The elimination of retiree coverage under these circumstances is a deferred loss of coverage for those retirees (and their

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

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

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

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

§ 54.4980B–5 COBRA continuation coverage.

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

Q–1: What is COBRA continuation coverage?

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

(b) In the case of a qualified beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the child is generally entitled to elect immediately to have the same coverage that dependent children of active employees receive under the benefit packages under which the covered employee has coverage at the time of the birth or placement for adoption. Such a child would be entitled to elect coverage different from that elected by the covered employee during the next available open enrollment period under the plan. See Q&A–4 of this section.

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

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

2. Special rules are set forth in paragraph (e) of this Q&A–2, and examples appear in paragraph (f) of this Q&A–2.

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

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

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

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

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

Example 1. (i) A group health plan applies a separate $100 annual deductible to each individual it covers. The plan provides that the spouse and dependent children of a covered employee will lose coverage on the last day of the month after the month of the covered employee's death. A covered employee dies on June 11, 2001. The spouse and the two dependent children elect COBRA continuation coverage, which will begin on August 1, 2001. As of July 31, 2001, the spouse has incurred $80 of covered expenses, the older child has incurred no covered expenses, and the younger one has incurred $120 of covered expenses (and therefore has already satisfied the deductible).

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

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

(ii) The resulting family consisting of the spouse and the two oldest children accumulated a total of $270 of covered expenses, and

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

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

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

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

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

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

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

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

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

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

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

Example 3. (i) A group health plan pays for 80 percent of covered expenses after satisfaction of a $100-per-individual deductible, and the plan pays for 100 percent of covered expenses after a family has incurred out-of-pocket costs of $2,000. The plan provides that upon the divorce of a covered employee, coverage will end immediately for the employee's spouse and any children who do not remain in the employee's custody. An employee and spouse with three dependent children divorce on June 1, 2001, and one of the children remains with the employee. The spouse elects COBRA continuation coverage as of that date for the spouse and the other two children. During January through May of 2001, the spouse incurred $600 of covered expenses and each of the two children in the spouse's custody after the divorce incurred covered expenses of $1,100. This resulted in total out-of-pocket costs for these three individuals of $800 ($300 total for the three deductibles, plus $500 for 20 percent of the other $2,500 in incurred expenses [$600 + $1,100 + $1,100 = $2,800; $2,800 − $300 = $2,500]).

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

Q–4: Can a qualified beneficiary who elects COBRA continuation coverage ever change from the coverage received

by that individual immediately before the qualifying event?

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

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

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

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

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

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

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

to be covered under a new plan or to add or eliminate family coverage.

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

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

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

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

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

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

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

(d) The right to add new family members under this Q&A–5 is in addition to the rights that newborn and adopted children of covered employees may have as qualified beneficiaries; see Q&A–1 in § 54.4980B–3.

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

§ 54.4980B–6 Electing COBRA continuation coverage.

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

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

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

end before the date that is 60 days after the later of—

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

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

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

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

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

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

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

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

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

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

(1) The date of the qualifying event; or

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

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

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

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

(b) In the case of an indemnity or reimbursement arrangement, the employer or employee organization can

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

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

(i) Electing and paying for the coverage; or

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

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

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

A–4: If, during the election period, a qualified beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver of COBRA continuation coverage is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the employer, employee organization, or plan administrator, as applicable.

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

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

the COBRA continuation coverage requirements. Furthermore, any purported waiver obtained by means of such a withholding is invalid.

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

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

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

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

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

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

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

§ 54.4980B–7 Duration of COBRA continuation coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A–2: (a) If a qualified beneficiary first becomes covered under another group health plan (including for this purpose any group health plan of a governmental employer or employee organization) after the date on which COBRA continuation coverage is elected for the qualified beneficiary and the other coverage satisfies the requirements of paragraphs (b), (c), and (d) of this Q&A–2, then the plan may terminate the qualified beneficiary's COBRA continuation coverage upon the date on which the qualified beneficiary first becomes covered under the other group health plan (even if the other coverage is less valuable to the qualified beneficiary). By contrast, if a qualified beneficiary first becomes covered under another group health plan on or before the date on which COBRA continuation coverage is elected, then the other coverage cannot be a basis for terminating the qualified beneficiary's COBRA continuation coverage.

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

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

(d) The requirement of this paragraph (d) is satisfied if the other group health plan does not contain any exclusion or limitation with respect to any preexisting condition of the qualified beneficiary (other than such an exclusion or limitation that does not apply

to, or is satisfied by, the qualified beneficiary by reason of the provisions in section 9801 (relating to limitations on preexisting condition exclusion periods in group health plans)).

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

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

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

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

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

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

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

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

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

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

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

A–4: (a) Except as otherwise provided in this Q&A–4, the maximum coverage period ends 36 months after the qualifying event. The maximum coverage period for a qualified beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage is the maximum coverage period for the qualifying event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption. Paragraph (b) of this Q&A–4 describes the starting point from which the end of the maximum coverage period is measured. The date that the maximum coverage period ends is described in paragraph (c) of this Q&A–4 in a case where the qualifying event is a termination of employment or reduction of hours of employment, in paragraph (d) of this Q&A–4 in a case where a covered employee becomes entitled to Medicare benefits under title XVIII of the Social Security Act (42 U.S.C. 1395–1395ggg) before experiencing a qualifying event that is a termination of employment or reduction of hours of employment, and in paragraph (e) of this Q&A–4 in the case of a qualifying event that is the bankruptcy of the employer. See Q&A–8 of § 54.4980B–2 for limitations that apply to certain health flexible spending arrangements. See also Q&A–6 of this section in the case of multiple qualifying events. Nothing in §§ 54.4980B–1

through 54.4980B–10 prohibits a group health plan from providing coverage that continues beyond the end of the maximum coverage period.

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

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

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

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

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

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

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

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

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

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

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

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

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

A–5: (a) A qualified beneficiary becomes entitled to a disability extension if the requirements of paragraphs (b), (c), and (d) of this Q&A–5 are satisfied with respect to the qualified beneficiary. If the disability extension applies with respect to a qualifying event, it applies with respect to each qualified beneficiary entitled to COBRA continuation coverage because of that qualifying event. Thus, for example, the 29-month maximum coverage period applies to each qualified beneficiary who is not disabled as well as to the qualified beneficiary who is disabled, and it applies independently

with respect to each of the qualified beneficiaries. See Q&A–1 in § 54.4980B–8, which permits a plan to require payment of an increased amount during the disability extension.

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

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

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

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

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

(b) The requirements of this paragraph (b) are satisfied if a qualifying event that gives rise to an 18-month maximum coverage period (or a 29-month maximum coverage period in the case of a disability extension) is followed, within that 18-month period (or within that 29-month period, in the case of a disability extension), by a second qualifying event (for example, a death or a divorce) that gives rise to a 36-month maximum coverage period. (Thus, a termination of employment following a qualifying event that is a reduction of hours of employment cannot be a second qualifying event that expands the maximum coverage period; the bankruptcy of an employer also cannot be a second qualifying event that expands the maximum coverage period.) In such a case, the original 18-month period (or 29-month period, in the case of a disability extension) is expanded to 36 months, but only for those individuals who were qualified beneficiaries under the group health plan in connection with the first qualifying event and who are still qualified beneficiaries at the time of the second qualifying event. No qualifying event (other than a qualifying event that is the bankruptcy of the employer) can give rise to a maximum coverage period that ends more than 36 months after the date of the first qualifying event (or more than 36 months after the date of the loss of coverage, in the case of a plan that provides for the extension of the required periods; see paragraph (b) in Q&A–4 of this section). For example, if an employee covered by a group health plan that is subject to

COBRA terminates employment (for reasons other than gross misconduct) on December 31, 2000, the termination is a qualifying event giving rise to a maximum coverage period that extends for 18 months to June 30, 2002. If the employee dies after the employee and the employee's spouse and dependent children have elected COBRA continuation coverage and on or before June 30, 2002, the spouse and dependent children (except anyone among them whose COBRA continuation coverage had already ended for some other reason) will be able to receive COBRA continuation coverage through December 31, 2003. See Q&A–8(b) of § 54.4980B–2 for a special rule that applies to certain health flexible spending arrangements.

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

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

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

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

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

A–8: If a qualified beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the maximum coverage period, the group health plan must, during the 180-day period that ends on that expiration date, provide the qualified beneficiary the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated nonCOBRA beneficiaries under the group health plan. If such a conversion option is not otherwise generally available, it need not be made available to qualified beneficiaries.

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

§ 54.4980B–8 Paying for COBRA continuation coverage.

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

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

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

to the plan with respect to that qualified beneficiary (see Q&A–1 of § 54.4980B–7). For the meaning of *timely payment*, see Q&A–5 of this section.

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

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

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

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

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

(c) A group health plan does not fail to comply with section 9802(b) (which generally prohibits an individual from being charged, on the basis of health status, a higher premium than that

charged for similarly situated individuals enrolled in the plan) with respect to a qualified beneficiary entitled to the disability extension merely because the plan requires payment of an amount permitted under paragraph (b) of this Q&A–1.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) If timely payment is made to the plan in an amount that is not significantly less than the amount the plan requires to be paid for a period of coverage, then the amount paid is deemed to satisfy the plan's requirement for the amount that must be paid, unless the plan notifies the qualified beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. For this purpose, as a safe harbor, 30 days after the date the notice is provided is deemed to be a reasonable period of time. An amount is not significantly less than the amount the plan requires to be paid for a period of coverage if and only if the shortfall is no greater than the lesser of the following two amounts:

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

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

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

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

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

The following questions-and-answers address who has the obligation to make COBRA continuation coverage available to affected qualified beneficiaries

in the context of business reorganizations and employer withdrawals from multiemployer plans:

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

A–1: For purposes of this section:

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

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

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

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

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

A–2: In the case of a stock sale—

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

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

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

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

A–3: In the case of an asset sale—

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

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

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

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

(b) Stock sales: In the case of a stock sale, an individual is an M&A qualified beneficiary if the individual is a qualified beneficiary whose qualifying event occurred prior to or in connection with the sale and who is, or whose qualifying event occurred in connection with, a covered employee whose last employment prior to the qualifying event was with the acquired organization.

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

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

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

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

A–6: (a) Yes, unless—

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

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

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

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

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

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

A–8: (a) In the case of a business reorganization (whether a stock sale or an asset sale), so long as the selling group maintains a group health plan after the sale, a group health plan maintained by the selling group has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to that sale. This Q&A–8 prescribes rules for cases in which the selling group ceases to provide any group health plan to any employee in connection with the sale. Paragraph (b) of this Q&A–8 contains these rules for stock sales, and paragraph (c) of this Q&A–8 contains these rules for asset sales. Neither a stock sale nor an asset sale has any effect on the COBRA continuation coverage requirements applicable to any group health plan for any period before the sale.

(b)(1) In the case of a stock sale, if the selling group ceases to provide any group health plan to any employee in connection with the sale, a group health plan maintained by the buying group has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to that stock sale. A group health plan of the buying group has this obligation beginning on the later of the following two dates and

continuing as long as the buying group continues to maintain a group health plan (but subject to the rules in § 54.4980B–7, relating to the duration of COBRA continuation coverage)—

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

(ii) The date of the stock sale.

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

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

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

(ii) The date of the asset sale.

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

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

Stock Sale Examples

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

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

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

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

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

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

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

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

Asset Sale Examples

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

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

Example 6. (i) Selling Group *S* provides group health plan coverage to employees at each of its operating divisions. *S* sells substantially all of the assets of all of its divisions to Buying Group *P*, and *S* ceases to provide any group health plan to any employee on the date of the sale. *P* hires all but one of *S*'s employees on the date of the asset sale by *S*, gives those employees the same positions that they had with *S* before the sale, and continues the business operations of those divisions without substantial change or interruption. *P* provides these employees

with coverage under a group health plan. Immediately before the sale, there are 10 qualified beneficiaries receiving COBRA continuation coverage under a group health plan of *S* whose qualifying events occurred in connection with a covered employee whose last employment prior to the qualifying event was associated with the assets sold to *P*.

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

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

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

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

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

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

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

Example 8. (i) Selling Group *S* provides group health plan coverage to employees at each of its operating divisions. *S* sells substantially all of the assets of all of its divisions to Buying Group *P*. *P* hires most of *S*'s employees on the date of the purchase of *S*'s assets, retains those employees in the same positions that they had with *S* before the purchase, and continues the business operations of those divisions without substantial change or interruption. *P* provides these employees with coverage under a group health plan. *S* continues to employ a few employees for the principal purpose of winding up the affairs of *S* in preparation for liquidation. *S* continues to provide coverage under a group health plan to these few remaining employees for several weeks after the date of the sale and then ceases to provide any group health plan to any employee.

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

the sale beginning on the date that *S* ceases to provide any group health plan to any employee. (A group health plan of *S* retains this obligation for the several weeks after the date of the sale until *S* ceases to provide any group health plan to any employee.)

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

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

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

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

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

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

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

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

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

Example 3. (i) Employer *Y* employs two classes of employees—skilled and unskilled laborers—covered by a collective bargaining agreement and participating in multiemployer group health plan *M*. As required by the collective bargaining agreement, *Y* has been making contributions to *M*. *Y* stops

making contributions to *M* but continues to employ all the employees covered by the collective bargaining agreement. *Y*'s cessation of contributions to *M* causes those employees (and their spouses and dependent children) to lose coverage under *M*. *Y* makes group health plan coverage available to the skilled laborers immediately after their coverage ceases under *M*, but *Y* does not make group health plan coverage available to any of the unskilled laborers.

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

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

(ii) Under these facts, *M* has the obligation to make COBRA continuation coverage available from July 1, 2001 until August 31, 2001, and the group health plan established by *X* has the obligation to make COBRA continuation coverage available from September 1, 2001 until the obligation ends (see Q&A–1 of § 54.4980B–7) to any qualified beneficiary who experienced a qualifying event that preceded or coincided with the cessation of contributions to *M* and whose coverage under *M* on the day before the qualifying event was due to an employment affiliation with *X*. The loss of coverage under *M* for those employees of *X* who continue in employment (and the loss of coverage for their spouses and dependent children) does not constitute a qualifying event.

Example 5. (i) Employer *W* employs a class of employees covered by a collective bargaining agreement and participating in multiemployer group health plan *M*. As required by the collective bargaining agreement, *W* has been making contributions to *M*. The employees covered by the collective bargaining agreement vote to decertify their current employee representative effective January 1, 2002 and vote to certify a new employee representative effective the same date. As a consequence, on January 1, 2002 they cease to be covered under *M* and commence to be covered under multiemployer group health plan *N*.

(ii) Effective January 1, 2002, *N* has the obligation to make COBRA continuation coverage available to any qualified beneficiary who experienced a qualifying event that preceded or coincided with the cessation of contributions to *M* and whose coverage under *M* on the day before the qualifying event was due to an employment affiliation with W. The loss of coverage under *M* for those employees of W who continue in employment (and the loss of coverage for their spouses and dependent children) does not constitute a qualifying event.

[T.D. 8928, 66 FR 1855, Jan. 10, 2001]

§ 54.4980B–10 Interaction of FMLA and COBRA.

The following questions-and-answers address how the taking of leave under the Family and Medical Leave Act of 1993 (FMLA) (29 U.S.C. 2601–2619) affects the COBRA continuation coverage requirements:

Q–1: In what circumstances does a qualifying event occur if an employee does not return from leave taken under FMLA?

A–1: (a) The taking of leave under FMLA does not constitute a qualifying event. A qualifying event under Q&A–1 of § 54.4980B–4 occurs, however, if—

(1) An employee (or the spouse or a dependent child of the employee) is covered on the day before the first day of FMLA leave (or becomes covered during the FMLA leave) under a group health plan of the employee's employer;

(2) The employee does not return to employment with the employer at the end of the FMLA leave; and

(3) The employee (or the spouse or a dependent child of the employee) would, in the absence of COBRA continuation coverage, lose coverage under the group health plan before the end of the maximum coverage period.

(b) However, the satisfaction of the three conditions in paragraph (a) of this Q&A–1 does not constitute a qualifying event if the employer eliminates, on or before the last day of the employee's FMLA leave, coverage under a group health plan for the class of employees (while continuing to employ that class of employees) to which the employee would have belonged if the employee had not taken FMLA leave.

Q–2: If a qualifying event described in Q&A–1 of this section occurs, when does it occur, and how is the maximum coverage period measured?

A–2: A qualifying event described in Q&A–1 of this section occurs on the last day of FMLA leave. (The determination of when FMLA leave ends is not made under the rules of this section. See the FMLA regulations, 29 CFR Part 825 (§§ 825.100–825.800).) The maximum coverage period (see Q&A–4 of § 54.4980B–7) is measured from the date of the qualifying event (that is, the last day of FMLA leave). If, however, coverage under the group health plan is lost at a later date and the plan provides for the extension of the required periods (see paragraph (b) of Q&A–4 of § 54.4980B–7), then the maximum coverage period is measured from the date when coverage is lost. The rules of this Q&A–2 are illustrated by the following examples:

Example 1. (i) Employee *B* is covered under the group health plan of Employer *X* on January 31, 2001. *B* takes FMLA leave beginning February 1, 2001. *B*'s last day of FMLA leave is 12 weeks later, on April 25, 2001, and *B* does not return to work with *X* at the end of the FMLA leave. If *B* does not elect COBRA continuation coverage, *B* will not be covered under the group health plan of *X* as of April 26, 2001.

(ii) *B* experiences a qualifying event on April 25, 2001, and the maximum coverage period is measured from that date. (This is the case even if, for part or all of the FMLA leave, *B* fails to pay the employee portion of premiums for coverage under the group health plan of *X* and is not covered under *X*'s plan. See Q&A–3 of this section.)

Example 2. (i) Employee *C* and *C*'s spouse are covered under the group health plan of Employer *Y* on August 15, 2001. *C* takes FMLA leave beginning August 16, 2001. *C* informs *Y* less than 12 weeks later, on September 28, 2001, that *C* will not be returning to work. Under the FMLA regulations, 29 CFR Part 825 (§§ 825.100–825.800), *C*'s last day of FMLA leave is September 28, 2001. *C* does not return to work with *Y* at the end of the FMLA leave. If *C* and *C*'s spouse do not elect COBRA continuation coverage, they will not be covered under the group health plan of *Y* as of September 29, 2001.

(ii) *C* and *C*'s spouse experience a qualifying event on September 28, 2001, and the maximum coverage period (generally 18 months) is measured from that date. (This is the case even if, for part or all of the FMLA leave, *C* fails to pay the employee portion of premiums for coverage under the group health plan of *Y* and *C* or *C*'s spouse is not covered under *Y*'s plan. See Q&A–3 of this section.)

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

A–3: No. Any lapse of coverage under a group health plan during FMLA leave is irrelevant in determining whether a set of circumstances constitutes a qualifying event under Q&A–1 of this section or when such a qualifying event occurs under Q&A–2 of this section.

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

A–4: No. Any state or local law that requires coverage under a group health plan to be maintained during a leave of absence for a period longer than that required under FMLA (for example, for 16 weeks of leave rather than for the 12 weeks required under FMLA) is disregarded for purposes of determining when a qualifying event occurs under Q&A–1 through Q&A–3 of this section.

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

A–5: No. The U.S. Department of Labor has published rules describing

the circumstances in which an employer may recover premiums it pays to maintain coverage, including family coverage, under a group health plan during FMLA leave from an employee who fails to return from leave. See 29 CFR 825.213. Even if recovery of premiums is permitted under 29 CFR 825.213, the right to COBRA continuation coverage cannot be conditioned upon the employee's reimbursement of the employer for premiums the employer paid to maintain coverage under a group health plan during FMLA leave.

[T.D. 8928, 66 FR 1855, Jan. 10, 2001]

§ 54.4980D–1 Requirement of return and time for filing of the excise tax under section 4980D.

Q–1: If a person is liable for the excise tax under section 4980D, what form must the person file and what is the due date for the filing and payment of the excise tax?

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

(b) *Due date for filing of return by employers. See* § 54.6071–1(b)(1).

(c) *Due date for filing of return by multiemployer plans or multiple employer health plans. See* § 54.6071–1(b)(2).

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

[T.D. 9457, 74 FR 45997, Sept. 8, 2009]

§ 54.4980E–1 Requirement of return and time for filing of the excise tax under section 4980E.

Q–1: If a person is liable for the excise tax under section 4980E, what form must the person file and what is the due date for the filing and payment of the excise tax?

A–1: (a) *In general. See* §§ 54.6011–2, 54.6151–1 and 54.6071–1(c).

(b) *Effective/applicability date.* The rules in this Q & A–1 are effective for plan years beginning on or after January 1, 2010.

[T.D. 9457, 74 FR 45997, Sept. 8, 2009]

§ 54.4980F–1 Notice requirements for certain pension plan amendments significantly reducing the rate of future benefit accrual.

The following questions and answers concern the notification requirements imposed by 4980F of the Internal Revenue Code and section 204(h) of ERISA relating to a plan amendment of an applicable pension plan that significantly reduces the rate of future benefit accrual or that eliminates or significantly reduces an early retirement benefit or retirement-type subsidy.

LIST OF QUESTIONS

Q–1. What are the notice requirements of section 4980F(e) of the Internal Revenue Code and section 204(h) of ERISA?
Q–2. What are the differences between section 4980F and section 204(h)?
Q–3. What is an ''applicable pension plan'' to which section 4980F and section 204(h) apply?
Q–4. What is ''section 204(h) notice'' and what is a ''section 204(h) amendment''?
Q–5. For which amendments is section 204(h) notice required?
Q–6. What is an amendment that reduces the rate of future benefit accrual or reduces an early retirement benefit or retirement-type subsidy for purposes of determining whether section 204(h) notice is required?
Q–7. What plan provisions are taken into account in determining whether an amendment is a section 204(h) amendment?
Q–8. What is the basic principle used in determining whether a reduction in the rate of future benefit accrual or a reduction in an early retirement benefit or retirement-type subsidy is significant for purposes of section 4980F and section 204(h)?
Q–9. When must section 204(h) notice be provided?
Q–10. To whom must section 204(h) notice be provided?
Q–11. What information is required to be provided in a section 204(h) notice?
Q–12. What special rules apply if participants can choose between the old and new benefit formulas?
Q–13. How may section 204(h) notice be provided?
Q–14. What are the consequences if a plan administrator fails to provide section 204(h) notice?

Q–15. What are some of the rules that apply with respect to the excise tax under section 4980F?
Q–16. How do section 4980F and section 204(h) apply when a business is sold?
Q–17. How are amendments to cease accruals and terminate a plan treated under section 4980F and section 204(h)?
Q–18. What are the effective dates of section 4980F, section 204(h), as amended by EGTRRA, and these regulations?

QUESTIONS AND ANSWERS

Q–1. What are the notice requirements of section 4980F(e) of the Internal Revenue Code and section 204(h) of ERISA?

A–1. (a) *Requirements of Internal Revenue Code section 4980F(e) and ERISA section 204(h).* Section 4980F of the Internal Revenue Code (section 4980F) and section 204(h) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), 29 U.S.C. 1054(h) (section 204(h)) each generally requires notice of an amendment to an applicable pension plan that either provides for a significant reduction in the rate of future benefit accrual or that eliminates or significantly reduces an early retirement benefit or retirement-type subsidy. The notice is required to be provided to plan participants and alternate payees who are applicable individuals (as defined in Q&A–10 of this section), to certain employee organizations, and to contributing employers under a multiemployer plan (as described in Q&A–10(a) of this section). The plan administrator must generally provide the notice before the effective date of the plan amendment. Q&A–9 of this section sets forth the time frames for providing notice, Q&A–11 of this section sets forth the content requirements for the notice, and Q&A–12 of this section contains special rules for cases in which participants can choose between the old and new benefit formulas.

(b) *Other notice requirements.* Other provisions of law may require that certain parties be notified of a plan amendment. See, for example, sections 102 and 104 of ERISA, and the regulations thereunder, for requirements relating to summary plan descriptions and summaries of material modifications.

Q–2. What are the differences between section 4980F and section 204(h)?

A–2. The notice requirements of section 4980F generally are parallel to the notice requirements of section 204(h), as amended by the Economic Growth and Tax Relief Reconciliation Act of 2001, Public Law 107–16 (115 Stat. 38) (2001) (EGTRRA). However, the consequences of the failure to satisfy the requirements of the two provisions differ: Section 4980F imposes an excise tax on a failure to satisfy the notice requirements, while section 204(h)(6), as amended by EGTRRA, contains a special rule with respect to an egregious failure to satisfy the notice requirements. See Q&A–14 and Q&A–15 of this section. Except to the extent specifically indicated, these regulations apply both to section 4980F and to section 204(h).

Q–3. What is an ''applicable pension plan'' to which section 4980F and section 204(h) apply?

A–3. (a) *In general.* Section 4980F and section 204(h) apply to an applicable pension plan. For purposes of section 4980F, an *applicable pension plan* means a defined benefit plan qualifying under section 401(a) or 403(a) of the Internal Revenue Code, or an individual account plan that is subject to the funding standards of section 412 of the Internal Revenue Code. For purposes of section 204(h), an *applicable pension plan* means a defined benefit plan that is subject to part 2 of subtitle B of title I of ERISA, or an individual account plan that is subject to such part 2 and to the funding standards of section 412 of the Internal Revenue Code. Accordingly, individual account plans that are not subject to the funding standards of section 412 of the Internal Revenue Code, such as profit-sharing and stock bonus plans and contracts under section 403(b) of the Internal Revenue Code, are not applicable pension plans to which section 4980F or section 204(h) apply. Similarly, a defined benefit plan that neither qualifies under section 401(a) or 403(a) of the Internal Revenue Code nor is subject to part 2 of subtitle B of title I of ERISA is not an applicable pension plan. Further, neither a governmental plan (within the meaning of section 414(d) of the Internal Revenue Code), nor a church plan (within the meaning

of section 414(e) of the Internal Revenue Code) with respect to which no election has been made under section 410(d) of the Internal Revenue Code is an applicable pension plan.

(b) *Section 204(h) notice not required for small plans covering no employees.* Section 204(h) notice is not required for a plan under which no employees are participants covered under the plan, as described in § 2510.3–3(b) of the Department of Labor regulations, and which has fewer than 100 participants.

Q–4. What is ''section 204(h) notice'' and what is a ''section 204(h) amendment''?

A–4. (a) *Section 204(h) notice* is notice that complies with section 4980F(e) of the Internal Revenue Code, section 204(h)(1) of ERISA, and this section.

(b) A *section 204(h) amendment* is an amendment for which section 204(h) notice is required under this section.

Q–5. For which amendments is section 204(h) notice required?

A–5. (a) *Significant reduction in the rate of future benefit accrual.* Section 204(h) notice is required for an amendment to an applicable pension plan that provides for a significant reduction in the rate of future benefit accrual.

(b) *Early retirement benefits and retirement-type subsidies.* Section 204(h) notice is also required for an amendment to an applicable pension plan that provides for the significant reduction of an early retirement benefit or retirement-type subsidy. For purposes of this section, *early retirement benefit* and *retirement-type subsidy* mean early retirement benefits and retirement-type subsidies within the meaning of section 411(d)(6)(B)(i).

(c) *Elimination or cessation of benefits.* For purposes of this section, the terms *reduce* or *reduction* include eliminate or cease or elimination or cessation.

(d) *Delegation of authority to Commissioner.* The Commissioner may provide in revenue rulings, notices, or other guidance published in the Internal Revenue Bulletin (*see* § 601.601(d)(2) of this chapter) that section 204(h) notice need not be provided for plan amendments otherwise described in paragraph (a) or (b) of this Q&A–5 that the Commissioner determines to be necessary or appropriate, as a result of changes in the law, to maintain compliance with the requirements of the Internal Revenue Code (including requirements for tax qualification), ERISA, or other applicable federal law.

Q–6. What is an amendment that reduces the rate of future benefit accrual or reduces an early retirement benefit or retirement-type subsidy for purposes of determining whether section 204(h) notice is required?

A–6. (a) *In general.* For purposes of determining whether section 204(h) notice is required, an amendment reduces the rate of future benefit accrual or reduces an early retirement benefit or retirement-type subsidy only as provided in paragraph (b) or (c) of this Q&A–6.

(b) *Reduction in rate of future benefit accrual*—(1) *Defined benefit plans.* For purposes of section 4980F and section 204(h), an amendment to a defined benefit plan reduces the rate of future benefit accrual only if it is reasonably expected that the amendment will reduce the amount of the future annual benefit commencing at normal retirement age (or at actual retirement age, if later) for benefits accruing for a year. For this purpose, the annual benefit commencing at normal retirement age is the benefit payable in the form in which the terms of the plan express the accrued benefit (or, in the case of a plan in which the accrued benefit is not expressed in the form of an annual benefit commencing at normal retirement age, the benefit payable in the form of a single life annuity commencing at normal retirement age that is the actuarial equivalent of the accrued benefit expressed under the terms of the plan, as determined in accordance with section 411(c)(3) of the Internal Revenue Code).

(2) *Individual account plans.* For purposes of section 4980F and section 204(h), an amendment to an individual account plan reduces the rate of future benefit accrual only if it is reasonably expected that the amendment will reduce the amount of contributions or forfeitures allocated for any future year. Changes in the investments or investment options under an individual account plan are not taken into account for this purpose.

(3) *Determination of rate of future benefit accrual.* The rate of future benefit

accrual for purposes of this paragraph (b) is determined without regard to optional forms of benefit within the meaning of § 1.411(d)–4, Q&A–1(b) of this chapter (other than the annual benefit described in paragraph (b)(1) of this Q&A–6). The rate of future benefit accrual is also determined without regard to ancillary benefits and other rights or features as defined in § 1.401(a)(4)–4(e) of this chapter.

(c) *Reduction of early retirement benefits or retirement-type subsidies.* For purposes of section 4980F and section 204(h), an amendment reduces an early retirement benefit or retirement-type subsidy only if it is reasonably expected that the amendment will eliminate or reduce an early retirement benefit or retirement-type subsidy.

Q–7. What plan provisions are taken into account in determining whether an amendment is a section 204(h) amendment?

A–7. (a) *Plan provisions taken into account*—(1) *In general.* All plan provisions that may affect the rate of future benefit accrual, early retirement benefits, or retirement-type subsidies of participants or alternate payees must be taken into account in determining whether an amendment is a section 204(h) amendment. For example, plan provisions that may affect the rate of future benefit accrual include the dollar amount or percentage of compensation on which benefit accruals are based; the definition of service or compensation taken into account in determining an employee's benefit accrual; the method of determining average compensation for calculating benefit accruals; the definition of normal retirement age in a defined benefit plan; the exclusion of current participants from future participation; benefit offset provisions; minimum benefit provisions; the formula for determining the amount of contributions and forfeitures allocated to participants' accounts in an individual account plan; in the case of a plan using permitted disparity under section 401(l) of the Internal Revenue Code, the amount of disparity between the excess benefit percentage or excess contribution percentage and the base benefit percentage or base contribution percentage (all as defined in section 401(l) of the Internal Revenue Code); and the actuarial assumptions used to determine contributions under a target benefit plan (as defined in § 1.401(a)(4)–8(b)(3)(i) of this chapter). Plan provisions that may affect early retirement benefits or retirement-type subsidies include the right to receive payment of benefits after severance from employment and before normal retirement age and actuarial factors used in determining optional forms for distribution of retirement benefits.

(2) *Provisions incorporated by reference in plan.* If all or a part of a plan's rate of future benefit accrual, or an early retirement benefit or retirement-type subsidy provided under the plan, depends on provisions in another document that are referenced in the plan document, a change in the provisions of the other document is an amendment of the plan.

(b) *Plan provisions not taken into account*—(1) *In general.* Plan provisions that do not affect the rate of future benefit accrual of participants or alternate payees are not taken into account in determining whether there has been a reduction in the rate of future benefit accrual.

(2) *Interaction with section 411(d)(6).* Any benefit that is not a section 411(d)(6) protected benefit as described in §§ 1.411(d)–3(g)(14) and 1.411(d)–4, Q&A–1(d) of this chapter, or that is a section 411(d)(6) protected benefit that may be eliminated or reduced as permitted under § 1.411(d)–3(c), (d), or (f), or under § 1.411(d)–4, Q&A–2(a)(2), (a)(3), (b)(1), or (b)(2)(ii) through (b)(2)(xi) of this chapter, is not taken into account in determining whether an amendment is a section 204(h) amendment. Thus, for example, provisions relating to the right to make after-tax deferrals are not taken into account.

(c) *Examples.* The following examples illustrate the rules in this Q&A–7:

Example 1. (i) *Facts.* A defined benefit plan provides a normal retirement benefit equal to 50% of highest 5-year average pay multiplied by a fraction (not in excess of one), the numerator of which equals the number of years of participation in the plan and the denominator of which is 20. A plan amendment is adopted that changes the numerator or denominator of that fraction.

(ii) *Conclusion*. The plan amendment must be taken into account in determining whether there has been a reduction in the rate of future benefit accrual.

Example 2. (i) *Facts*. Plan C is a multiemployer defined benefit plan subject to several collective bargaining agreements. The specific benefit formula under Plan C that applies to an employee depends on the hourly rate of contribution of the employee's employer, which is set forth in the provisions of the collective bargaining agreements that are referenced in the Plan C document. Collective Bargaining Agreement A between Employer B and the union representing employees of Employer B is renegotiated to provide that the hourly contribution rate for an employee of B who is subject to the Collective Bargaining Agreement A will decrease. That decrease will result in a decrease in the rate of future benefit accrual for employees of B.

(ii) *Conclusion*. Under paragraph (a)(2) of this Q&A–7, the change to Collective Bargaining Agreement A is a plan amendment that is a section 204(h) amendment if the reduction in the rate of future benefit accrual is significant.

Q–8. What is the basic principle used in determining whether a reduction in the rate of future benefit accrual or a reduction in an early retirement benefit or retirement-type subsidy is significant for purposes of section 4980F and section 204(h)?

A–8. (a) *General rule*. Whether an amendment reducing the rate of future benefit accrual or eliminating or reducing an early retirement benefit or retirement-type subsidy provides for a reduction that is significant for purposes of section 4980F (and section 204(h) of ERISA) is determined based on reasonable expectations taking into account the relevant facts and circumstances at the time the amendment is adopted, or, if earlier, at the effective date of the amendment.

(b) *Application for determining significant reduction in the rate of future benefit accrual*. For a defined benefit plan, the determination of whether an amendment provides for a significant reduction in the rate of future benefit accrual is made by comparing the amount of the annual benefit commencing at normal retirement age (or at actual retirement age, if later), as determined under Q&A–6(b)(1) of this section, under the terms of the plan as amended with the amount of the annual benefit commencing at normal retirement age (or at actual retirement age, if later), as determined under Q&A–6(b)(1) of this section, under the terms of the plan prior to amendment. For an individual account plan, the determination of whether an amendment provides for a significant reduction in the rate of future benefit accrual is made in accordance with Q&A–6(b)(2) of this section by comparing the amounts to be allocated in the future to participants' accounts under the terms of the plan as amended with the amounts to be allocated in the future to participants' accounts under the terms of the plan prior to amendment. An amendment to convert a money purchase pension plan to a profit-sharing or other individual account plan that is not subject to section 412 of the Internal Revenue Code is, in all cases, deemed to be an amendment that provides for a significant reduction in the rate of future benefit accrual.

(c) *Application to certain amendments reducing early retirement benefits or retirement-type subsidies*. Section 204(h) notice is not required for an amendment that reduces an early retirement benefit or retirement-type subsidy if the amendment is permitted under the third sentence of section 411(d)(6)(B) of the Internal Revenue Code and paragraphs (c), (d), and (f) of § 1.411(d)–3 of this chapter (relating to the elimination or reduction of benefits or subsidies which create significant burdens or complexities for the plan and plan participants unless the amendment adversely affects the rights of any participant in a more than *de minimis* manner). However, in determining whether an amendment reducing a retirement-type subsidy constitutes a significant reduction because it reduces a retirement-type subsidy as permitted under § 1.411(d)–3(e)(6) of this chapter, the amendment is treated in the same manner as an amendment that limits the retirement-type subsidy to benefits that accrue before the applicable amendment date (as defined at § 1.411(d)–3(g)(4) of this chapter) with respect to each participant or alternate payee to whom the reduction is reasonably expected to apply.

(d) *Plan amendments reflecting a change in statutorily mandated minimum present value rules*. If a defined benefit

plan offers a distribution to which the minimum present value rules of section 417(e)(3) apply (other than a payment to which section 411(a)(13)(A) applies) and the plan is amended to reflect the changes to the applicable interest rate and applicable mortality table in section 417(e)(3) made by the Pension Protection Act of 2006, Public Law 109–780 (120 Stat. 780) (PPA '06) (and no change is made in the dates on which the payment will be made), no section 204(h) notice is required to be provided.

(e) *Examples*. The following examples illustrate the rules in this Q&A–8:

Example 1. (i) *Facts*. Pension Plan A is a defined benefit plan that provides a rate of benefit accrual of 1% of highest-5 years pay multiplied by years of service, payable annually for life commencing at normal retirement age (or at actual retirement age, if later). An amendment to Plan A is adopted on August 1, 2009, effective January 1, 2010, to provide that any participant who separates from service after December 31, 2009, and before January 1, 2015, will have the same number of years of service he or she would have had if his or her service continued to December 31, 2014.

(ii) *Conclusion*. In this example, the effective date of the plan amendment is January 1, 2010. While the amendment will result in a reduction in the annual rate of future benefit accrual from 2011 through 2014 (because, under the amendment, benefits based upon an additional 5 years of service accrue on January 1, 2010, and no additional service is credited after January 1, 2010 until January 1, 2015), the amendment does not result in a reduction that is significant because the amount of the annual benefit commencing at normal retirement age (or at actual retirement age, if later) under the terms of the plan as amended is not under any conditions less than the amount of the annual benefit commencing at normal retirement age (or at actual retirement age, if later) to which any participant would have been entitled under the terms of the plan had the amendment not been made.

Example 2. (i) *Facts*. The facts are the same as in *Example 1*, except that the 2009 amendment does not alter the plan provisions relating to a participant's number of years of service, but instead amends the plan's provisions relating to early retirement benefits. Before the amendment, the plan provides for distributions before normal retirement age to be actuarially reduced, but, if a participant retires after attainment of age 55 and completion of 10 years of service, the applicable early retirement reduction factor is 3% per year for the years between the ages 65 and 62 and 6% per year for the ages from 62 to 55. The amendment changes these provisions so that an actuarial reduction applies in all cases, but, in accordance with section 411(d)(6)(B), provides that no participant's early retirement benefit will be less than the amount provided under the plan as in effect on December 31, 2009 with respect to service before January 1, 2010. For participant X, the reduction is significant.

(ii) *Conclusion*. The amendment will result in a reduction in a retirement-type subsidy provided under Plan A (*i.e.*, Plan A's early retirement subsidy). Section 204(h) notice must be provided to participant X and any other participant for whom the reduction is significant and the notice must be provided at least 45 days before January 1, 2010 (or by such other date as may apply under Q&A–9 of this section).

Example 3. (i) *Facts*. The facts are the same as in *Example 2*, except that, for participant X, the change does not go into effect for any annuity commencement date before January 1, 2011. Participant X continues employment through January 1, 2011.

(ii) *Conclusion*. The conclusion is the same as in *Example 2*. Taking into account the rule in the second sentence of Q&A–8(c) of this section, the reduction that occurs for participant X on January 1, 2011, is treated as the same reduction that occurs under *Example 2*. Accordingly, assuming that the reduction is significant, section 204(h) notice must be provided to participant X at least 45 days before the January 1, 2010 effective date of the amendment (or by such other date as may apply under Q&A–9 of this section).

Q–9. When must section 204(h) notice be provided?

A–9. (a) *45-day general rule*. Except as otherwise provided in this Q&A–9, section 204(h) notice must be provided at least 45 days before the effective date of any section 204(h) amendment. See paragraph (e) of this Q&A–9 for special rules for amendments permitting participant choice.

(b) *15-day rule for small plans*. Except for amendments described in paragraphs (d)(2) and (g) of this Q&A–9, section 204(h) notice must be provided at least 15 days before the effective date of any section 204(h) amendment in the case of a small plan. For purposes of this section, a small plan is a plan that the plan administrator reasonably expects to have, on the effective date of the section 204(h) amendment, fewer than 100 participants who have an accrued benefit under the plan.

(c) *15-day rule for multiemployer plans*. Except for amendments described in

paragraphs (d)(2) and (g) of this Q&A–9, section 204(h) notice must be provided at least 15 days before the effective date of any section 204(h) amendment in the case of a multiemployer plan. For purposes of this section, a multiemployer plan means a multiemployer plan as defined in section 414(f) of the Internal Revenue Code.

(d) *Special timing rule for business transactions*—(1) *15-day rule for section 204(h) amendment in connection with an acquisition or disposition*. Except for amendments described in paragraphs (d)(2) and (g) of this Q&A–9, if a section 204(h) amendment is adopted in connection with an acquisition or disposition, section 204(h) notice must be provided at least 15 days before the effective date of the section 204(h) amendment.

(2) *Later notice permitted for a section 204(h) amendment significantly reducing early retirement benefit or retirement-type subsidies in connection with certain plan transfers, mergers, or consolidations*. If a section 204(h) amendment is adopted with respect to liabilities that are transferred to another plan in connection with a transfer, merger, or consolidation of assets or liabilities as described in section 414(l) of the Internal Revenue Code and §1.414(l)–1 of this chapter, the amendment is adopted in connection with an acquisition or disposition, and the amendment significantly reduces an early retirement benefit or retirement-type subsidy, but does not significantly reduce the rate of future benefit accrual, then section 204(h) notice must be provided no later than 30 days after the effective date of the section 204(h) amendment.

(3) *Definition of acquisition or disposition*. For purposes of this paragraph (d), see §1.410(b)–2(f) of this chapter for the definition of acquisition or disposition.

(e) *Timing rule for amendments permitting participant choice*. In general, section 204(h) notice of a section 204(h) amendment that provides applicable individuals with a choice between the old and the new benefit formulas (as described in Q&A–12 of this section) must be provided in accordance with the time period applicable under paragraphs (a) through (d) of this Q&A–9. See Q&A–12 of this section for additional guidance regarding section 204(h) notice in connection with participant choice.

(f) *Special timing rule for certain plans maintained by commercial airlines*. *See* section 402 of PPA '06 for a special rule that applies to certain plans maintained by an employer that is a commercial passenger airline or the principal business of which is providing catering services to a commercial passenger airline. Under this special rule, section 204(h) notice must be provided at least 15 days before the effective date of the amendment.

(g) *Special timing rules relating to certain section 204(h) amendments that reduce section 411(d)(6) protected benefits*—(1) *Plan amendments permitted to reduce prior accruals*. This paragraph (g) generally provides special rules with respect to a plan amendment that would not violate section 411(d)(6) even if the amendment were to reduce section 411(d)(6) protected benefits, which are limited to accrued benefits that are attributable to service before the applicable amendment date. For example, this paragraph (g) applies to amendments that are permitted to be effective retroactively under section 412(d)(2) of the Code (section 412(c)(8) for plan years beginning before January 1, 2008), section 418D of the Code, section 418E of the Code, section 4281 of ERISA, or section 1107 of PPA '06. *See*, generally, §1.411(d)–3(a)(1).

(2) *General timing rule for amendments to which this paragraph (g) applies*. For an amendment to which this paragraph (g) applies, the amendment is effective on the first date on which the plan is operated as if the amendment were in effect. Thus, except as otherwise provided in this paragraph (g), a section 204(h) notice for an amendment to which paragraph (a) of this section applies that is adopted after the effective date of the amendment must be provided, with respect to any applicable individual, at least 45 days before (or such other date as may apply under paragraph (b), (c), (d), or (f) of this Q&A–9) the date the amendment is put into operational effect.

(3) *Special rules for section 204(h) notices provided in connection with other disclosure requirements*—(i) *In general*. Notwithstanding the requirements in this Q&A–9 and Q&A–11 of this section,

if a plan provides one of the notices in paragraph (g)(3)(ii) of this Q&A–9, in accordance with the applicable timing and content rules for such notice, the plan is treated as timely providing a section 204(h) notice with respect to a section 204(h) amendment.

(ii) *Notice requirements*. The notices in this paragraph (g)(3)(ii) are—

(A) A notice required under any revenue ruling, notice, or other guidance published under the authority of the Commissioner in the Internal Revenue Bulletin to affected parties in connection with a retroactive plan amendment described in section 412(d)(2) (section 412(c)(8) for plan years beginning before January 1, 2008);

(B) A notice required under section 101(j) of ERISA if an amendment is adopted to comply with the benefit limitation requirements of section 206(g) of ERISA (section 436 of the Code);

(C) A notice required under section 432(b)(3)(D) of the Code for an amendment adopted to comply with the benefit restrictions under section 432(f)(2);

(D) A notice required under section 418D, or section 4244A(b) of ERISA, for an amendment that reduces or eliminates accrued benefits attributable to employer contributions with respect to a multiemployer plan in reorganization;

(E) A notice required under section 418E, or section 4245(e) of ERISA, relating to the effects of the insolvency status for a multiemployer plan; and

(F) A notice required under section 4281 of ERISA for an amendment of a multiemployer plan reducing benefits pursuant to section 4281(c) of ERISA.

(4) *Delegation of authority to Commissioner*. The Commissioner may provide special rules under section 4980F, in revenue rulings, notices, or other guidance published in the Internal Revenue Bulletin (*see* § 601.601(d)(2)(ii)(*b*) of this chapter), that the Commissioner determines to be necessary or appropriate with respect to a section 204(h) amendment—

(A) That applies to benefits accrued before the applicable amendment date but that does not violate section 411(d)(6); or

(B) For which there is a required notice relating to a reduction in benefits and such notice has timing and content requirements similar to a section 204(h) notice with respect to a significant reduction in the rate of future benefit accruals.

Q–10. To whom must section 204(h) notice be provided?

A–10. (a) *In general*. Section 204(h) notice must be provided to each applicable individual, to each employee organization representing participants who are applicable individuals, and, for plan years beginning after December 31, 2007, to each employer that has an obligation to contribute (within the meaning of section 4212(a) of ERISA) to a multiemployer plan. A special rule is provided in paragraph (d) of this Q&A–10.

(b) *Applicable individual*. Applicable individual means each participant in the plan, and any alternate payee, whose rate of future benefit accrual under the plan is reasonably expected to be significantly reduced, or for whom an early retirement benefit or retirement-type subsidy under the plan may reasonably be expected to be significantly reduced, by the section 204(h) amendment. The determination is made with respect to individuals who are reasonably expected to be participants or alternate payees in the plan at the effective date of the section 204(h) amendment.

(c) *Alternate payee*. Alternate payee means a beneficiary who is an alternate payee (within the meaning of section 414(p)(8) of the Internal Revenue Code) under an applicable qualified domestic relations order (within the meaning of section 414(p)(1)(A) of the Internal Revenue Code).

(d) *Designees*. Section 204(h) notice may be provided to a person designated in writing by an applicable individual or by an employee organization representing participants who are applicable individuals, instead of being provided to that applicable individual or employee organization. Any designation of a representative made through an electronic method that satisfies standards similar to those of Q&A–13(c)(1) of this section satisfies the requirement that a designation be in writing.

(e) *Facts and circumstances test*. Whether a participant or alternate

payee is an applicable individual is determined on a typical business day that is reasonably proximate to the time the section 204(h) notice is provided (or at the latest date for providing section 204(h) notice, if earlier), based on all relevant facts and circumstances.

(f) *Examples*. The following examples illustrate the rules in this Q&A–10:

Example 1. (i) *Facts*. A defined benefit plan requires an individual to complete 1 year of service to become a participant who can accrue benefits, and participants cease to accrue benefits under the plan at severance from employment with the employer. There are no alternate payees and employees are not represented by an employee organization. On November 18, 2004, the plan is amended effective as of January 1, 2005 to reduce significantly the rate of future benefit accrual. Section 204(h) notice is provided on November 1, 2004.

(ii) *Conclusion*. Section 204(h) notice is only required to be provided to individuals who, based on the facts and circumstances on November 1, 2004, are reasonably expected to have completed at least 1 year of service and to be employed by the employer on January 1, 2005.

Example 2. (i) *Facts*. The facts are the same as in *Example 1*, except that the sole effect of the plan amendment is to alter the pre-amendment plan provisions under which benefits payable to an employee who retires after 20 or more years of service are unreduced for commencement before normal retirement age. The amendment requires 30 or more years of service in order for benefits commencing before normal retirement age to be unreduced, but the amendment only applies for future benefit accruals.

(ii) *Conclusion*. Section 204(h) notice is only required to be provided to individuals who, on January 1, 2005, have completed at least 1 year of service but less than 30 years of service, are employed by the employer, have not attained normal retirement age, and will have completed 20 or more years of service before normal retirement age if their employment continues to normal retirement age.

Example 3. (i) *Facts*. A plan is amended to reduce significantly the rate of future benefit accrual for all current employees who are participants. Based on the facts and circumstances, it is reasonable to expect that the amendment will not reduce the rate of future benefit accrual of former employees who are currently receiving benefits or of former employees who are entitled to deferred vested benefits.

(ii) *Conclusion*. The plan administrator is not required to provide section 204(h) notice to any former employees.

Example 4. (i) *Facts*. The facts are the same as in *Example 3*, except that the plan covers two groups of alternate payees. The alternate payees in the first group are entitled to a certain percentage or portion of the former spouse's accrued benefit and, for this purpose, the accrued benefit is determined at the time the former spouse begins receiving retirement benefits under the plan. The alternate payees in the second group are entitled to a certain percentage or portion of the former spouse's accrued benefit and, for this purpose, the accrued benefit was determined at the time the qualified domestic relations order was issued by the court.

(ii) *Conclusion*. It is reasonable to expect that the benefits to be received by the second group of alternate payees will not be affected by any reduction in a former spouse's rate of future benefit accrual. Accordingly, the plan administrator is not required to provide section 204(h) notice to the alternate payees in the second group.

Example 5. (i) *Facts*. A plan covers hourly employees and salaried employees. The plan provides the same rate of benefit accrual for both groups. The employer amends the plan to reduce significantly the rate of future benefit accrual of the salaried employees only. At that time, it is reasonable to expect that only a small percentage of hourly employees will become salaried in the future.

(ii) *Conclusion*. The plan administrator is not required to provide section 204(h) notice to the participants who are currently hourly employees.

Example 6. (i) *Facts*. A plan covers employees in Division M and employees in Division N. The plan provides the same rate of benefit accrual for both groups. The employer amends the plan to reduce significantly the rate of future benefit accrual of employees in Division M. At that time, it is reasonable to expect that in the future only a small percentage of employees in Division N will be transferred to Division M.

(ii) *Conclusion*. The plan administrator is not required to provide section 204(h) notice to the participants who are employees in Division N.

Example 7. (i) *Facts*. The facts are the same facts as in *Example 6*, except that at the time the amendment is adopted, it is expected that thereafter Division N will be merged into Division M in connection with a corporate reorganization (and the employees in Division N will become subject to the plan's amended benefit formula applicable to the employees in Division M).

(ii) *Conclusion*. In this case, the plan administrator must provide section 204(h) notice to the participants who are employees in Division M and to the participants who are employees in Division N.

Example 8. (i) *Facts*. A plan is amended to reduce significantly the rate of future benefit accrual for all current employees who

are participants. The plan amendment will be effective on January 1, 2004. The plan will provide the notice to applicable individuals on October 31, 2003. In determining which current employees are applicable individuals, the plan administrator determines that October 1, 2003, is a typical business day that is reasonably proximate to the time the section 204(h) notice is provided.

(ii) *Conclusion*. In this case, October 1, 2003 is a typical business day that satisfies the requirements of Q&A–10(e) of this section.

Q–11. What information is required to be provided in a section 204(h) notice?

A–11. (a) *Explanation of notice requirements*—(1) *In general*. Section 204(h) notice must include sufficient information to allow applicable individuals to understand the effect of the plan amendment. In order to satisfy this rule, a plan administrator providing section 204(h) notice must generally satisfy paragraphs (a)(2), (a)(3), (a)(4), (a)(5), and (a)(6) of this Q&A–11. See paragraph (g)(3) of Q&A–9 of this section for special rules relating to section 204(h) notices provided in connection with certain other written notices. *See* also paragraph (g)(4) of Q&A–9 of this section for a delegation of authority to the Commissioner to provide special rules.

(2) *Information in section 204(h) notice*. The information in a section 204(h) notice must be written in a manner calculated to be understood by the average plan participant and to apprise the applicable individual of the significance of the notice.

(3) *Required narrative description of amendment*—(i) *Reduction in rate of future benefit accrual*. In the case of an amendment reducing the rate of future benefit accrual, the notice must include a description of the benefit or allocation formula prior to the amendment, a description of the benefit or allocation formula under the plan as amended, and the effective date of the amendment.

(ii) *Reduction in early retirement benefit or retirement-type subsidy*. In the case of an amendment that reduces an early retirement benefit or retirement-type subsidy (other than as a result of an amendment reducing the rate of future benefit accrual), the notice must describe how the early retirement benefit or retirement-type subsidy is calculated from the accrued benefit before the amendment, how the early retirement benefit or retirement-type subsidy is calculated from the accrued benefit after the amendment, and the effective date of the amendment. For example, if, for a plan with a normal retirement age of 65, the change is from an unreduced normal retirement benefit at age 55 to an unreduced normal retirement benefit at age 60 for benefits accrued in the future, with an actuarial reduction to apply for benefits accrued in the future to the extent that the early retirement benefit begins before age 60, the notice must state the change and specify the factors that apply in calculating the actuarial reduction (for example, a 5% per year reduction applies for early retirement before age 60).

(4) *Sufficient information to determine the approximate magnitude of reduction*—(i) *General rule*. (A) Section 204(h) notice must include sufficient information for each applicable individual to determine the approximate magnitude of the expected reduction for that individual. Thus, in any case in which it is not reasonable to expect that the approximate magnitude of the reduction for each applicable individual will be reasonably apparent from the description of the amendment provided in accordance with paragraph (a)(3) of this Q&A–11, further information is required. The further information may be provided by furnishing additional narrative information or in other information that satisfies this paragraph of this section.

(B) To the extent any expected reduction is not uniformly applicable to all participants, the notice must either identify the general classes of participants to whom the reduction is expected to apply, or by some other method include sufficient information to allow each applicable individual receiving the notice to determine which reductions are expected to apply to that individual.

(ii) *Illustrative examples*—(A) *Requirement generally*. The requirement to include sufficient information for each applicable individual to determine the approximate magnitude of the expected reduction for that individual under (a)(4)(i)(A) of this Q&A–11 is deemed satisfied if the notice includes one or

more illustrative examples showing the approximate magnitude of the reduction in the examples, as provided in this paragraph (a)(4)(ii). Illustrative examples are in any event required to be provided for any change from a traditional defined benefit formula to a cash balance formula or a change that results in a period of time during which there are no accruals (or minimal accruals) with regard to normal retirement benefits or an early retirement subsidy (a wear-away period).

(B) *Examples must bound the range of reductions.* Where an amendment results in reductions that vary (either among participants, as would occur for an amendment converting a traditional defined benefit formula to a cash balance formula, or over time as to any individual participant, as would occur for an amendment that results in a wear-away period), the illustrative example(s) provided in accordance with this paragraph (a)(4)(ii) must show the approximate range of the reductions. However, any reductions that are likely to occur in only a de minimis number of cases are not required to be taken into account in determining the range of the reductions if a narrative statement is included to that effect and examples are provided that show the approximate range of the reductions in other cases. Amendments for which the maximum reduction occurs under identifiable circumstances, with proportionately smaller reductions in other cases, may be illustrated by one example illustrating the maximum reduction, with a statement that smaller reductions also occur. Further, assuming that the reduction varies from small to large depending on service or other factors, two illustrative examples may be provided showing the smallest likely reduction and the largest likely reduction.

(C) *Assumptions used in examples.* The examples provided under this paragraph (a)(4)(ii) are not required to be based on any particular form of payment (such as a life annuity or a single sum), but may be based on whatever form appropriately illustrates the reduction. The examples generally may be based on any reasonable assumptions (for example, assumptions relating to the representative participant's age, years of service, and compensation, along with any interest rate and mortality table used in the illustrations, as well as salary scale assumptions used in the illustrations for amendments that alter the compensation taken into account under the plan), but the section 204(h) notice must identify those assumptions. However, if a plan's benefit provisions include a factor that varies over time (such as a variable interest rate), the determination of whether an amendment is reasonably expected to result in a wear-away period must be based on the value of the factor applicable under the plan at a time that is reasonably close to the date section 204(h) notice is provided, and any wear-away period that is solely a result of a future change in the variable factor may be disregarded. For example, to determine whether a wear-away occurs as a result of a section 204(h) amendment that converts a defined benefit plan to a cash balance pension plan that will credit interest based on a variable interest factor specified in the plan, the future interest credits must be projected based on the interest rate applicable under the variable factor at the time section 204(h) notice is provided.

(D) *Individual statements.* This paragraph (a)(4)(ii) may be satisfied by providing a statement to each applicable individual projecting what that individual's future benefits are reasonably expected to be at various future dates and what that individual's future benefits would have been under the terms of the plan as in effect before the section 204(h) amendment, provided that the statement includes the same information required for examples under paragraphs (a)(4)(ii)(A) through (C) of this Q&A–11, including showing the approximate range of the reductions for the individual if the reductions vary over time and identification of the assumptions used in the projections.

(5) *No false or misleading information.* A section 204(h) notice may not include materially false or misleading information (or omit information so as to cause the information provided to be misleading).

(6) *Additional information when reduction not uniform*—(i) *In general.* If an

amendment by its terms affects different classes of participants differently (e.g., one new benefit formula will apply to Division A and another to Division B), then the requirements of paragraph (a) of this Q&A–11 apply separately with respect to each such general class of participants. In addition, the notice must include sufficient information to enable an applicable individual who is a participant to understand which class he or she is a member of.

(ii) *Option for different section 204(h) notices.* If a section 204(h) amendment affects different classes of applicable individuals differently, the plan administrator may provide to differently affected classes of applicable individuals a section 204(h) notice appropriate to those individuals. Such section 204(h) notice may omit information that does not apply to the applicable individuals to whom it is furnished, but must identify the class or classes of applicable individuals to whom it is provided.

(b) *Examples.* The following examples illustrate the requirements paragraph (a) of this Q&A–11. In each example, it is assumed that the actual notice provided is written in a manner calculated to be understood by the average plan participant and to apprise the applicable individual of the significance of the notice in accordance with paragraph (a)(2) of this Q&A–11. The examples are as follows:

Example 1. (i) *Facts.* Plan A provides that a participant is entitled to a normal retirement benefit of 2% of the participant's average pay over the 3 consecutive years for which the average is the highest (highest average pay) multiplied by years of service. Plan A is amended to provide that, effective January 1, 2004, the normal retirement benefit will be 2% of the participant's highest average pay multiplied by years of service before the effective date, plus 1% of the participant's highest average pay multiplied by years of service after the effective date. The plan administrator provides notice that states: ''Under the Plan's current benefit formula, a participant's normal retirement benefit is 2% of the participant's average pay over the 3 consecutive years for which the average is the highest multiplied by the participant's years of service. This formula is being changed by a plan amendment. Under the Plan as amended, a participant's normal retirement benefit will be the sum of 2% of the participant's average pay over the 3 consecutive years for which the average is the highest multiplied by years of service before the January 1, 2004 effective date, plus 1% of the participant's average pay over the 3 consecutive years for which the average is the highest multiplied by the participant's years of service after December 31, 2003. This change is effective on January 1, 2004.'' The notice does not contain any additional information.

(ii) *Conclusion.* The notice satisfies the requirements of paragraph (a) of this Q&A–11.

Example 2. (i) *Facts.* Plan B provides that a participant is entitled to a normal retirement benefit at age 64 of 2.2% of the participant's career average pay multiplied by years of service. Plan B is amended to cease all accruals, effective January 1, 2004. The plan administrator provides notice that includes a description of the old benefit formula, a statement that, after December 31, 2003, no participant will earn any further accruals, and the effective date of the amendment. The notice does not contain any additional information.

(ii) *Conclusion.* The notice satisfies the requirements of paragraph (a) of this Q&A–11.

Example 3. (i) *Facts.* Plan C provides that a participant is entitled to a normal retirement benefit at age 65 of 2% of career average compensation multiplied by years of service. Plan C is amended to provide that the normal retirement benefit will be 1% of average pay over the 3 consecutive years for which the average is the highest multiplied by years of service. The amendment only applies to accruals for years of service after the amendment, so that each employee's accrued benefit is equal to the sum of the benefit accrued as of the effective date of the amendment plus the accrued benefit equal to the new formula applied to years of service beginning on or after the effective date. The plan administrator provides notice that describes the old and new benefit formulas and also explains that for an individual whose compensation increases over the individual's career such that the individual's highest 3-year average exceeds the individual's career average, the reduction will be less or there may be no reduction. The notice does not contain any additional information.

(ii) *Conclusion.* The notice satisfies the requirements of paragraph (a) of this Q&A–11.

Example 4. (i) *Facts.* (A) Plan D is a defined benefit pension plan under which each participant accrues a normal retirement benefit, as a life annuity beginning at the normal retirement age of 65, equal to the participant's number of years of service multiplied by 1.5 percent multiplied by the participant's average pay over the 3 consecutive years for which the average is the highest. Plan D provides early retirement benefits for former employees beginning at or after age 55 in the form of an early retirement annuity that is actuarially equivalent to the normal

retirement benefit, with the reduction for early commencement based on reasonable actuarial assumptions that are specified in Plan D. Plan D provides for the suspension of benefits of participants who continue in employment beyond normal retirement age, in accordance with section 203(a)(3)(B) of ERISA and regulations thereunder issued by the Department of Labor. The pension of a participant who retires after age 65 is calculated under the same normal retirement benefit formula, but is based on the participant's service credit and highest 3-year pay at the time of late retirement with any appropriate actuarial increases.

(B) Plan D is amended, effective July 1, 2005, to change the formula for all future accruals to a cash balance formula under which the opening account balance for each participant on July 1, 2005, is zero, hypothetical pay credits equal to 5 percent of pay are credited to the account thereafter, and hypothetical interest is credited monthly based on the applicable interest rate under section 417(e)(3) of the Internal Revenue Code at the beginning of the quarter. Any participant who terminates employment with vested benefits can receive an actuarially equivalent annuity (based on the same reasonable actuarial assumptions that are specified in Plan D) commencing at any time after termination of employment and before the plan's normal retirement age of 65. The benefit resulting from the hypothetical account balance is in addition to the benefit accrued before July 1, 2005 (taking into account only service and highest 3-year pay before July 1, 2005), so that it is reasonably expected that no wear-away period will result from the amendment. The plan administrator expects that, as a general rule, depending on future pay increases and future interest rates, the rate of future benefit accrual after the conversion is higher for participants who accrue benefits before approximately age 50 and after approximately age 70, but is lower for participants who accrue benefits between approximately age 50 and age 70.

(C) The plan administrator of Plan D announces the conversion to a cash balance formula on May 16, 2005. The announcement is delivered to all participants and includes a written notice that describes the old formula, the new formula, and the effective date.

(D) In addition, the notice states that the Plan D formula before the conversion provided a normal retirement benefit equal to the product of a participant's number of years of service multiplied by 1.5 percent multiplied by the participant's average pay over the 3 years for which the average is the highest (highest 3-year pay). The notice includes an example showing the normal retirement benefit that will be accrued after June 30, 2005 for a participant who is age 49 with 10 years of service at the time of the conversion. The plan administrator reasonably believes that such a participant is representative of the participants whose rate of future benefit accrual will be reduced as a result of the amendment. The example estimates that, if the participant continues employment to age 65, the participant's normal retirement benefit for service from age 49 to age 65 will be $657 per month for life. The example assumes that the participant's pay is $50,000 at age 49. The example states that the estimated $657 monthly pension accrues over the 16-year period from age 49 to age 65 and that, based on assumed future pay increases, this amount annually would be 9.1 percent of the participant's highest 3-year pay at age 65, which over the 16 years from age 49 to age 65 averages 0.57 percent per year multiplied by the participant's highest 3-year pay. The example also states that the sum of the monthly annuity accrued before the conversion in the 10-year period from age 39 to age 49 plus the $657 monthly annuity estimated to be accrued over the 16-year period from age 49 to age 65 is $1,235 and that, based on assumed future increases in pay, this would be 17.1 percent of the participant's highest 3-year pay at age 65, which over the employee's career from age 39 to age 65 averages 0.66 percent per year multiplied by the participant's highest 3-year pay. The notice also includes two other examples with similar information, one of which is intended to show the circumstances in which a small reduction may occur and the other of which shows the largest reduction that the plan administrator thinks is likely to occur. The notice states that the estimates are based on the assumption that pay increases annually after June 30, 2005, at a 4 percent rate. The notice also specifies that the applicable interest rate under section 417(e) for hypothetical interest credits after June 30, 2005 is assumed to be 6 percent, which is the section 417(e) of the Internal Revenue Code applicable interest rate under the plan for 2005.

(ii) *Conclusion.* The information in the notice, as described in paragraph (i)(C) and (i)(D) of this *Example 4,* satisfies the requirements of paragraph (a)(3) of this Q&A–11 with respect to applicable individuals who are participants. The requirements of paragraph (a)(4) of this Q&A–11 are satisfied because, as noted in paragraph (i)(D) of this *Example 4,* the notice describes the old formula and describes the estimated future accruals under the new formula in terms that can be readily compared to the old formula, *i.e.,* the notice states that the estimated $657 monthly pension accrued over the 16-year period from age 49 to age 65 averages 0.57 percent of the participant's highest 3-year pay at age 65. The requirement in paragraph (a)(4)(ii) of this Q&A–11 that the examples include sufficient information to be able to determine the approximate magnitude of the reduction would also be satisfied if the notice instead

directly stated the amount of the monthly pension that would have accrued over the 16-year period from age 49 to age 65 under the old formula.

Example 5. (i) *Facts.* The facts are the same as in *Example 4,* except that, under the plan as in effect before the amendment, the early retirement pension for a participant who terminates employment after age 55 with at least 20 years of service is equal to the normal retirement benefit without reduction from age 65 to age 62 and reduced by only 5 percent per year for each year before age 62. As a result, early retirement benefits for such a participant constitute a retirement-type subsidy. The plan as in effect after the amendment provides an early retirement benefit equal to the sum of the early retirement benefit payable under the plan as in effect before the amendment taking into account only service and highest 3-year pay before July 1, 2005, plus an early retirement annuity that is actuarially equivalent to the account balance for service after June 30, 2005. The notice provided by the plan administrator describes the old early retirement annuity, the new early retirement annuity, and the effective date. The notice includes an estimate of the early retirement annuity payable to the illustrated participant for service after the conversion if the participant were to retire at age 59 (which the plan administrator believes is a typical early retirement age) and elect to begin receiving an immediate early retirement annuity. The example states that the normal retirement benefit expected to be payable at age 65 as a result of service from age 49 to age 59 is $434 per month for life beginning at age 65 and that the early retirement annuity expected to be payable as a result of service from age 49 to age 59 is $270 per month for life beginning at age 59. The example states that the monthly early retirement annuity of $270 is 38 percent less than the monthly normal retirement benefit of $434, whereas a 15 percent reduction would have applied under the plan as in effect before the amendment. The notice also includes similar information for examples that show the smallest and largest reduction that the plan administrator thinks is likely to occur in the early retirement benefit. The notice also specifies the applicable interest rate, mortality table, and salary scale used in the example to calculate the early retirement reductions.

(ii) *Conclusion.* The information in the notice, as described in paragraphs (i)(C) and (D) of *Example 4* and paragraph (i) of this *Example 5,* satisfies the requirements of paragraph (a)(3) of this Q&A–11 with respect to applicable individuals who are participants. The requirements of paragraph (a)(4) of this Q&A–11 are satisfied because, as noted in paragraph (i) of this *Example 5,* the notice describes the early retirement subsidy under the old formula and describes the estimated early retirement pension under the new formula in terms that can be readily compared to the old formula, *i.e.*, the notice states that the monthly early retirement pension of $270 is 38 percent less than the monthly normal retirement benefit of $434, whereas a 15 percent reduction would have applied under the plan as in effect before the amendment. The requirements of paragraph (a)(4)(ii) of this Q&A–11 that the examples include sufficient information to be able to determine the approximate magnitude of the reduction would also be satisfied if the notice instead directly stated the amount of the monthly early retirement pension that would be payable at age 59 under the old formula.

Q–12. What special rules apply if participants can choose between the old and new benefit formulas?

A–12. In any case in which an applicable individual can choose between the benefit formula (including any early retirement benefit or retirement-type subsidy) in effect before the section 204(h) amendment (old formula) or the benefit formula in effect after the section 204(h) amendment (new formula), section 204(h) notice has not been provided unless the applicable individual has been provided the information required under Q&A–11 of this section, and has also been provided sufficient information to enable the individual to make an informed choice between the old and new benefit formulas. The information required under Q&A–11 of this section must be provided by the date otherwise required under Q&A–9 of this section. The information sufficient to enable the individual to make an informed choice must be provided within a period that is reasonably contemporaneous with the date by which the individual is required to make his or her choice and that allows sufficient advance notice to enable the individual to understand and consider the additional information before making that choice.

Q–13. How may section 204(h) notice be provided?

A–13. (a) *Delivering section 204(h) notice.* A plan administrator (including a person acting on behalf of the plan administrator, such as the employer or plan trustee) must provide section 204(h) notice through a method that results in actual receipt of the notice or the plan administrator must take appropriate and necessary measures reasonably calculated to ensure that the

method for providing section 204(h) notice results in actual receipt of the notice. Section 204(h) notice must be provided either in the form of a paper document or in an electronic form that satisfies the requirements of paragraph (c) of this Q&A–13. First class mail to the last known address of the party is an acceptable delivery method. Likewise, hand delivery is acceptable. However, the posting of notice is not considered provision of section 204(h) notice. Section 204(h) notice may be enclosed with or combined with other notice provided by the employer or plan administrator (for example, a notice of intent to terminate under title IV of ERISA). Except as provided in paragraph (c) of this Q&A–13, a section 204(h) notice is deemed to have been provided on a date if it has been provided by the end of that day. When notice is delivered by first class mail, the notice is considered provided as of the date of the United States postmark stamped on the cover in which the document is mailed.

(b) *Example*. The following example illustrates the provisions of paragraph (a) of this Q&A–13:

Example. (i) *Facts*. Plan A is amended to reduce significantly the rate of future benefit accrual effective January 1, 2005. Under Q&A–9 of this section, section 204(h) notice is required to be provided at least 45 days before the effective date of the amendment. The plan administrator causes section 204(h) notice to be mailed to all affected participants. The mailing is postmarked November 16, 2004.

(ii) *Conclusion*. Because section 204(h) notice is given 45 days before the effective date of the plan amendment, it satisfies the timing requirement of Q&A–9 of this section.

(c) *New technologies*—(1) *General rule*. A section 204(h) notice may be provided to an applicable individual through an electronic method (other than an oral communication or a recording of an oral communication), provided that all of the following requirements are satisfied:

(i) Either the notice is actually received by the applicable individual or the plan administrator takes appropriate and necessary measures reasonably calculated to ensure that the method for providing section 204(h) notice results in actual receipt of the notice by the applicable individual.

(ii) The section 204(h) notice is delivered using an electronic medium (other than an oral communication or a recording of an oral communication) under an electronic system that satisfies the applicable notice requirements of § 1.401(a)–21.

(iii) *Special effective date*. For plan years beginning prior to January 1, 2007, Q&A–13 of this section, as it appeared in the April 1, 2006 edition of 26 CFR part 1, applies.

(2) *Examples*. The following examples illustrate the requirement in paragraph (c)(1)(i) of this Q&A–13. In these examples, it is assumed that the notice satisfies the requirements in paragraphs (c)(1)(ii) of this section. The examples are as follows:

Example 1. (i) *Facts*. On July 1, 2003, M, a plan administrator of Company N's plan, sends notice intended to constitute section 204(h) notice to A, an employee of Company N and a participant in the plan. The notice is sent through e-mail to A's e-mail address on Company N's electronic information system. Accessing Company N's electronic information system is not an integral part of A's duties. M sends the e-mail with a request for a computer-generated notification that the message was received and opened. M receives notification indicating that the e-mail was received and opened by A on July 9, 2003.

(ii) *Conclusion*. With respect to A, although M has failed to take appropriate and necessary measures reasonably calculated to ensure that the method for providing section 204(h) notice results in actual receipt of the notice, M satisfies the requirement of paragraph (c)(1)(i) of this Q&A–13 on July 9, 2003, which is when A actually receives the notice.

Example 2. (i) *Facts*. On August 1, 2003, O, a plan administrator of Company P's plan, sends a notice intended to constitute section 204(h) notice of ERISA to B, who is an employee of Company P and a participant in Company P's plan. The notice is sent through e-mail to B's e-mail address on Company P's electronic information system. B has the ability to effectively access electronic documents from B's e-mail address on Company P's electronic information system and accessing the system is an integral part of B's duties.

(ii) *Conclusion*. Because access to the system is an integral part of B's duties, O has taken appropriate and necessary measures reasonably calculated to ensure that the method for providing section 204(h) notice results in actual receipt of the notice. Thus, regardless of whether B actually accesses B's email on that date, O satisfies the requirement of paragraph (c)(1)(i) of this Q&A–13 on August 1, 2003, with respect to B.

Q–14. What are the consequences if a plan administrator fails to provide section 204(h) notice?

A–14. (a) *Egregious failures*—(1) *Effect of egregious failure to provide section 204(h) notice.* Section 204(h)(6)(A) of ERISA provides that, in the case of any egregious failure to meet the notice requirements with respect to any plan amendment, the plan provisions are applied so that all applicable individuals are entitled to the greater of the benefit to which they would have been entitled without regard to the amendment, or the benefit under the plan with regard to the amendment. For a special rule applicable in the case of a plan termination, *see* Q&A–17(b) of this section.

(2) *Definition of egregious failure.* For purposes of section 204(h) of ERISA and this Q&A–14, there is an egregious failure to meet the notice requirements if a failure to provide required notice is within the control of the plan sponsor and is either an intentional failure or a failure, whether or not intentional, to provide most of the individuals with most of the information they are entitled to receive. For this purpose, an intentional failure includes any failure to promptly provide the required notice or information after the plan administrator discovers an unintentional failure to meet the requirements. A failure to give section 204(h) notice is deemed not to be egregious if the plan administrator reasonably determines, taking into account section 4980F, section 204(h), these regulations, other administrative pronouncements, and relevant facts and circumstances, that the reduction in the rate of future benefit accrual resulting from an amendment is not significant (as described in Q&A–8 of this section), or that an amendment does not significantly reduce an early retirement benefit or retirement-type subsidy.

(3) Example. The following example illustrates the provisions of this paragraph (a):

Example. (i) *Facts.* Plan A is amended to reduce significantly the rate of future benefit accrual effective January 1, 2003. Section 204(h) notice is required to be provided 45 days before January 1, 2003. Timely section 204(h) notice is provided to all applicable individuals (and to each employee organization representing participants who are applicable individuals), except that the employer intentionally fails to provide section 204(h) notice to certain participants until May 16, 2003.

(ii) *Conclusion.* The failure to provide section 204(h) notice is egregious. Accordingly, for the period from January 1, 2003 through June 30, 2003 (which is the date that is 45 days after May 16, 2003), all participants and alternate payees are entitled to the greater of the benefit to which they would have been entitled under Plan A as in effect before the amendment or the benefit under the plan as amended.

(b) *Effect of non-egregious failure to provide section 204(h) notice.* If an egregious failure has not occurred, the amendment with respect to which section 204(h) notice is required may become effective with respect to all applicable individuals. However, see section 502 of ERISA for civil enforcement remedies. Thus, where there is a failure, whether or not egregious, to provide section 204(h) notice in accordance with this section, individuals may have recourse under section 502 of ERISA.

(c) *Excise taxes.* See section 4980F and Q&A–15 of this section for excise taxes that may apply to a failure to notify applicable individuals of a pension plan amendment that provides for a significant reduction in the rate of future benefit accrual or eliminates or significantly reduces an early retirement benefit or retirement-type subsidy, regardless of whether or not the failure is egregious.

Q–15. What are some of the rules that apply with respect to the excise tax under section 4980F?

A–15. (a) *Person responsible for excise tax.* In the case of a plan other than a multiemployer plan, the employer is responsible for reporting and paying the excise tax. In the case of a multiemployer plan, the plan is responsible for reporting and paying the excise tax.

(b) *Excise tax inapplicable in certain cases.* Under section 4980F(c)(1) of the Internal Revenue Code, no excise tax is imposed on a failure for any period during which it is established to the satisfaction of the Commissioner that the employer (or other person responsible for the tax) exercised reasonable diligence, but did not know that the failure existed. Under section 4980F(c)(2) of the Internal Revenue Code, no excise tax applies to a failure to provide section 204(h) notice if the employer (or

other person responsible for the tax) exercised reasonable diligence and corrects the failure within 30 days after the employer (or other person responsible for the tax) first knew, or exercising reasonable diligence would have known, that such failure existed. For purposes of section 4980F(c)(1) of the Internal Revenue Code, a person has exercised reasonable diligence, but did not know that the failure existed if and only if—

(1) The person exercised reasonable diligence in attempting to deliver section 204(h) notice to applicable individuals by the latest date permitted under this section; and

(2) At the latest date permitted for delivery of section 204(h) notice, the person reasonably believes that section 204(h) notice was actually delivered to each applicable individual by that date.

(c) *Example*. The following example illustrates the provisions of paragraph (b) of this Q&A–15:

Example. (i) *Facts*. Plan A is amended to reduce significantly the rate of future benefit accrual. The employer sends out a section 204(h) notice to all affected participants and other applicable individuals and to any employee organization representing applicable individuals, including actual delivery by hand to employees at worksites and by first-class mail for any other applicable individual and to any employee organization representing applicable individuals. However, although the employer exercises reasonable diligence in seeking to deliver the notice, the notice is not delivered to any participants at one worksite due to a failure of an overnight delivery service to provide the notice to appropriate personnel at that site for them to timely hand deliver the notice to affected employees. The error is discovered when the employer subsequently calls to confirm delivery. Appropriate section 204(h) notice is then promptly delivered to all affected participants at the worksite.

(ii) *Conclusion*. Because the employer exercised reasonable diligence, but did not know that a failure existed, no excise tax applies, assuming that participants at the worksite receive section 204(h) notice within 30 days after the employer first knew, or exercising reasonable diligence would have known, that the failure occurred.

Q–16. How do section 4980F and section 204(h) apply when a business is sold?

A–16. (a) *Generally*. Whether section 204(h) notice is required in connection with the sale of a business depends on whether a plan amendment is adopted that significantly reduces the rate of future benefit accrual or significantly reduces an early retirement benefit or retirement-type subsidy.

(b) *Examples*. The following examples illustrate the rules of this Q&A–16:

Example 1. (i) *Facts*. Corporation Q maintains Plan A, a defined benefit plan that covers all employees of Corporation Q, including employees in its Division M. Plan A provides that participating employees cease to accrue benefits when they cease to be employees of Corporation Q. On January 1, 2006, Corporation Q sells all of the assets of Division M to Corporation R. Corporation R maintains Plan B, which covers all of the employees of Corporation R. Under the sale agreement, employees of Division M become employees of Corporation R on the date of the sale (and cease to be employees of Corporation Q), Corporation Q continues to maintain Plan A following the sale, and the employees of Division M become participants in Plan B.

(ii) *Conclusion*. No section 204(h) notice is required because no plan amendment was adopted that reduced the rate of future benefit accrual. The employees of Division M who become employees of Corporation R ceased to accrue benefits under Plan A because their employment with Corporation Q terminated.

Example 2. (i) *Facts*. Subsidiary Y is a wholly owned subsidiary of Corporation S. Subsidiary Y maintains Plan C, a defined benefit plan that covers employees of Subsidiary Y. Corporation S sells all of the stock of Subsidiary Y to Corporation T. At the effective date of the sale of the stock of Subsidiary Y, in accordance with the sale agreement between Corporation S and Corporation T, Subsidiary Y amends Plan C so that all benefit accruals cease.

(ii) *Conclusion*. Section 204(h) notice is required to be provided because Subsidiary Y adopted a plan amendment that significantly reduced the rate of future benefit accrual in Plan C.

Example 3. (i) *Facts*. As a result of an acquisition, Corporation U maintains two defined benefit plans: Plan D covers employees of Division N and Plan E covers the rest of the employees of Corporation U. Plan E provides a significantly lower rate of future benefit accrual than Plan D. Plan D is merged with Plan E, and all of the employees of Corporation U will accrue benefits under the merged plan in accordance with the benefit formula of former Plan E.

(ii) *Conclusion*. Section 204(h) notice is required.

Example 4. (i) *Facts.* The facts are the same as in *Example 3,* except that the rate of future benefit accrual in Plan E is not significantly lower. In addition, Plan D has a retirement-type subsidy that Plan E does not have and the Plan D employees' rights to the subsidy under the merged plan are limited to benefits accrued before the merger.

(ii) *Conclusion.* Section 204(h) notice is required for any participants or beneficiaries for whom the reduction in the retirement-type subsidy is significant (and for any employee organization representing such participants).

Example 5. (i) *Facts.* Corporation V maintains several plans, including Plan F, which covers employees of Division P. Plan F provides that participating employees cease to accrue further benefits under the plan when they cease to be employees of Corporation V. Corporation V sells all of the assets of Division P to Corporation W, which maintains Plan G for its employees. Plan G provides a significantly lower rate of future benefit accrual than Plan F. Plan F is merged with Plan G as part of the sale, and employees of Division P who become employees of Corporation W will accrue benefits under the merged plan in accordance with the benefit formula of former Plan G.

(ii) *Conclusion.* No section 204(h) notice is required because no plan amendment was adopted that reduces the rate of future benefit accrual or eliminates or significantly reduces an early retirement benefit or retirement-type subsidy. Under the terms of Plan F as in effect prior to the merger, employees of Division P cease to accrue any further benefits (including benefits with respect to early retirement benefits and any retirement-type subsidy) under Plan F after the date of the sale because their employment with Corporation V terminated.

Q–17. How are amendments to cease accruals and terminate a plan treated under section 4980F and section 204(h)?

A–17. (a) *General rule*—(1) *Rule.* An amendment providing for the cessation of benefit accruals on a specified future date and for the termination of a plan is subject to section 4980F and section 204(h).

(2) *Example.* The following example illustrates the rule of paragraph (a)(1) of this Q&A–17:

Example. (i) *Facts.* An employer adopts an amendment that provides for the cessation of benefit accruals under a defined benefit plan on December 31, 2003, and for the termination of the plan pursuant to title IV of ERISA as of a proposed termination date that is also December 31, 2003. As part of the notice of intent to terminate required under title IV in order to terminate the plan, the plan administrator gives section 204(h) notice of the amendment ceasing accruals, which states that benefit accruals will cease ''on December 31, 2003 whether or not the plan is terminated on that date.'' However, because all the requirements of title IV for a plan termination are not satisfied, the plan cannot be terminated until a date that is later than December 31, 2003.

(ii) *Conclusion.* Nonetheless, because section 204(h) notice was given stating that the plan was amended to cease accruals on December 31, 2003, section 204(h) does not prevent the amendment to cease accruals from being effective on December 31, 2003. The result would be the same had the section 204(h) notice informed the participants that the plan was amended to provide for a proposed termination date of December 31, 2003 and to provide that ''benefit accruals will cease on the proposed termination date whether or not the plan is terminated on that date.'' However, neither section 4980F nor section 204(h) would be satisfied with respect to the December 31, 2003 effective date if the section 204(h) notice had merely stated that benefit accruals would cease ''on the termination date'' or ''on the proposed termination date.''

(3) *Additional requirements under title IV of ERISA. See* 29 CFR 4041.23(b)(4) and 4041.43(b)(5) for special rules applicable to plans terminating under title IV of ERISA.

(b) *Terminations in accordance with title IV of ERISA.* A plan that is terminated in accordance with title IV of ERISA is deemed to have satisfied section 4980F and section 204(h) not later than the termination date (or date of termination, as applicable) established under section 4048 of ERISA. Accordingly, neither section 4980F nor section 204(h) would in any event require that any additional benefits accrue after the effective date of the termination.

(c) *Amendment effective before termination date of a plan subject to title IV of ERISA.* To the extent that an amendment providing for a significant reduction in the rate of future benefit accrual or a significant reduction in an early retirement benefit or retirement-type subsidy has an effective date that is earlier than the termination date (or date of termination, as applicable) established under section 4048 of ERISA, that amendment is subject to section 4980F and section 204(h). Accordingly, the plan administrator must provide section 204(h) notice (either separately, with, or as part of the notice of intent

to terminate) with respect to such an amendment.

Q–18. What are the effective dates of section 4980F, section 204(h), as amended by EGTRRA, and these regulations?

A–18. (a) *Statutory effective date*—(1) *General rule*. Section 4980F and section 204(h), as amended by EGTRRA, apply to plan amendments taking effect on or after June 7, 2001 (statutory effective date), which is the date of enactment of EGTRRA.

(2) *Transition rule*. For amendments applying after the statutory effective date in paragraph (a)(1) of this Q&A–18 and prior to the regulatory effective date in paragraph (c) of this Q&A–18, the requirements of section 4980F(e)(2) and (3) of the Internal Revenue Code and section 204(h), as amended by EGTRRA, are treated as satisfied if the plan administrator makes a reasonable, good faith effort to comply with those requirements.

(3) *Special notice rule*—(i) *In general*. Notwithstanding Q&A–9 of this section, section 204(h) notice is not required by section 4980F(e) of the Internal Revenue Code or section 204(h), as amended by EGTRRA, to be provided prior to September 7, 2001 (the date that is three months after the date of enactment of EGTRRA).

(ii) *Reasonable notice*. The requirements of section 4980F and section 204(h), as amended by EGTRRA, do not apply to any plan amendment that takes effect on or after June 7, 2001 if, before April 25, 2001, notice was provided to participants and beneficiaries adversely affected by the plan amendment (and their representatives) which was reasonably expected to notify them of the nature and effective date of the plan amendment. For purposes of this paragraph (a)(3)(ii), notice that complies with §1.411(d)–6 of this chapter, as it appeared in the April 1, 2001 edition of 26 CFR part 1, is deemed to be notice which was reasonably expected to notify participants and beneficiaries adversely affected by the plan amendment (and their representatives) of the nature and effective date of the plan amendment.

(4) *Special effective date for certain section 204(h) amendments made by plans of commercial airlines*. Section 402 of PPA '06 applies to section 204(h) amendments adopted in plan years ending after August 17, 2006.

(5) *Special effective date for rule relating to contributing employers*. Section 502(c) of PPA '06, which amended section 4980F(e)(1) of the Internal Revenue Code, applies to section 204(h) amendments adopted in plan years beginning after December 31, 2007.

(b) *Regulatory effective date*—(1) *General effective date*. Except as otherwise provided in this paragraph (b) of this section, Q&A–1 through Q&A–18 of this section apply to amendments with an effective date that is on or after September 1, 2003.

(2) *Effective date for Q&A–7(a)(2)*. Q&A–7(a)(2) of this section applies to amendments with an effective date that is on or after January 1, 2004.

(3) *Effective dates for Q&A–9(g)(1), (g)(3), and (g)(4)*—(i) *General effective date*. Except as otherwise provided in Q&A–18(b)(3)(ii) or (b)(3)(iii) of this section, Q&A–9(g)(1), (g)(3), and (g)(4) of this section apply to amendments that are effective on or after January 1, 2008.

(ii) *Effective dates for Q&A–9(g)(2) and Q&A–7(b)*. Except as otherwise provided in Q&A–18(b)(3)(iii) of this section, Q&A–9(g)(2) and Q&A–7(b) of this section apply to section 204(h) amendments adopted in plan years beginning after July 1, 2008.

(iii) *Special rules for section 204(h) amendments to an applicable defined benefit plan*. Except as otherwise provided in paragraph (b)(3)(i) or (b)(3)(ii) of this Q&A–18, with respect to any section 204(h) notice provided in connection with a section 204(h) amendment to an applicable defined benefit plan within the meaning of section 411(a)(13)(C)(i) to limit distributions as permitted under section 411(a)(13)(A) for distributions made after August 17, 2006, that is made pursuant to section 701 of PPA '06, paragraphs (g)(1) and (g)(2) of Q&A–9 of this section apply to amendments that are effective after December 21, 2006. For such an amendment that is effective not later than December 31, 2008, section 204(h) notice does not fail to be timely if the notice is provided at least 30 days, rather than 45 days, before the date that the amendment is first effective.

(c) *Amendments taking effect prior to June 7, 2001.* For rules applicable to amendments taking effect prior to June 7, 2001, *see* § 1.411(d)–6 of this chapter, as it appeared in the April 1, 2001 edition of 26 CFR part 1.

[T.D. 9052, 68 FR 17281, Apr. 9, 2003, as amended by T.D. 9219, 70 FR 47126, Aug. 12, 2005; T.D. 9294, 71 FR 61888, Oct. 20, 2006; T.D. 9472, 74 FR 61276, Nov. 24, 2009]

§ 54.4980G–0 Table of contents.

This section contains the questions for §§ 54.4980G–1, 54.4980G–2, 54.4980G–3, 54.4980G–4, and 54.4980G–5.

§ 54.4980G–1 Failure of employer to make comparable health savings account contributions.

Q–1: What are the comparability rules that apply to employer contributions to Health Savings Accounts (HSAs)?

Q–2: What are the categories of HDHP coverage for purposes of applying the comparability rules?

Q–3: What is the testing period for making comparable contributions to employees' HSAs?

Q–4: How is the excise tax computed if employer contributions do not satisfy the comparability rules for a calendar year?

§ 54.4980G–2 Employer contribution defined.

Q–1: Do the comparability rules apply to amounts rolled over from an employee's HSA or Archer Medical Savings Account (Archer MSA)?

Q–2: If an employee requests that his or her employer deduct after-tax amounts from the employee's compensation and forward these amounts as employee contributions to the employee's HSA, do the comparability rules apply to these amounts?

§ 54.4980G–3 Employee for comparability testing.

Q–1: Do the comparability rules apply to contributions that an employer makes to the HSAs of independent contractors or self-employed individuals?

Q–2: May a sole proprietor who is an eligible individual contribute to his or her own HSA without contributing to the HSAs of his or her employees who are eligible individuals?

Q–3: Do the comparability rules apply to contributions by a partnership to a partner's HSA?

Q–4: How are members of controlled groups treated when applying the comparability rules?

Q–5: What are the categories of employees for comparability testing?

Q–6: Are employees who are included in a unit of employees covered by a collective bargaining agreement comparable participating employees?

Q–7: Is an employer permitted to make comparable contributions only to the HSAs of comparable participating employees who have coverage under the employer's HDHP?

Q–8: If an employee and his or her spouse are eligible individuals who work for the same employer and one employee-spouse has family coverage for both employees under the employer's HDHP, must the employer make comparable contributions to the HSAs of both employees?

Q–9: Does an employer that makes HSA contributions only for one class of non-collectively bargained employees who are eligible individuals, but not for another class of non-collectively bargained employees who are eligible individuals (for example, management v. non-management) satisfy the requirement that the employer make comparable contributions?

Q–10: If an employer contributes to the HSAs of former employees who are eligible individuals, do the comparability rules apply to these contributions?

Q–11: Is an employer permitted to make comparable contributions only to the HSAs of comparable participating former employees who have coverage under the employer's HDHP?

Q–12: If an employer contributes only to the HSAs of former employees who are eligible individuals with coverage under the employer's HDHP, must the employer make comparable contributions to the HSAs of former employees who are eligible individuals with coverage under the employer's HDHP because of an election under a COBRA continuation provision (as defined in section 9832(d)(1))?

Q–13: How do the comparability rules apply if some employees have HSAs and other employees have Archer MSAs?

§ 54.4980G–4 Calculating comparable contributions.

Q–1: What are comparable contributions?

Q–2: How does an employer comply with the comparability rules when some non-collectively bargained employees who are eligible individuals do not work for the employer during the entire calendar year?

Q–3: How do the comparability rules apply to employer contributions to employees' HSAs if some non-collectively bargained employees work full-time during the entire calendar year, and other non-collectively bargained employees work full-time for less than the entire calendar year?

Q–4: May an employer make contributions for the entire year to the HSAs of its employees who are eligible individuals at the beginning of the calendar year (*i.e.*, on a pre-

funded basis) instead of contributing on a pay-as-you-go or on a look-back basis?

Q–5: Must an employer use the same contribution method as described in Q & A–2 and Q & A–4 of this section for all employees for any month during the calendar year?

Q–6: How does an employer comply with the comparability rules if an employee has not established an HSA at the time the employer contributes to its employees' HSAs?

Q–7: If an employer bases its contributions on a percentage of the HDHP deductible, how is the correct percentage or dollar amount computed?

Q–8: Does an employer that contributes to the HSA of each comparable participating employee in an amount equal to the employee's HSA contribution or a percentage of the employee's HSA contribution (matching contributions) satisfy the rule that all comparable participating employees receive comparable contributions?

Q–9: If an employer conditions contributions by the employer to an employee's HSA on an employee's participation in health assessments, disease management programs or wellness programs and makes the same contributions available to all employees who participate in the programs, do the contributions satisfy the comparability rules?

Q–10: If an employer makes additional contributions to the HSAs of all comparable participating employees who have attained a specified age or who have worked for the employer for a specified number of years, do the contributions satisfy the comparability rules?

Q–11: If an employer makes additional contributions to the HSAs of all comparable participating employees who are eligible to make the additional contributions (HSA catch-up contributions) under section 223(b)(3), do the contributions satisfy the comparability rules?

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Q–13: What constitutes a reasonable interest rate for purposes of making comparable contributions?

Q–14: How does an employer comply with the comparability rules if an employee has not established an HSA by December 31st?

Q–15: For any calendar year, may an employer accelerate part or all of its contributions for the entire year to the HSAs of employees who have incurred, during the calendar year, qualified medical expenses (as defined in section 223(d)(2)) exceeding the employer's cumulative HSA contributions at that time?

Q–16: What is the effective date for the rules in Q & A–14 and Q & A–15 of this section?

§ 54.4980G–5 HSA comparability rules and cafeteria plans and waiver of excise tax.

Q–1: If an employer makes contributions through a section 125 cafeteria plan to the HSA of each employee who is an eligible individual, are the contributions subject to the comparability rules?

Q–2: If an employer makes contributions through a cafeteria plan to the HSA of each employee who is an eligible individual in an amount equal to the amount of the employee's HSA contribution or a percentage of the amount of the employee's HSA contribution (*i.e.*, matching contributions), are the contributions subject to the section 4980G comparability rules?

Q–3: If under the employer's cafeteria plan, employees who are eligible individuals and who participate in health assessments, disease management programs or wellness programs receive an employer contribution to an HSA and the employees have the right to elect to make pre-tax salary reduction contributions to their HSAs, are the contributions subject to the comparability rules?

Q–4: May all or part of the excise tax imposed under section 4980G be waived?

[T.D. 9277, 71 FR 43058, July 31, 2006; 71 FR 53967, Sept. 13, 2006, as amended by T.D. 9393, 73 FR 20795, Apr. 17, 2008]

§ 54.4980G–1 Failure of employer to make comparable health savings account contributions.

Q–1: What are the comparability rules that apply to employer contributions to Health Savings Accounts (HSAs)?

A–1: If an employer makes contributions to any employee's HSA, the employer must make comparable contributions to the HSAs of all comparable participating employees. See Q & A–1 in § 54.4980G–4 for the definition of comparable contributions. Comparable participating employees are eligible individuals (as defined in section 223(c)(1)) who are in the same category of employees and who have the same category of high deductible health plan (HDHP) coverage. See sections 4980G(b) and 4980E(d)(3). See section 223(c)(2) and (g) for the definition of an HDHP. See also Q & A–5 in § 54.4980G–3 for the categories of employees and Q & A–2 of this section for the categories of HDHP coverage. But *see* Q & A–6 in § 54.4980G–3 for treatment of collectively bargained employees and Q & A–1 in § 54.4980G–6 for the rules allowing larger comparable contributions to non-highly compensated employees.

Q–2: What are the categories of HDHP coverage for purposes of applying the comparability rules?

A–2: (a) *In general*. Generally, the categories of coverage are self-only HDHP coverage and family HDHP coverage. Family HDHP coverage means any coverage other than self-only HDHP coverage. The comparability rules apply separately to self-only HDHP coverage and family HDHP coverage. In addition, if an HDHP has family coverage options meeting the descriptions listed in paragraph (b) of this Q & A–2, each such coverage option may be treated as a separate category of coverage and the comparability rules may be applied separately to each category. However, if the HDHP has more than one category that provides coverage for the same number of individuals, all such categories are treated as a single category for purposes of the comparability rules. Thus, the categories of ''employee plus spouse'' and ''employee plus dependent,'' each providing coverage for two individuals, are treated as the single category ''self plus one'' for comparability purposes. See, however, the final sentence of paragraph (a) of Q & A–1 of § 54.4980G–4 for a special rule that applies if different amounts are contributed for different categories of family coverage. *See also* § 54.4980G–6 for the rules allowing larger comparable contributions to nonhighly compensated employees.

(b) *HDHP Family coverage categories*. The coverage categories are—

(1) Self plus one;

(2) Self plus two; and

(3) Self plus three or more.

(c) *Examples*. The rules of this Q & A–2 are illustrated by the following examples:

Example 1. Employer A maintains an HDHP and contributes to the HSAs of eligible employees who elect coverage under the HDHP. The HDHP has self-only coverage and family coverage. Thus, the categories of coverage are self-only and family coverage. Employer A contributes $750 to the HSA of each eligible employee with self-only HDHP coverage and $1,000 to the HSA of each eligible employee with family HDHP coverage. Employer A's contributions satisfy the comparability rules.

Example 2. (i) Employer B maintains an HDHP and contributes to the HSAs of eligible employees who elect coverage under the HDHP. The HDHP has the following coverage options:

(A) Self-only;

(B) Self plus spouse;

(C) Self plus dependent;

(D) Self plus spouse plus one dependent;

(E) Self plus two dependents; and

(F) Self plus spouse and two or more dependents.

(ii) The self plus spouse category and the self plus dependent category constitute the same category of HDHP coverage (self plus one) and Employer B must make the same comparable contributions to the HSAs of all eligible individuals who are in either the self plus spouse category of HDHP coverage or the self plus dependent category of HDHP coverage. Likewise, the self plus spouse plus one dependent category and the self plus two dependents category constitute the same category of HDHP coverage (self plus two) and Employer B must make the same comparable contributions to the HSAs of all eligible individuals who are in either the self plus spouse plus one dependent category of HDHP coverage or the self plus two dependents category of HDHP coverage.

Example 3. (i) Employer C maintains an HDHP and contributes to the HSAs of eligible employees who elect coverage under the HDHP. The HDHP has the following coverage options:

(A) Self-only;

(B) Self plus one;

(C) Self plus two; and

(D) Self plus three or more.

(ii) Employer C contributes $500 to the HSA of each eligible employee with self-only HDHP coverage, $750 to the HSA of each eligible employee with self plus one HDHP coverage, $900 to the HSA of each eligible employee with self plus two HDHP coverage and $1,000 to the HSA of each eligible employee with self plus three or more HDHP coverage. Employer C's contributions satisfy the comparability rules.

Q–3: What is the testing period for making comparable contributions to employees' HSAs?

A–3: To satisfy the comparability rules, an employer must make comparable contributions for the calendar year to the HSAs of employees who are comparable participating employees. See section 4980G(a). See Q & A–3 and Q & A–4 in § 54.4980G–4 for a discussion of HSA contribution methods.

Q–4: How is the excise tax computed if employer contributions do not satisfy the comparability rules for a calendar year?

A–4: (a) *Computation of tax*. If employer contributions do not satisfy the comparability rules for a calendar

year, the employer is subject to an excise tax equal to 35% of the aggregate amount contributed by the employer to HSAs for that period.

(b) *Example*. The following example illustrates the rules in paragraph (a) of this Q & A–4:

Example. During the 2007 calendar year, Employer D has 8 employees who are eligible individuals with self-only coverage under an HDHP provided by Employer D. The deductible for the HDHP is $2,000. For the 2007 calendar year, Employer D contributes $2,000 each to the HSAs of two employees and $1,000 each to the HSAs of the other six employees, for total HSA contributions of $10,000. Employer D's contributions do not satisfy the comparability rules. Therefore, Employer D is subject to an excise tax of $3,500 (35% of $10,000) for its failure to make comparable contributions to its employees' HSAs.

Q–5: If a person is liable for the excise tax under section 4980G, what form must the person file and what is the due date for the filing and payment of the excise tax?

A–5: (a) *In general*. §§ 54.6011–2, 54.6151–1 and 54.6071–1(d).

(b) *Effective/applicability date*. The rules in this Q & A–5 are effective for employer contributions made for calendar years beginning on or after January 1, 2010.

[T.D. 9277, 71 FR 43058, July 31, 2006, as amended by T.D. 9457, 74 FR 45997, Sept. 8, 2009]

§ 54.4980G–2 Employer contribution defined.

Q–1: Do the comparability rules apply to amounts rolled over from an employee's HSA or Archer Medical Savings Account (Archer MSA)?

A–1: No. The comparability rules do not apply to amounts rolled over from an employee's HSA or Archer MSA.

Q–2: If an employee requests that his or her employer deduct after-tax amounts from the employee's compensation and forward these amounts as employee contributions to the employee's HSA, do the comparability rules apply to these amounts?

A–2: No. Section 106(d) provides that amounts contributed by an employer to an eligible employee's HSA shall be treated as employer-provided coverage for medical expenses and are excludible from the employee's gross income up to the limit in section 223(b). After-tax employee contributions to an HSA are not subject to the comparability rules because they are not employer contributions under section 106(d).

[T.D. 9277, 71 FR 43058, July 31, 2006]

§ 54.4980G–3 Failure of employer to make comparable health savings account contributions.

Q–1: Do the comparability rules apply to contributions that an employer makes to the HSAs of independent contractors or self-employed individuals?

A–1: No. The comparability rules apply only to contributions that an employer makes to the HSAs of employees.

Q–2: May a sole proprietor who is an eligible individual contribute to his or her own HSA without contributing to the HSAs of his or her employees who are eligible individuals?

A–2: (a) *Sole proprietor not an employee*. Yes. The comparability rules apply only to contributions made by an employer to the HSAs of employees. Because a sole proprietor is not an employee, the comparability rules do not apply to contributions the sole proprietor makes to his or her own HSA. However, if a sole proprietor contributes to any employee's HSA, the sole proprietor must make comparable contributions to the HSAs of all comparable participating employees. In determining whether the comparability rules are satisfied, contributions that a sole proprietor makes to his or her own HSA are not taken into account.

(b) *Example*. The following example illustrates the rules in paragraph (a) of this Q & A–2:

Example. In a calendar year, B, a sole proprietor is an eligible individual and contributes $1,000 to B's own HSA. B also contributes $500 for the same calendar year to the HSA of each employee who is an eligible individual. The comparability rules are not violated by B's $1,000 contribution to B's own HSA.

Q–3: Do the comparability rules apply to contributions by a partnership to a partner's HSA?

A–3: (a) *Partner not an employee*. No. Contributions by a partnership to a bona fide partner's HSA are not subject to the comparability rules because the contributions are not contributions by

an employer to the HSA of an employee. The contributions are treated as either guaranteed payments under section 707(c) or distributions under section 731. However, if a partnership contributes to the HSAs of any employee who is not a partner, the partnership must make comparable contributions to the HSAs of all comparable participating employees.

(b) *Example*. The following example illustrates the rules in paragraph (a) of this Q & A–3:

Example. (i) Partnership X is a limited partnership with three equal individual partners, A (a general partner), B (a limited partner), and C (a limited partner). C is to be paid $300 annually for services rendered to Partnership X in her capacity as a partner without regard to partnership income (a section 707(c) guaranteed payment). D and E are the only employees of Partnership X and are not partners in Partnership X. A, B, C, D, and E are eligible individuals and each has an HSA. During Partnership X's Year 1 taxable year, which is also a calendar year, Partnership X makes the following contributions—

(A) A $300 contribution to each of A's and B's HSAs which are treated as section 731 distributions to A and B;

(B) A $300 contribution to C's HSA in lieu of paying C the guaranteed payment directly; and

(C) A $200 contribution to each of D's and E's HSAs, who are comparable participating employees.

(ii) Partnership X's contributions to A's and B's HSAs are section 731 distributions, which are treated as cash distributions. Partnership X's contribution to C's HSA is treated as a guaranteed payment under section 707(c). The contribution is not excludible from C's gross income under section 106(d) because the contribution is treated as a distributive share of partnership income for purposes of all Code sections other than sections 61(a) and 162(a), and a guaranteed payment to a partner is not treated as compensation to an employee. Thus, Partnership X's contributions to the HSAs of A, B, and C are not subject to the comparability rules. Partnership X's contributions to D's and E's HSAs are subject to the comparability rules because D and E are employees of Partnership X and are not partners in Partnership X. Partnership X's contributions satisfy the comparability rules.

Q–4: How are members of controlled groups treated when applying the comparability rules?

A–4: All persons or entities treated as a single employer under section 414 (b), (c), (m), or (o) are treated as one employer. See sections 4980G(b) and 4980E(e).

Q–5: What are the categories of employees for comparability testing?

A–5: (a) *Categories*. The categories of employees for comparability testing are as follows (but *see* Q & A–6 of this section for the treatment of collectively bargained employees and Q & A–1 of § 54.4980G–6 for a special rule for contributions made to the HSAs of nonhighly compensated employees)—

(1) Current full-time employees;

(2) Current part-time employees; and

(3) Former employees (except for former employees with coverage under the employer's HDHP because of an election under a COBRA continuation provision (as defined in section 9832(d)(1)).

(b) *Part-time and full-time employees*. For purposes of section 4980G, part-time employees are customarily employed for fewer than 30 hours per week and full-time employees are customarily employed for 30 or more hours per week. See sections 4980G(b) and 4980E(d)(4)(A) and (B).

(c) *In general*. Except as provided in Q & A–6 of this section, the categories of employees in paragraph (a) of this Q & A–5 are the exclusive categories of employees for comparability testing. An employer must make comparable contributions to the HSAs of all comparable participating employees (eligible individuals who are in the same category of employees with the same category of HDHP coverage) during the calendar year without regard to any classification other than these categories. For example, full-time eligible employees with self-only HDHP coverage and part-time eligible employees with self-only HDHP coverage are separate categories of employees and different amounts can be contributed to the HSAs for each of these categories. But *see* § 54.4980G–6 for a special rule for contributions made to the HSAs of nonhighly compensated employees.

Q–6: Are employees who are included in a unit of employees covered by a collective bargaining agreement comparable participating employees?

A–6: (a) *In general*. No. Collectively bargained employees who are covered by a bona fide collective bargaining

agreement between employee representatives and one or more employers are not comparable participating employees, if health benefits were the subject of good faith bargaining between such employee representatives and such employer or employers. Former employees covered by a collective bargaining agreement also are not comparable participating employees.

(b) *Examples*. The following examples illustrate the rules in paragraph (a) of this Q & A–6. The examples read as follows:

Example 1. Employer A offers its employees an HDHP with a $1,500 deductible for self-only coverage. Employer A has collectively bargained and non-collectively bargained employees. The collectively bargained employees are covered by a collective bargaining agreement under which health benefits were bargained in good faith. In the 2007 calendar year, Employer A contributes $500 to the HSAs of all eligible non-collectively bargained employees with self-only coverage under Employer A's HDHP. Employer A does not contribute to the HSAs of the collectively bargained employees. Employer A's contributions to the HSAs of non-collectively bargained employees satisfy the comparability rules. The comparability rules do not apply to collectively bargained employees.

Example 2. Employer B offers its employees an HDHP with a $1,500 deductible for self-only coverage. Employer B has collectively bargained and non-collectively bargained employees. The collectively bargained employees are covered by a collective bargaining agreement under which health benefits were bargained in good faith. In the 2007 calendar year and in accordance with the terms of the collective bargaining agreement, Employer B contributes to the HSAs of all eligible collectively bargained employees. Employer B does not contribute to the HSAs of the non-collectively bargained employees. Employer B's contributions to the HSAs of collectively bargained employees are not subject to the comparability rules because the comparability rules do not apply to collectively bargained employees. Accordingly, Employer B's failure to contribute to the HSAs of the non-collectively bargained employees does not violate the comparability rules.

Example 3. Employer C has two units of collectively bargained employees—unit Q and unit R—each covered by a collective bargaining agreement under which health benefits were bargained in good faith. In the 2007 calendar year and in accordance with the terms of the collective bargaining agreement, Employer C contributes to the HSAs of all eligible collectively bargained employees in unit Q. In accordance with the terms of the collective bargaining agreement, Employer C makes no HSA contributions for collectively bargained employees in unit R. Employer C's contributions to the HSAs of collectively bargained employees are not subject to the comparability rules because the comparability rules do not apply to collectively bargained employees.

Example 4. Employer D has a unit of collectively bargained employees that are covered by a collective bargaining agreement under which health benefits were bargained in good faith. In accordance with the terms of the collective bargaining agreement, Employer D contributes an amount equal to a specified number of cents per hour for each hour worked to the HSAs of all eligible collectively bargained employees. Employer D's contributions to the HSAs of collectively bargained employees are not subject to the comparability rules because the comparability rules do not apply to collectively bargained employees.

Q–7: Is an employer permitted to make comparable contributions only to the HSAs of comparable participating employees who have coverage under the employer's HDHP?

A–7: (a) *Employer-provided HDHP coverage*. If during a calendar year, an employer contributes to the HSA of any employee who is an eligible individual covered under an HDHP provided by the employer, the employer is required to make comparable contributions to the HSAs of all comparable participating employees with coverage under any HDHP provided by the employer. An employer that contributes only to the HSAs of employees who are eligible individuals with coverage under the employer's HDHP is not required to make comparable contributions to HSAs of employees who are eligible individuals but are not covered under the employer's HDHP.

(b) *Non-employer provided HDHP coverage*. An employer that contributes to the HSA of any employee who is an eligible individual with coverage under any HDHP that is not an HDHP provided by the employer, must make comparable contributions to the HSAs of all comparable participating employees whether or not covered under the employer's HDHP. An employer that makes a reasonable good faith effort to identify all comparable participating employees with non-employer provided HDHP coverage and makes

comparable contributions to the HSAs of such employees satisfies the requirements in paragraph (b) of this Q & A–7.

(c) *Examples*. The following examples illustrate the rules in this Q & A–7. None of the employees in the following examples are covered by a collective bargaining agreement. The examples read as follows:

Example 1. In a calendar year, Employer E offers an HDHP to its full-time employees. Most full-time employees are covered under Employer E's HDHP and Employer E makes comparable contributions only to these employees' HSAs. Employee W, a full-time employee of Employer E and an eligible individual, is covered under an HDHP provided by the employer of W's spouse and not under Employer E's HDHP. Employer E is not required to make comparable contributions to W's HSA.

Example 2. In a calendar year, Employer F does not offer an HDHP. Several full-time employees of Employer F, who are eligible individuals, have HSAs. Employer F contributes to these employees' HSAs. Employer F must make comparable contributions to the HSAs of all full-time employees who are eligible individuals.

Example 3. In a calendar year, Employer G offers an HDHP to its full-time employees. Most full-time employees are covered under Employer G's HDHP and Employer G makes comparable contributions to these employees' HSAs and also to the HSAs of full-time employees who are eligible individuals and who are not covered under Employer G's HDHP. Employee S, a full-time employee of Employer G and a comparable participating employee, is covered under an HDHP provided by the employer of S's spouse and not under Employer G's HDHP. Employer G must make comparable contributions to S's HSA.

Q–8: If an employee and his or her spouse are eligible individuals who work for the same employer and one employee-spouse has family coverage for both employees under the employer's HDHP, must the employer make comparable contributions to the HSAs of both employees?

A–8: (a) *In general*. If the employer makes contributions only to the HSAs of employees who are eligible individuals covered under its HDHP where only one employee-spouse has family coverage for both employees under the employer's HDHP, the employer is not required to contribute to the HSAs of both employee-spouses. The employer is required to contribute to the HSA of the employee-spouse with coverage under the employer's HDHP, but is not required to contribute to the HSA of the employee-spouse covered under the employer's HDHP by virtue of his or her spouse's coverage. However, if the employer contributes to the HSA of any employee who is an eligible individual with coverage under an HDHP that is not an HDHP provided by the employer, the employer must make comparable contributions to the HSAs of both employee-spouses if they are both eligible individuals. If an employer is required to contribute to the HSAs of both employee-spouses, the employer is not required to contribute amounts in excess of the annual contribution limits in section 223(b).

(b) *Examples*. The following examples illustrate the rules in paragraph (a) of this Q & A–8. None of the employees in the following examples are covered by a collective bargaining agreement. The examples read as follows:

Example 1. In a calendar year, Employer H offers an HDHP to its full-time employees. Most full-time employees are covered under Employer H's HDHP and Employer H makes comparable contributions only to these employees' HSAs. T and U are a married couple. Employee T, who is a full-time employee of Employer H and an eligible individual, has family coverage under Employer H's HDHP for T and T's spouse. Employee U, who is also a full-time employee of Employer H and an eligible individual, does not have coverage under Employer H's HDHP except as the spouse of Employee T. Employer H is required to make comparable contributions to T's HSA, but is not required to make comparable contributions to U's HSA.

Example 2. In a calendar year, Employer J offers an HDHP to its full-time employees. Most full-time employees are covered under Employer J's HDHP and Employer J makes comparable contributions to these employees' HSAs and to the HSAs of full-time employees who are eligible individuals but are not covered under Employer J's HDHP. R and S are a married couple. Employee S, who is a full-time employee of Employer J and an eligible individual, has family coverage under Employer J's HDHP for S and S's spouse. Employee R, who is also a full-time employee of Employer J and an eligible individual, does not have coverage under Employer J's HDHP except as the spouse of Employee S. Employer J must make comparable contributions to S's HSA and to R's HSA.

Q–9: Does an employer that makes HSA contributions only for one class of non-collectively bargained employees who are eligible individuals, but not for another class of non-collectively bargained employees who are eligible individuals (for example, management v. non-management) satisfy the requirement that the employer make comparable contributions?

A–9: (a) *Different classes of employees.* No. If the two classes of employees are comparable participating employees, the comparability rules are not satisfied. The only categories of employees for comparability purposes are current full-time employees, current part-time employees, and former employees. Collectively bargained employees are not comparable participating employees. But see Q & A–1 in 54.4980G–5 on contributions made through a cafeteria plan. *See* § 54.4980G–6 for a special rule for contributions made to the HSAs of nonhighly compensated employees.

(b) *Examples.* The following examples illustrate the rules in paragraph (a) of this Q & A–9. None of the employees in the following examples are covered by a collective bargaining agreement. The examples read as follows:

Example 1. In a calendar year, Employer K maintains an HDHP covering all management and non-management employees. Employer K contributes to the HSAs of non-management employees who are eligible individuals covered under its HDHP. Employer K does not contribute to the HSAs of its management employees who are eligible individuals covered under its HDHP. The comparability rules are not satisfied.

Example 2. All of Employer L's employees are located in city X and city Y. In a calendar year, Employer L maintains an HDHP for all employees working in city X only. Employer L does not maintain an HDHP for its employees working in city Y. Employer L contributes $500 to the HSAs of city X employees who are eligible individuals with coverage under its HDHP. Employer L does not contribute to the HSAs of any of its city Y employees. The comparability rules are satisfied because none of the employees in city Y are covered under an HDHP of Employer L. (However, if any employees in city Y were covered by an HDHP of Employer L, Employer L could not fail to contribute to their HSAs merely because they work in a different city.)

Example 3. Employer M has two divisions—division N and division O. In a calendar year, Employer M maintains an HDHP for employees working in division N and division O. Employer M contributes to the HSAs of division N employees who are eligible individuals with coverage under its HDHP. Employer M does not contribute to the HSAs of division O employees who are eligible individuals covered under its HDHP. The comparability rules are not satisfied.

Q–10: If an employer contributes to the HSAs of former employees who are eligible individuals, do the comparability rules apply to these contributions?

A–10: (a) *Former employees.* Yes. The comparability rules apply to contributions an employer makes to former employees' HSAs. Therefore, if an employer contributes to any former employee's HSA, it must make comparable contributions to the HSAs of all comparable participating former employees (former employees who are eligible individuals with the same category of HDHP coverage). However, an employer is not required to make comparable contributions to the HSAs of former employees with coverage under the employer's HDHP because of an election under a COBRA continuation provision (as defined in section 9832(d)(1)). See Q & A–5 and Q & A–12 of this section. The comparability rules apply separately to former employees because they are a separate category of covered employee. See Q & A–5 of this section. Also, former employees who were covered by a collective bargaining agreement immediately before termination of employment are not comparable participating employees. See Q & A–6 of this section.

(b) *Locating former employees.* An employer making comparable contributions to former employees must take reasonable actions to locate any missing comparable participating former employees. In general, such actions include the use of certified mail, the Internal Revenue Service Letter Forwarding Program or the Social Security Administration's Letter Forwarding Service.

(c) *Examples.* The following examples illustrate the rules in paragraph (a) of this Q & A–10. None of the employees in the following examples are covered by a collective bargaining agreement. The examples read as follows:

Example 1. In a calendar year, Employer N contributes $1,000 for the calendar year to

the HSA of each current employee who is an eligible individual with coverage under any HDHP. Employer N does not contribute to the HSA of any former employee who is an eligible individual. Employer N's contributions satisfy the comparability rules.

Example 2. In a calendar year, Employer O contributes to the HSAs of current employees and former employees who are eligible individuals covered under any HDHP. Employer O contributes $750 to the HSA of each current employee with self-only HDHP coverage and $1,000 to the HSA of each current employee with family HDHP coverage. Employer O also contributes $300 to the HSA of each former employee with self-only HDHP coverage and $400 to the HSA of each former employee with family HDHP coverage. Employer O's contributions satisfy the comparability rules.

Q–11: Is an employer permitted to make comparable contributions only to the HSAs of comparable participating former employees who have coverage under the employer's HDHP?

A–11: If during a calendar year, an employer contributes to the HSA of any former employee who is an eligible individual covered under an HDHP provided by the employer, the employer is required to make comparable contributions to the HSAs of all former employees who are comparable participating former employees with coverage under any HDHP provided by the employer. An employer that contributes only to the HSAs of former employees who are eligible individuals with coverage under the employer's HDHP is not required to make comparable contributions to the HSAs of former employees who are eligible individuals and who are not covered under the employer's HDHP. However, an employer that contributes to the HSA of any former employee who is an eligible individual with coverage under an HDHP that is not an HDHP of the employer, must make comparable contributions to the HSAs of all former employees who are eligible individuals whether or not covered under an HDHP of the employer.

Q–12: If an employer contributes only to the HSAs of former employees who are eligible individuals with coverage under the employer's HDHP, must the employer make comparable contributions to the HSAs of former employees who are eligible individuals with coverage under the employer's HDHP because of an election under a COBRA continuation provision (as defined in section 9832(d)(1))?

A–12: No. An employer that contributes only to the HSAs of former employees who are eligible individuals with coverage under the employer's HDHP is not required to make comparable contributions to the HSAs of former employees who are eligible individuals with coverage under the employer's HDHP because of an election under a COBRA continuation provision (as defined in section 9832(d)(1)).

Q–13: How do the comparability rules apply if some employees have HSAs and other employees have Archer MSAs?

A–13: (a) *HSAs and Archer MSAs.* The comparability rules apply separately to employees who have HSAs and employees who have Archer MSAs. However, if an employee has both an HSA and an Archer MSA, the employer may contribute to either the HSA or the Archer MSA, but not to both.

(b) *Example.* The following example illustrates the rules in paragraph (a) of this Q & A–13:

Example. In a calendar year, Employer P contributes $600 to the Archer MSA of each employee who is an eligible individual and who has an Archer MSA. Employer P contributes $500 for the calendar year to the HSA of each employee who is an eligible individual and who has an HSA. If an employee has both an Archer MSA and an HSA, Employer P contributes to the employee's Archer MSA and not to the employee's HSA. Employee X has an Archer MSA and an HSA. Employer P contributes $600 for the calendar year to X's Archer MSA but does not contribute to X's HSA. Employer P's contributions satisfy the comparability rules.

[T.D. 9277, 71 FR 43058, July 31, 2006, as amended by T.D. 9457, 74 FR 45998, Sept. 8, 2009]

§ 54.4980G–4 Calculating comparable contributions.

Q–1: What are comparable contributions?

A–1: (a) *Definition.* Contributions are comparable if, for each month in a calendar year, the contributions are either the same amount or the same percentage of the deductible under the HDHP for employees who are eligible individuals with the same category of coverage on the first day of that month. Employees with self-only

HDHP coverage are tested separately from employees with family HDHP coverage. Similarly, employees with different categories of family HDHP coverage may be tested separately. See Q & A–2 in § 54.4980G–1. An employer is not required to contribute the same amount or the same percentage of the deductible for employees who are eligible individuals with one category of HDHP coverage that it contributes for employees who are eligible individuals with a different category of HDHP coverage. For example, an employer that satisfies the comparability rules by contributing the same amount to the HSAs of all employees who are eligible individuals with family HDHP coverage is not required to contribute any amount to the HSAs of employees who are eligible individuals with self-only HDHP coverage, or to contribute the same percentage of the self-only HDHP deductible as the amount contributed with respect to family HDHP coverage. However, the contribution with respect to the self plus two category may not be less than the contribution with respect to the self plus one category and the contribution with respect to the self plus three or more category may not be less than the contribution with respect to the self plus two category. But *see* Q & A–1 of § 54.4980G–6 for a special rule for contributions made to the HSAs of nonhighly compensated employees.

(b) *Examples*. The following examples illustrate the rules in paragraph (a) of this Q & A–1. None of the employees in the following examples are covered by a collective bargaining agreement. The examples read as follows:

Example 1. In the 2007 calendar year, Employer A offers its full-time employees three health plans, including an HDHP with self-only coverage and a $2,000 deductible. Employer A contributes $1,000 for the calendar year to the HSA of each employee who is an eligible individual electing the self-only HDHP coverage. Employer A makes no HSA contributions for employees with family HDHP coverage or for employees who do not elect the employer's self-only HDHP. Employer A's HSA contributions satisfy the comparability rules.

Example 2. In the 2007 calendar year, Employer B offers its employees an HDHP with a $3,000 deductible for self-only coverage and a $4,000 deductible for family coverage. Employer B contributes $1,000 for the calendar year to the HSA of each employee who is an eligible individual electing the self-only HDHP coverage. Employer B contributes $2,000 for the calendar year to the HSA of each employee who is an eligible individual electing the family HDHP coverage. Employer B's HSA contributions satisfy the comparability rules.

Example 3. In the 2007 calendar year, Employer C offers its employees an HDHP with a $1,500 deductible for self-only coverage and a $3,000 deductible for family coverage. Employer C contributes $1,000 for the calendar year to the HSA of each employee who is an eligible individual electing the self-only HDHP coverage. Employer C contributes $1,000 for the calendar year to the HSA of each employee who is an eligible individual electing the family HDHP coverage. Employer C's HSA contributions satisfy the comparability rules.

Example 4. In the 2007 calendar year, Employer D offers its employees an HDHP with a $1,500 deductible for self-only coverage and a $3,000 deductible for family coverage. Employer D contributes $1,500 for the calendar year to the HSA of each employee who is an eligible individual electing the self-only HDHP coverage. Employer D contributes $1,000 for the calendar year to the HSA of each employee who is an eligible individual electing the family HDHP coverage. Employer D's HSA contributions satisfy the comparability rules.

Example 5. (i) In the 2007 calendar year, Employer E maintains two HDHPs. Plan A has a $2,000 deductible for self-only coverage and a $4,000 deductible for family coverage. Plan B has a $2,500 deductible for self-only coverage and a $4,500 deductible for family coverage. For the calendar year, Employer E makes contributions to the HSA of each full-time employee who is an eligible individual covered under Plan A of $600 for self-only coverage and $1,000 for family coverage. Employer E satisfies the comparability rules, if it makes either of the following contributions for the 2007 calendar year to the HSA of each full-time employee who is an eligible individual covered under Plan B—

(A) $600 for each full-time employee with self-only coverage and $1,000 for each full-time employee with family coverage; or

(B) $750 for each employee with self-only coverage and $1,125 for each employee with family coverage (the same percentage of the deductible Employer E contributes for full-time employees covered under Plan A, 30% of the deductible for self-only coverage and 25% of the deductible for family coverage).

(ii) Employer E also makes contributions to the HSA of each part-time employee who is an eligible individual covered under Plan A of $300 for self-only coverage and $500 for family coverage. Employer E satisfies the comparability rules, if it makes either of the following contributions for the 2007 calendar

year to the HSA of each part-time employee who is an eligible individual covered under Plan B—

(A) $300 for each part-time employee with self-only coverage and $500 for each part-time employee with family coverage; or

(B) $375 for each part-time employee with self-only coverage and $563 for each part-time employee with family coverage (the same percentage of the deductible Employer E contributes for part-time employees covered under Plan A, 15% of the deductible for self-only coverage and 12.5% of the deductible for family coverage).

Example 6. (i) In the 2007 calendar year, Employer F maintains an HDHP. The HDHP has the following coverage options—

(A) A $2,500 deductible for self-only coverage;

(B) A $3,500 deductible for self plus one dependent (self plus one);

(C) A $3,500 deductible for self plus spouse (self plus one);

(D) A $3,500 deductible for self plus spouse and one dependent (self plus two); and

(E) A $3,500 deductible for self plus spouse and two or more dependents (self plus three or more).

(ii) Employer F makes the following contributions for the calendar year to the HSA of each full-time employee who is an eligible individual covered under the HDHP—

(A) $750 for self-only coverage;

(B) $1,000 for self plus one dependent;

(C) $1,000 for self plus spouse;

(D) $1,500 for self plus spouse and one dependent; and

(E) $2,000 for self plus spouse and two or more dependents.

(iii) Employer F's HSA contributions satisfy the comparability rules.

Example 7. (i) In a calendar year, Employer G offers its employees an HDHP and a health flexible spending arrangement (health FSA). The health FSA reimburses employees for medical expenses as defined in section 213(d). Some of Employer G's employees have coverage under the HDHP and the health FSA, some have coverage under the HDHP and their spouse's FSA, and some have coverage under the HDHP and are enrolled in Medicare. For the calendar year, Employer G contributes $500 to the HSA of each employee who is an eligible individual. No contributions are made to the HSAs of employees who have coverage under Employer G's health FSA or under a spouse's health FSA or who are enrolled in Medicare.

(ii) The employees who have coverage under a health FSA (whether Employer H's or their spouse's FSA) or who are covered under Medicare are not eligible individuals. Specifically, the employees who have coverage under the health FSA or under a spouse's health FSA are not comparable participating employees because they are not eligible individuals under section 223(c)(1). Similarly, the employees who are enrolled in Medicare are not comparable participating employees because they are not eligible individuals under section 223(b)(7) and (c)(1). Therefore, employees who have coverage under the health FSA or under a spouse's health FSA and employees who are enrolled in Medicare are excluded from comparability testing. See sections 4980G(b) and 4980E. Employer G's contributions satisfy the comparability rules.

Q–2: How does an employer comply with the comparability rules when some non-collectively bargained employees who are eligible individuals do not work for the employer during the entire calendar year?

A–2: (a) *In general.* In determining whether the comparability rules are satisfied, an employer must take into account all full-time and part-time employees who were employees and eligible individuals for any month during the calendar year. (Full-time and part-time employees are tested separately. See Q & A–5 in § 54.4980G–3.) There are two methods to comply with the comparability rules when some employees who are eligible individuals do not work for the employer during the entire calendar year; contributions may be made on a pay-as-you-go basis or on a look-back basis. See Q & A–9 through Q & A–11 in § 54.4980G–3 for the rules regarding comparable contributions to the HSAs of former employees.

(b) *Contributions on a pay-as-you-go basis.* An employer may comply with the comparability rules by contributing amounts at one or more dates during the calendar year to the HSAs of employees who are eligible individuals as of the first day of the month, if contributions are the same amount or the same percentage of the HDHP deductible for employees who are eligible individuals as of the first day of the month with the same category of coverage and are made at the same time. Contributions made at the employer's usual payroll interval for different groups of employees are considered to be made at the same time. For example, if salaried employees are paid monthly and hourly employees are paid bi-weekly, an employer may contribute to the HSAs of hourly employees on a bi-weekly basis and to the HSAs of salaried employees on a monthly basis. An employer may change the amount

that it contributes to the HSAs of employees at any point. However, the changed contribution amounts must satisfy the comparability rules.

(c) *Examples*. The following examples illustrate the rules in paragraph (b) of this Q & A–2: The examples read as follows:

Example 1. (i) Beginning on January 1st, Employer H contributes $50 per month on the first day of each month to the HSA of each employee who is an eligible individual on that date. Employer H does not contribute to the HSAs of former employees. In mid-March of the same year, Employee X, an eligible individual, terminates employment after Employer H has contributed $150 to X's HSA. After X terminates employment, Employer H does not contribute additional amounts to X's HSA. In mid-April of the same year, Employer H hires Employee Y, an eligible individual, and contributes $50 to Y's HSA in May and $50 in June. Effective in July of the same year, Employer H stops contributing to the HSAs of all employees and makes no contributions to the HSA of any employee for the months of July through December. In August, Employer H hires Employee Z, an eligible individual. Employer H does not contribute to Z's HSA. After Z is hired, Employer H does not hire additional employees. As of the end of the calendar year, Employer H has made the following HSA contributions to its employees' HSAs—

(A) Employer H contributed $150 to X's HSA;

(B) Employer H contributed $100 to Y's HSA;

(C) Employer H did not contribute to Z's HSA; and

(D) Employer H contributed $300 to the HSA of each employee who was an eligible individual and employed by Employer J from January through June.

(ii) Employer H's contributions satisfy the comparability rules.

Example 2. In a calendar year, Employer J offers its employees an HDHP and contributes on a monthly pay-as-you-go basis to the HSAs of employees who are eligible individuals with coverage under Employer J's HDHP. In the calendar year, Employer J contributes $50 per month to the HSA of each employee with self-only HDHP coverage and $100 per month to the HSA of each employee with family HDHP coverage. From January 1st through March 31st of the calendar year, Employee X is an eligible individual with self-only HDHP coverage. From April 1st through December 31st of the calendar year, X is an eligible individual with family HDHP coverage. For the months of January, February and March of the calendar year, Employer J contributes $50 per month to X's HSA. For the remaining months of the calendar year, Employer J contributes $100 per month to X's HSA. Employer J's contributions to X's HSA satisfy the comparibility rules.

(d) *Contributions on a look-back basis*. An employer may also satisfy the comparability rules by determining comparable contributions for the calendar year at the end of the calendar year, taking into account all employees who were eligible individuals for any month during the calendar year and contributing the same percentage of the HDHP deductible or the same dollar amount to the HSAs of all employees with the same category of coverage for that month.

(e) *Examples*. The following examples illustrate the rules in paragraph (d) of this Q & A–2. The examples read as follows:

Example 1. In a calendar year, Employer K offers its employees an HDHP and contributes on a look-back basis to the HSAs of employees who are eligible individuals with coverage under Employer K's HDHP. Employer K contributes $600 ($50 per month) for the calendar year to the HSA of each employee with self-only HDHP coverage and $1,200 ($100 per month) for the calendar year to the HSA of each employee with family HDHP coverage. From January 1st through June 30th of the calendar year, Employee Y is an eligible individual with family HDHP coverage. From July 1st through December 31st, Y is an eligible individual with self-only HDHP coverage. Employer K contributes $900 on a look-back basis for the calendar year to Y's HSA ($100) per month for the months of January through June and $50 per month for the months of July through December. Employer K's contributions to Y's HSA satisfy the comparability rules.

Example 2. On December 31st, Employer L contributes $50 per month on a look-back basis to each employee's HSA for each month in the calendar year that the employee was an eligible individual. In mid-March of the same year, Employee T, an eligible individual, terminated employment. In mid-April of the same year, Employer L hired Employee U, who becomes an eligible individual as of May 1st and works for Employer L through December 31st. On December 31st, Employer L contributes $150 to Employee T's HSA and $400 to Employee U's HSA. Employer L's contributions satisfy the comparability rules.

(f) *Periods and dates for making contributions*. With both the pay-as-you-go method and the look-back method, an

employer may establish, on a reasonable and consistent basis, periods for which contributions will be made (for example, a quarterly period covering three consecutive months in a calendar year) and the dates on which such contributions will be made for that designated period (for example, the first day of the quarter or the last day of the quarter in the case of an employer who has established a quarterly period for making contributions). An employer that makes contributions on a pay-as-you-go basis for a period covering more than one month will not fail to satisfy the comparability rules because an employee who terminates employment prior to the end of the period for which contributions were made has received more contributions on a monthly basis than employees who have worked the entire period. In addition, an employer that makes contributions on a pay-as-you-go basis for a period covering more than one month must make HSA contributions for any comparable participating employees hired after the date of initial funding for that period.

(g) *Example*. The following example illustrates the rules in paragraph (f) of this Q & A–2:

Example. Employer M has established, on a reasonable and consistent basis, a quarterly period for making contributions to the HSAs of eligible employees on a pay-as-you-go basis. Beginning on January 1st, Employer M contributes $150 for the first three months of the calendar year to the HSA of each employee who is an eligible individual on that date. On January 15th, Employee V, an eligible individual, terminated employment after Employer M has contributed $150 to V's HSA. On January 15th, Employer M hired Employee W, who becomes an eligible individual as of February 1st. On April 1st, Employer M has contributed $100 to W's HSA for the two months (February and March) in the quarter period that Employee W was an eligible employee. Employer M's contributions satisfy the comparability rules.

(h) *Maximum contribution permitted for all employees who are eligible individuals during the last month of the taxable year*. An employer may contribute up to the maximum annual contribution amount for the calendar year (based on the employees' HDHP coverage) to the HSAs of all employees who are eligible individuals on the first day of the last month of the employees' taxable year, including employees who worked for the employer for less than the entire calendar year and employees who became eligible individuals after January 1st of the calendar year. For example, such contribution may be made on behalf of an eligible individual who is hired after January 1st or an employee who becomes an eligible individual after January 1st. Employers are not required to provide more than a pro-rata contribution based on the number of months that an individual was an eligible individual and employed by the employer during the year. However, if an employer contributes more than a pro-rata amount for the calendar year to the HSA of any eligible individual who is hired after January 1st of the calendar year or any employee who becomes an eligible individual any time after January 1st of the calendar year, the employer must contribute that same amount on an equal and uniform basis to the HSAs of all comparable participating employees (as defined in Q & A–1 in § 54.4980G–1) who are hired or become eligible individuals after January 1st of the calendar year. Likewise, if an employer contributes the maximum annual contribution amount for the calendar year to the HSA of any eligible individual who is hired after January 1st of the calendar year or any employee who becomes an eligible individual any time after January 1st of the calendar year, the employer must contribute the maximum annual contribution amount on an equal and uniform basis to the HSAs of all comparable participating employees (as defined in Q & A–1 in § 54.4980G–1) who are hired or become eligible individuals after January 1st of the calendar year. An employer who makes the maximum calendar year contribution or more than a pro-rata contribution to the HSAs of employees who become eligible individuals after the first day of the calendar year or eligible individuals who are hired after the first day of the calendar year will not fail to satisfy comparability merely because some employees will have received more contributions on a monthly basis than employees who worked the entire calendar year.

(i) *Examples*. The following examples illustrate the rules in paragraph (h) in this Q & A–2. In the following examples, no contributions are made through a section 125 cafeteria plan and none of the employees are covered by a collective bargaining agreement.

Example 1. On January 1, 2010, Employer Q contributes $1,000 for the calendar year to the HSAs of employees who are eligible individuals with family HDHP coverage. In mid-March of the same year, Employer Q hires Employee A, an eligible individual with family HDHP coverage. On April 1, 2010, Employer Q contributes $1,000 to the HSA of Employee A. In September of the same year, Employee B becomes an eligible individual with family HDHP coverage. On October 1, 2010, Employer G contributes $1,000 to the HSA of Employee B. Employer Q does not make any other contributions for the 2010 calendar year. Employer Q's contributions satisfy the comparability rules.

Example 2. For the 2010 calendar year, Employer R only has two employees, Employee C and Employee D. Employee C, an eligible individual with family HDHP coverage, works for Employer R for the entire calendar year. Employee D, an eligible individual with family HDHP coverage works for Employer R from July 1st through December 31st. Employer R contributes $1,200 for the calendar year to the HSA of Employee C and $600 to the HSA of Employee D. Employer R does not make any other contributions for the 2010 calendar year. Employer R's contributions satisfy the comparability rules.

(j) *Effective/applicability date*. The rules in paragraphs (h) and (i) of Q & A–2 are effective for employer contributions made for calendar years beginning on or after January 1, 2010.

Q–3: How do the comparability rules apply to employer contributions to employees' HSAs if some non-collectively bargained employees work full-time during the entire calendar year, and other non-collectively bargained employees work full-time for less than the entire calendar year?

A–3: Employer contributions to the HSAs of employees who work full-time for less than twelve months satisfy the comparability rules if the contribution amount is comparable when determined on a month-to-month basis. For example, if the employer contributes $240 to the HSA of each full-time employee who works the entire calendar year, the employer must contribute $60 to the HSA of each full-time employee who works on the first day of each three months of the calendar year. The rules set forth in this Q & A–2 apply to employer contributions made on a pay-as-you-go basis or on a look-back basis as described in Q & A–3 of this section. See sections 4980G(b) and 4980E(d)(2)(B).

Q–4: May an employer make contributions for the entire year to the HSAs of its employees who are eligible individuals at the beginning of the calendar year (on a pre-funded basis) instead of contributing on a pay-as-you-go or on a look-back basis?

A–4: (a) *Contributions on a pre-funded basis*. Yes. An employer may make contributions for the entire year to the HSAs of its employees who are eligible individuals at the beginning of the calendar year. An employer that pre-funds the HSAs of its employees will not fail to satisfy the comparability rules because an employee who terminates employment prior to the end of the calendar year has received more contributions on a monthly basis than employees who work the entire calendar year. See Q & A–12 of this section. Under section 223(d)(1)(E), an account beneficiary's interest in an HSA is nonforfeitable. An employer must make comparable contributions for all employees who are comparable participating employees for any month during the calendar year, including employees who are eligible individuals hired after the date of initial funding. An employer that makes HSA contributions on a pre-funded basis may also contribute on a pre-funded basis to the HSAs of employees who are eligible individuals hired after the date of initial funding. Alternatively, an employer that has pre-funded the HSAs of comparable participating employees may contribute to the HSAs of employees who are eligible individuals hired after the date of initial funding on a pay-as-you-go basis or on a look-back basis. An employer that makes HSA contributions on a pre-funded basis must use the same contribution method for all employees who are eligible individuals hired after the date of initial funding.

(b) *Example*. The following example illustrates the rules in paragraph (a) of this Q & A–4:

Example. (i) On January 1, Employer N contributes $1,200 for the calendar year on a prefunded basis to the HSA of each employee who is an eligible individual. In mid-May, Employer N hires Employee B, who becomes an eligible individual as of June 1st. Therefore, Employer N is required to make comparable contributions to B's HSA beginning in June. Employer N satisfies the comparability rules with respect to contributions to B's HSA if it makes HSA contributions in any one of the following ways—

(A) Pre-funding B's HSA by contributing $700 to B's HSA;

(B) Contributing $100 per month on a pay-as-you-go basis to B's HSA; or

(C) Contributing to B's HSA at the end of the calendar year taking into account each month that B was an eligible individual and employed by Employer M.

(ii) If Employer M hires additional employees who are eligible individuals after initial funding, it must use the same contribution method for these employees that it used to contribute to B's HSA.

Q–5: Must an employer use the same contribution method as described in Q & A–2 and Q & A–4 of this section for all employees who were comparable participating employees for any month during the calendar year?

A–5: Yes. If an employer makes comparable HSA contributions on a pay-as-you-go basis, it must do so for each employee who is a comparable participating employee as of the first day of the month. If an employer makes comparable contributions on a look-back basis, it must do so for each employee who was a comparable participating employee for any month during the calendar year. If an employer makes HSA contributions on a pre-funded basis, it must do so for all employees who are comparable participating employees at the beginning of the calendar year and must make comparable HSA contributions for all employees who are comparable participating employees for any month during the calendar year, including employees who are eligible individuals hired after the date of initial funding. See Q & A–4 of this section for rules regarding contributions for employees hired after initial funding.

Q–6: How does an employer comply with the comparability rules if an employee has not established an HSA at the time the employer contributes to its employees' HSAs?

A–6: (a) *Employee has not established an HSA at the time the employer funds its employees' HSAs*. If an employee has not established an HSA at the time the employer funds its employees' HSAs, the employer complies with the comparability rules by contributing comparable amounts plus reasonable interest to the employee's HSA when the employee establishes the HSA, taking into account each month that the employee was a comparable participating employee. See Q & A–13 of this section for rules regarding reasonable interest.

(b) *Example*. The following example illustrates the rules in paragraph (a) of this Q & A–6:

Example. Beginning on January 1st, Employer O contributes $500 per calendar year on a pay-as-you-go basis to the HSA of each employee who is an eligible individual. Employee C is an eligible individual during the entire calendar year but does not establish an HSA until March. Notwithstanding C's delay in establishing an HSA, Employer O must make up the missed HSA contributions plus reasonable interest for January and February by April 15th of the following calendar year.

Q–7: If an employer bases its contributions on a percentage of the HDHP deductible, how is the correct percentage or dollar amount computed?

A–7: (a) *Computing HSA contributions*. The correct percentage is determined by rounding to the nearest 1/100th of a percentage point and the dollar amount is determined by rounding to the nearest whole dollar.

(b) *Example*. The following example illustrates the rules in paragraph (a) of this Q & A–7:

Example. In this *Example*, assume that each HDHP provided by Employer P satisfies the definition of an HDHP for the 2007 calendar year. In the 2007 calendar year, Employer P maintains two HDHPs. Plan A has a deductible of $3,000 for self-only coverage. Employer P contributes $1,000 for the calendar year to the HSA of each employee covered under Plan A. Plan B has a deductible of $3,500 for self-only coverage. Employer P satisfies the comparability rules if it makes either of the following contributions for the 2007 calendar year to the HSA of each employee who is an eligible individual with self-only coverage under Plan B—

(i) $1,000; or

(ii) $1,167 (33.33% of the deductible rounded to the nearest whole dollar amount).

Q–8: Does an employer that contributes to the HSA of each comparable participating employee in an amount equal to the employee's HSA contribution or a percentage of the employee's HSA contribution (matching contributions) satisfy the rule that all comparable participating employees receive comparable contributions?

A–8: No. If all comparable participating employees do not contribute the same amount to their HSAs and, consequently, do not receive comparable contributions to their HSAs, the comparability rules are not satisfied, notwithstanding that the employer offers to make available the same contribution amount to each comparable participating employee. But see Q & A–1 in § 54.4980G–5 on contributions to HSAs made through a cafeteria plan.

Q–9: If an employer conditions contributions by the employer to an employee's HSA on an employee's participation in health assessments, disease management programs or wellness programs and makes the same contributions available to all employees who participate in the programs, do the contributions satisfy the comparability rules?

A–9: No. If all comparable participating employees do not elect to participate in all the programs and consequently, all comparable participating employees do not receive comparable contributions to their HSAs, the employer contributions fail to satisfy the comparability rules. But see Q & A–1 in § 54.4980G–5 on contributions made to HSAs through a cafeteria plan.

Q–10: If an employer makes additional contributions to the HSAs of all comparable participating employees who have attained a specified age or who have worked for the employer for a specified number of years, do the contributions satisfy the comparability rules?

A–10: No. If all comparable participating employees do not meet the age or length of service requirement, all comparable participating employees do not receive comparable contributions to their HSAs and the employer contributions fail to satisfy the comparability rules.

Q–11: If an employer makes additional contributions to the HSAs of all comparable participating employees who are eligible to make the additional contributions (HSA catch-up contributions) under section 223(b)(3), do the contributions satisfy the comparability rules?

A–11: No. If all comparable participating employees are not eligible to make the additional HSA contributions under section 223(b)(3), all comparable participating employees do not receive comparable contributions to their HSAs, and the employer contributions fail to satisfy the comparability rules.

Q–12: If an employer's contributions to an employee's HSA result in noncomparable contributions, may the employer recoup the excess amount from the employee's HSA?

A–12: No. An employer may not recoup from an employee's HSA any portion of the employer's contribution to the employee's HSA. Under section 223(d)(1)(E), an account beneficiary's interest in an HSA is nonforfeitable. However, an employer may make additional HSA contributions to satisfy the comparability rules. An employer may contribute up until April 15th following the calendar year in which the noncomparable contributions were made. An employer that makes additional HSA contributions to correct non-comparable contributions must also contribute reasonable interest. However, an employer is not required to contribute amounts in excess of the annual contribution limits in section 223(b). See Q & A–13 of this section for rules regarding reasonable interest.

Q–13: What constitutes a reasonable interest rate for purposes of making comparable contributions?

A–13: The determination of whether a rate of interest used by an employer is reasonable will be based on all of the facts and circumstances. If an employer calculates interest using the Federal short-term rate as determined by the Secretary in accordance with section 1274(d), the employer is deemed to use a reasonable interest rate.

Q–14: Does an employer fail to satisfy the comparability rules for a calendar year if the employer fails to make contributions with respect to eligible employees because the employee has not

established an HSA or because the employer does not know that the employee has established an HSA?

A–14: (a) *In general*. An employer will not fail to satisfy the comparability rules for a calendar year (Year 1) merely because the employer fails to make contributions with respect to an eligible employee because the employee has not established an HSA or because the employer does not know that the employee has established an HSA, if—

(1) The employer provides timely written notice to all such eligible employees that it will make comparable contributions for Year 1 for eligible employees who, by the last day of February of the following calendar year (Year 2), both establish an HSA and notify the employer (in accordance with a procedure specified in the notice) that they have established an HSA; and

(2) For each such eligible employee who establishes an HSA and so notifies the employer on or before the last day of February of Year 2, the employer contributes to the HSA for Year 1 comparable amounts (taking into account each month that the employee was a comparable participating employee) plus reasonable interest by April 15th of Year 2.

(b) *Notice*. The notice described in paragraph (a) of this Q & A–14 must be provided to each eligible employee who has not established an HSA by December 31 of Year 1 or if the employer does not know if the employee established an HSA. The employer may provide the notice to other employees as well. However, if an employee has earlier notified the employer that he or she has established an HSA, or if the employer has previously made contributions to that employee's HSA, the employer may not condition making comparable contributions on receipt of any additional notice from that employee. For each calendar year, a notice is deemed to be timely if the employer provides the notice no earlier than 90 days before the first HSA employer contribution for that calendar year and no later than January 15 of the following calendar year.

(c) *Model notice*. Employers may use the following sample language as a basis in preparing their own notices.

Notice to Employees Regarding Employer Contributions to HSAs:

This notice explains how you may be eligible to receive contributions from [employer] if you are covered by a High Deductible Health Plan (HDHP). [Employer] provides contributions to the Health Savings Account (HSA) of each employee who is [insert employer's eligibility requirements for HSA contributions] (''eligible employee''). If you are an eligible employee, you must do the following in order to receive an employer contribution:

(1) Establish an HSA on or before the last day in February of [insert year after the year for which the contribution is being made] and;

(2) Notify [insert name and contact information for appropriate person to be contacted] of your HSA account information on or before the last day in February of [insert year after year for which the contribution is being made]. [Specify the HSA account information that the employee must provide (e.g., account number, name and address of trustee or custodian, etc.) and the method by which the employee must provide this account information (e.g., in writing, by e-mail, on a certain form, etc.)].

If you establish your HSA on or before the last day of February in [insert year after year for which the contribution is being made] and notify [employer] of your HSA account information, you will receive your HSA contributions, plus reasonable interest, for [insert year for which contribution is being made] by April 15 of [insert year after year for which contribution is being made]. If, however, you do not establish your HSA or you do not notify us of your HSA account information by the deadline, then we are not required to make any contributions to your HSA for [insert applicable year]. You may notify us that you have established an HSA by sending an [e-mail or] a written notice to [insert name, title and, if applicable, e-mail address]. If you have any questions about this notice, you can contact [insert name and title] at [insert telephone number or other contact information].

(d) [Reserved]

(e) *Electronic delivery*. An employer may furnish the notice required under this section electronically in accordance with § 1.401(a)-21 of this chapter.

(f) *Examples*. The following examples illustrate the rules in this Q & A–14:

Example 1. In a calendar year, Employer Q contributes to the HSAs of current employees who are eligible individuals covered under any HDHP. For the 2009 calendar year, Employer Q contributes $50 per month on the first day of each month, beginning January 1st, to the HSA of each employee who is an eligible employee on that date. For the 2009

calendar year, Employer Q provides written notice satisfying the content requirements of this Q & A–14 on October 16, 2008 to all employees regarding the availability of HSA contributions for eligible employees. For eligible employees who are hired after October 16, 2008, Employer Q provides such a notice no later than January 15, 2010. Employer Q's notice satisfies the notice timing requirements in paragraph (a)(1) of this Q & A–14.

Example 2. Employer R's written cafeteria plan permits employees to elect to make pre-tax salary reduction contributions to their HSAs. Employees making this election have the right to receive cash or other taxable benefits in lieu of their HSA pre-tax contribution. Employer R automatically contributes a non-elective matching contribution to the HSA of each employee who makes a pre-tax HSA contribution. Because Employer R's HSA contributions are made through the cafeteria plan, the comparability requirements do not apply to the HSA contributions made by Employer R. Consequently, Employer R is not required to provide written notice to its employees regarding the availability of this matching HSA contribution. See Q & A–1 in § 54.4980G–5 for treatment of HSA contributions made through a cafeteria plan.

Example 3. In a calendar year, Employer S maintains an HDHP and only contributes to the HSAs of eligible employees who elect coverage under its HDHP. For the 2009 calendar year, Employer S employs ten eligible employees and all ten employees have elected coverage under Employer S's HDHP and have established HSAs. For the 2009 calendar year, Employer S makes comparable contributions to the HSAs of all ten employees. Employer S satisfies the comparability rules. Thus, Employer S is not required to provide written notice to its employees regarding the availability of HSA contributions for eligible employees.

Example 4. In a calendar year, Employer T contributes to the HSAs of current full-time employees with family coverage under any HDHP. For the 2009 calendar year, Employer T provides timely written notice satisfying the content requirements of this section to all employees regardless of HDHP coverage. Employer T makes identical monthly contributions to all eligible employees (meaning full time employees with family HDHP coverage) that establish HSAs. Employer T contributes comparable amounts (taking into account each month that the employee was a comparable participating employee) plus reasonable interest to the HSAs of the eligible employees that establish HSAs and provide the necessary information after the end of the year but on or before the last day of February, 2010. Employer T makes no contribution to the HSAs of employees that do not establish an HSA or that do not provide the necessary information on or before the last day of February, 2010. Employer T satisfies the comparability requirements.

Example 5. For the 2009 calendar year, Employer V contributes to the HSAs of current full time employees with family coverage under any HDHP. Employer V has 500 current full time employees. As of the date for Employer V's first HSA contribution for the 2009 calendar year, 450 eligible employees have established HSAs. Employer V provides timely written notice satisfying the content requirements of this section only to those 50 eligible employees who have not established HSAs. Employer V makes identical quarterly contributions to the 450 eligible employees who established HSAs. By April 15, 2010, Employer V contributes comparable amounts to the other eligible employees who establish HSAs and provide the necessary information on or before the last day of February, 2010. Employer V makes no contribution to the HSAs of eligible employees that do not establish an HSA or that do not provide the necessary information on or before the last day of February, 2010. Employer V satisfies the comparability rules.

Q–15: For any calendar year, may an employer accelerate part or all of its contributions for the entire year to the HSAs of employees who have incurred, during the calendar year, qualified medical expenses (as defined in section 223(d)(2)) exceeding the employer's cumulative HSA contributions at that time?

A–15: (a) *In general.* Yes. For any calendar year, an employer may accelerate part or all of its contributions for the entire year to the HSAs of employees who have incurred, during the calendar year, qualified medical expenses exceeding the employer's cumulative HSA contributions at that time. If an employer accelerates contributions to the HSA of any such eligible employee, all accelerated contributions must be available throughout the calendar year on an equal and uniform basis to all such eligible employees. Employers must establish reasonable uniform methods and requirements for accelerated contributions and the determination of medical expenses.

(b) *Satisfying comparability.* An employer that accelerates contributions to the HSAs of its employees will not fail to satisfy the comparability rules because employees who incur qualifying medical expenses exceeding the employer's cumulative HSA contributions at that time have received more contributions in a given period than

comparable employees who do not incur such expenses, provided that all comparable employees receive the same amount or the same percentage for the calendar year. Also, an employer that accelerates contributions to the HSAs of its employees will not fail to satisfy the comparability rules because an employee who terminates employment prior to the end of the calendar year has received more contributions on a monthly basis than employees who work the entire calendar year. An employer is not required to contribute reasonable interest on either accelerated or non-accelerated HSA contributions. But see Q & A–6 and Q & A–12 of this section for when reasonable interest must be paid.

Q–16: What is the effective date for the rules in Q & A–14 and Q & A–15 of this section?

A–16: These regulations apply to employer contributions made for calendar years beginning on or after January 1, 2009.

[T.D. 9277, 71 FR 43058, July 31, 2006; 71 FR 53967, Sept. 13, 2006, as amended by T.D. 9393, 73 FR 20795, Apr. 17, 2008; T.D. 9457, 74 FR 45998, Sept. 8, 2009]

§ 54.4980G–5 HSA comparability rules and cafeteria plans and waiver of excise tax.

Q–1: If an employer makes contributions through a section 125 cafeteria plan to the HSA of each employee who is an eligible individual, are the contributions subject to the comparability rules?

A–1: (a) *In general.* No. The comparability rules do not apply to HSA contributions that an employer makes through a section 125 cafeteria plan. However, contributions to an HSA made through a cafeteria plan are subject to the section 125 nondiscrimination rules (eligibility rules, contributions and benefits tests and key employee concentration tests). See section 125(b), (c) and (g) and the regulations thereunder.

(b) *Contributions made through a section 125 cafeteria plan.* Employer contributions to employees' HSAs are made through a section 125 cafeteria plan and are subject to the section 125 cafeteria plan nondiscrimination rules and not the comparability rules if under the written cafeteria plan, the employees have the right to elect to receive cash or other taxable benefits in lieu of all or a portion of an HSA contribution (meaning that all or a portion of the HSA contributions are available as pre-tax salary reduction amounts), regardless of whether an employee actually elects to contribute any amount to the HSA by salary reduction.

Q–2: If an employer makes contributions through a cafeteria plan to the HSA of each employee who is an eligible individual in an amount equal to the amount of the employee's HSA contribution or a percentage of the amount of the employee's HSA contribution (matching contributions), are the contributions subject to the section 4980G comparability rules?

A–2: No. The comparability rules do not apply to HSA contributions that an employer makes through a section 125 cafeteria plan. Thus, where matching contributions are made by an employer through a cafeteria plan, the contributions are not subject to the comparability rules of section 4980G. However, contributions, including matching contributions, to an HSA made under a cafeteria plan are subject to the section 125 nondiscrimination rules (eligibility rules, contributions and benefits tests and key employee concentration tests). See Q & A–1 of this section.

Q–3: If under the employer's cafeteria plan, employees who are eligible individuals and who participate in health assessments, disease management programs or wellness programs receive an employer contribution to an HSA and the employees have the right to elect to make pre-tax salary reduction contributions to their HSAs, are the contributions subject to the comparability rules?

A–3: (a) *In general.* No. The comparability rules do not apply to employer contributions to an HSA made through a cafeteria plan. See Q & A–1 of this section.

(b) *Examples.* The following examples illustrate the rules in this § 54.4980G–5. The examples read as follows:

Example 1. Employer A's written cafeteria plan permits employees to elect to make pre-tax salary reduction contributions to their

HSAs. Employees making this election have the right to receive cash or other taxable benefits in lieu of their HSA pre-tax contribution. The section 125 cafeteria plan nondiscrimination rules and not the comparability rules apply because the HSA contributions are made through the cafeteria plan.

Example 2. Employer B's written cafeteria plan permits employees to elect to make pre-tax salary reduction contributions to their HSAs. Employees making this election have the right to receive cash or other taxable benefits in lieu of their HSA pre-tax contribution. Employer B automatically contributes a non-elective matching contribution or seed money to the HSA of each employee who makes a pre-tax HSA contribution. The section 125 cafeteria plan nondiscrimination rules and not the comparability rules apply to Employer B's HSA contributions because the HSA contributions are made through the cafeteria plan.

Example 3. Employer C's written cafeteria plan permits employees to elect to make pre-tax salary reduction contributions to their HSAs. Employees making this election have the right to receive cash or other taxable benefits in lieu of their HSA pre-tax contribution. Employer C makes a non-elective contribution to the HSAs of all employees who complete a health risk assessment and participate in Employer C's wellness program. Employees do not have the right to receive cash or other taxable benefits in lieu of Employer C's non-elective contribution. The section 125 cafeteria plan nondiscrimination rules and not the comparability rules apply to Employer C's HSA contributions because the HSA contributions are made through the cafeteria plan.

Example 4. Employer D's written cafeteria plan permits employees to elect to make pre-tax salary reduction contributions to their HSAs. Employees making this election have the right to receive cash or other taxable benefits in lieu of their HSA pre-tax contribution. Employees participating in the plan who are eligible individuals receive automatic employer contributions to their HSAs. Employees make no election with respect to Employer D's contribution and do not have the right to receive cash or other taxable benefits in lieu of Employer D's contribution but are permitted to make their own pre-tax salary reduction contributions to fund their HSAs. The section 125 cafeteria plan nondiscrimination rules and not the comparability rules apply to Employer D's HSA contributions because the HSA contributions are made through the cafeteria plan.

Q–4: May all or part of the excise tax imposed under section 4980G be waived?

A–4: In the case of a failure which is due to reasonable cause and not to willful neglect, all or a portion of the excise tax imposed under section 4980G may be waived to the extent that the payment of the tax would be excessive relative to the failure involved. See sections 4980G(b) and 4980E(c).

[T.D. 9277, 71 FR 43058, July 31, 2006]

§ 54.4980G–6 Special rule for contributions made to the HSAs of nonhighly compensated employees.

Q–1: May an employer make larger contributions to the HSAs of nonhighly compensated employees than to the HSAs of highly compensated employees?

A–1: Yes. Employers may make larger HSA contributions for nonhighly compensated employees who are comparable participating employees than for highly compensated employees who are comparable participating employees. *See* Q & A–1 in § 54.4980G–1 for the definition of comparable participating employee. For purposes of this section, highly compensated employee is defined under section 414(q). Nonhighly compensated employees are employees that are not highly compensated employees. The comparability rules continue to apply with respect to contributions to the HSAs of all nonhighly compensated employees. Employers must make comparable contributions for the calendar year to the HSA of each nonhighly compensated employee who is a comparable participating employee.

Q–2: May an employer make larger contributions to the HSAs of highly compensated employees than to the HSAs of nonhighly compensated employees?

A–2: (a) *In general.* No. Employer contributions to HSAs for highly compensated employees who are comparable participating employees may not be larger than employer HSA contributions for nonhighly compensated employees who are comparable participating employees. The comparability rules continue to apply with respect to contributions to the HSAs of all highly compensated employees. Employers must make comparable contributions for the calendar year to the HSA of each highly compensated comparable participating employee. *See* Q & A–1 in

§ 54.4980G–1 for the definition of comparable participating employee.

(b) *Examples*. The following examples illustrate the rules in Q & A–1 and Q & A–2 of this section. No contributions are made through a section 125 cafeteria plan and none of the employees in the following examples are covered by a collective bargaining agreement. All of the employees in the following examples have the same HDHP deductible for the same category of coverage.

Example 1. In 2010, Employer A contributes $1,000 for the calendar year to the HSA of each full-time nonhighly compensated employee who is an eligible individual with self-only HDHP coverage. Employer A makes no contribution to the HSA of any full-time highly compensated employee who is an eligible individual with self-only HDHP coverage. Employer A's HSA contributions for calendar year 2010 satisfy the comparability rules.

Example 2. In 2010, Employer B contributes $2,000 for the calendar year to the HSA of each full-time nonhighly compensated employee who is an eligible individual with self-only HDHP coverage. Employer B also contributes $1,000 for the calendar year to the HSA of each full-time highly compensated employee who is an eligible individual with self-only HDHP coverage. Employer B's HSA contributions for calendar year 2010 satisfy the comparability rules.

Example 3. In 2010, Employer C contributes $1,000 for the calendar year to the HSA of each full-time nonhighly compensated employee who is an eligible individual with self-only HDHP coverage. Employer C contributes $2,000 for the calendar year to the HSA of each full-time highly compensated employee who is an eligible individual with self-only HDHP coverage. Employer C's HSA contributions for calendar year 2010 do not satisfy the comparability rules.

Example 4. In 2010, Employer D contributes $1,000 for the calendar year to the HSA of each full-time nonhighly compensated employee who is an eligible individual with self-only HDHP coverage. Employer D also contributes $1,000 to the HSA of each full-time highly compensated employee who is an eligible individual with self-only HDHP coverage. In addition, the employer contributes an additional $500 to the HSA of each nonhighly compensated employee who participates in a wellness program. The nonhighly compensated employees did not receive comparable contributions, and, therefore, Employer D's HSA contributions for calendar year 2010 do not satisfy the comparability rules.

Example 5. In 2010, Employer E contributes $1,000 for the calendar year to the HSA of each full-time non-management nonhighly compensated employee who is an eligible individual with family HDHP coverage. Employer E also contributes $500 for the calendar year to the HSA of each full-time management nonhighly compensated employee who is an eligible individual with family HDHP coverage. The nonhighly compensated employees did not receive comparable contributions, and, therefore, Employer E's HSA contributions for calendar year 2010 do not satisfy the comparability rules.

Q–3: May an employer make larger HSA contributions for employees with self plus two HDHP coverage than employees with self plus one HDHP coverage even if the employees with self plus two are all highly compensated employees and the employees with self plus one are all nonhighly compensated employees?

A–3: (a) Yes. Q & A–1 in § 54.4980G–4 provides that an employer's contribution with respect to the self plus two category of HDHP coverage may not be less than the contribution with respect to the self plus one category and the contribution with respect to the self plus three or more category may not be less than the contribution with respect to the self plus two category. Therefore, the comparability rules are not violated if an employer makes a larger HSA contribution for the self plus two category of HDHP coverage than to self plus one coverage, even if the employees with self plus two coverage are all highly compensated employees and the employees with self plus one coverage are all nonhighly compensated employees. Likewise, the comparability rules are not violated if an employer makes a larger HSA contribution for the self plus three category of HDHP coverage than to self plus two coverage, even if the employees with self plus three coverage are all highly compensated employees and the employees with self plus two coverage are all nonhighly compensated employees.

(b) *Example*. The following example illustrates the rules in paragraph (a) of this Q & A–3. In the following example, no contributions are made through a section 125 cafeteria plan and none of the employees are covered by a collective bargaining agreement.

Example. In 2010, Employer F contributes $1,000 for the calendar year to the HSA of each full-time employee who is an eligible individual with self plus one HDHP coverage.

Employer F contributes $1,500 for the calendar year to the HSA of each employee who is an eligible individual with self plus two HDHP coverage. The deductible for both the self plus one HDHP and the self plus two HDHP is $2,000. Employee A, an eligible individual, is a nonhighly compensated employee with self plus one coverage. Employee B, an eligible individual, is a highly compensated employee with self plus two coverage. For the 2010 calendar year, Employer F contributes $1,000 to Employee A's HSA and $1,500 to Employee B's HSA. Employer F's HSA contributions satisfy the comparability rules.

Q–4:What is the effective date for the rules in this section?

A–4: The rules in this section are effective for employer contributions made for calendar years beginning on or after January 1, 2010.

[T.D. 9457, 74 FR 45998, Sept. 8, 2009]

§ 54.4980G–7 Special comparability rules for qualified HSA distributions contributed to HSAs on or after December 20, 2006 and before January 1, 2012.

Q–1 How do the comparability rules of section 4980G apply to qualified HSA distributions under section 106(e)(2)?

A–1:The comparability rules of section 4980G do not apply to amounts contributed to employee HSAs through qualified HSA distributions. However, in order to satisfy the comparability rules, if an employer offers qualified HSA distributions, as defined in section 106(e)(2), to any employee who is an eligible individual covered under any HDHP, the employer must offer qualified HSA distributions to all employees who are eligible individuals covered under any HDHP. However, if an employer offers qualified HSA distributions only to employees who are eligible individuals covered under the employer's HDHP, the employer is not required to offer qualified HSA distributions to employees who are eligible individuals but are not covered under the employer's HDHP.

Q–2: What is the effective date for the rules in this section?

A–2: The rules in this section are effective for are effective for employer contributions made for calendar years beginning on or after January 1, 2010.

[T.D. 9457, 74 FR 45999, Sept. 8, 2009]

§ 54.4980H–0 Table of contents.

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[T.D. 9655, 79 FR 8577, Feb. 12, 2014]

§ 54.4980H–1 Definitions.

(a) *Definitions*. The definitions in this section apply only for purposes of this section and §§ 54.4980H–2 through 54.4980H–6.

(1) *Administrative period*. The term *administrative period* means an optional period, selected by an applicable large employer member, of no longer than 90 days beginning immediately following the end of a measurement period and ending immediately before the start of the associated stability period. The administrative period also includes the period between a new employee's start date and the beginning of the initial measurement period, if the initial measurement period does not begin on the employee's start date.

(2) *Advance credit payment*. The term *advance credit payment* means an advance payment of the premium tax credit as provided in Affordable Care Act section 1412 (42 U.S.C. 18082).

(3) *Affordable Care Act*. The term *Affordable Care Act* means the Patient Protection and Affordable Care Act,

Public Law 111–148 (124 Stat. 119 (2010)), and the Health Care and Education Reconciliation Act of 2010, Public Law 111–152 (124 Stat. 1029 (2010)), as amended by the Medicare and Medicaid Extenders Act of 2010, Public Law 111–309 (124 Stat. 3285 (2010)), the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011, Public Law 112–9 (125 Stat. 36 (2011)), the Department of Defense and Full-Year Continuing Appropriations Act, 2011, Public Law 112–10 (125 Stat. 38 (2011)), and the 3% Withholding Repeal and Job Creation Act, Public Law 112–56 (125 Stat. 711 (2011)).

(4) *Applicable large employer*. The term *applicable large employer* means, with respect to a calendar year, an employer that employed an average of at least 50 full-time employees (including full-time equivalent employees) on business days during the preceding calendar year. For rules relating to the determination of applicable large employer status, see § 54.4980H–2.

(5) *Applicable large employer member*. The term *applicable large employer member* means a person that, together with one or more other persons, is treated as a single employer that is an applicable large employer. For this purpose, if a person, together with one or more other persons, is treated as a single employer that is an applicable large employer on any day of a calendar month, that person is an applicable large employer member for that calendar month. If the applicable large employer comprises one person, that one person is the applicable large employer member. An applicable large employer member does not include a person that is not an employer or only an employer of employees with no hours of service for the calendar year. For rules for government entities, and churches, or conventions or associations of churches, see § 54.4980H–2(b)(4).

(6) *Applicable premium tax credit*. The term *applicable premium tax credit* means any premium tax credit that is allowed or paid under section 36B and any advance payment of such credit.

(7) *Bona fide volunteer*. The term *bona fide volunteer* means an employee of a government entity or an organization described in section 501(c) that is exempt from taxation under section 501(a) whose only compensation from that entity or organization is in the form of—

(i) Reimbursement for (or reasonable allowance for) reasonable expenses incurred in the performance of services by volunteers, or

(ii) Reasonable benefits (including length of service awards), and nominal fees, customarily paid by similar entities in connection with the performance of services by volunteers.

(8) *Calendar month*. The term *calendar month* means one of the 12 full months named in the calendar, such as January, February, or March.

(9) *Church or a convention or association of churches*. The term *church or a convention or association of churches* has the same meaning as provided in § 1.170A–9(b).

(10) *Collective bargaining agreement*. The term *collective bargaining agreement* means an agreement that the Secretary of Labor determines to be a collective bargaining agreement, provided that the health benefits provided under the collective bargaining agreement are the subject of good faith bargaining between employee representatives and one or more employers, and the agreement between employee representatives and one or more employers satisfies section 7701(a)(46).

(11) *Cost-sharing reduction*. The term *cost-sharing reduction* means a cost-sharing reduction and any advance payment of the reduction as defined under section 1402 of the Affordable Care Act and 45 CFR 155.20.

(12) *Dependent*. The term *dependent* means a child (as defined in section 152(f)(1) but excluding a stepson, stepdaughter or an eligible foster child (and excluding any individual who is excluded from the definition of dependent under section 152 by operation of section 152(b)(3))) of an employee who has not attained age 26. A child attains age 26 on the 26th anniversary of the date the child was born. A child is a dependent for purposes of section 4980H for the entire calendar month during which he or she attains age 26. Absent knowledge to the contrary, applicable large employer members may rely on an employee's representation about that employee's children and the ages of those children. The term *dependent*

does not include the spouse of an employee.

(13) *Educational organization*. The term *educational organization* means an entity described in § 1.170A–9(c)(1), whether or not described in section 501(c)(3) and tax-exempt under section 501(a). Thus, the term *educational organization* includes taxable entities, tax-exempt entities and government entities.

(14) *Eligible employer-sponsored plan*. The term *eligible employer-sponsored plan* has the same meaning as provided under section 5000A(f)(2) and the regulations thereunder and any other applicable guidance.

(15) *Employee*. The term *employee* means an individual who is an employee under the common-law standard. See § 31.3401(c)–1(b). For purposes of this paragraph (a)(15), a leased employee (as defined in section 414(n)(2)), a sole proprietor, a partner in a partnership, a 2-percent S corporation shareholder, or a worker described in section 3508 is not an employee.

(16) *Employer*. The term *employer* means the person that is the employer of an employee under the common-law standard. See § 31.3121(d)–1(c). For purposes of determining whether an employer is an applicable large employer, all persons treated as a single employer under section 414(b), (c), (m), or (o) are treated as a single employer. Thus, all employees of a controlled group of entities under section 414(b) or (c), an affiliated service group under section 414(m), or an entity in an arrangement described under section 414(o), are taken into account in determining whether the members of the controlled group or affiliated service group together are an applicable large employer. For purposes of determining applicable large employer status, the term *employer* also includes a predecessor employer (see paragraph (a)(36) of this section) and a successor employer.

(17) *Employment break period*. The term *employment break period* means a period of at least four consecutive weeks (disregarding special unpaid leave), measured in weeks, during which an employee of an educational organization is not credited with hours of service for an applicable large employer.

(18) *Exchange*. The term *Exchange* means an Exchange as defined in 45 CFR 155.20.

(19) *Federal poverty line*. The term *federal poverty line* means for a plan year any of the poverty guidelines (updated periodically in the FEDERAL REGISTER by the Secretary of Health and Human Services under the authority of 42 U.S.C. 9902(2)) in effect within six months before the first day of the plan year of the applicable large employer member's health plan, as selected by the applicable large employer member.

(20) *Form W–2 wages*. The term *Form W–2 wages* with respect to an employee refers to the amount of wages as defined under section 3401(a) for the applicable calendar year (required to be reported in Box 1 of the Form W–2 (Wage and Tax Statement)) received from an applicable large employer.

(21) *Full-time employee*—(i) *In general*. The term *full-time employee* means, with respect to a calendar month, an employee who is employed an average of at least 30 hours of service per week with an employer. For rules on the determination of whether an employee is a full-time employee, including a description of the look-back measurement method and the monthly measurement method, see § 54.4980H–3. The look-back measurement method for identifying full-time employees is available only for purposes of determining and computing liability under section 4980H and not for the purpose of determining status as an applicable large employer under § 54.4980H–2.

(ii) *Monthly equivalency*. Except as otherwise provided in paragraph (a)(21)(iii) of this section, 130 hours of service in a calendar month is treated as the monthly equivalent of at least 30 hours of service per week, and this 130 hours of service monthly equivalency applies for both the look-back measurement method and the monthly measurement method for determining full-time employee status.

(iii) *Determination of full-time employee status using weekly rule under the monthly measurement method*. Under the optional weekly rule set forth in § 54.4980H–3(c)(3), full-time employee status for certain calendar months is

based on hours of service over four weekly periods and for certain other calendar months is based on hours of service over five weekly periods. With respect to a month with four weekly periods, an employee with at least 120 hours of service is a full-time employee, and with respect to a month with five weekly periods, an employee with at least 150 hours of service is a full-time employee. For purposes of this rule, the seven continuous calendar days that constitute a week (for example Sunday through Saturday) must be consistently applied for all calendar months of the calendar year.

(22) *Full-time equivalent employee (FTE).* The term *full-time equivalent employee*, or *FTE*, means a combination of employees, each of whom individually is not treated as a full-time employee because he or she is not employed on average at least 30 hours of service per week with an employer, who, in combination, are counted as the equivalent of a full-time employee solely for purposes of determining whether the employer is an applicable large employer. For rules on the method for determining the number of an employer's full-time equivalent employees, or FTEs, see § 54.4980H–2(c).

(23) *Government entity.* The term *government entity* means the government of the United States, any State or political subdivision thereof, any Indian tribal government (as defined in section 7701(a)(40)) or subdivision of an Indian tribal government (determined in accordance with section 7871(d)), or any agency or instrumentality of any of the foregoing.

(24) *Hour of service*—(i) *In general.* The term *hour of service* means each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer; and each hour for which an employee is paid, or entitled to payment by the employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence (as defined in 29 CFR 2530.200b–2(a)). For the rules for determining an employee's hours of service, see § 54.4980H–3.

(ii) *Excluded hours*—(A) *Bona fide volunteers.* The term *hour of service* does not include any hour for services performed as a bona fide volunteer.

(B) *Work-study program.* The term *hour of service* does not include any hour for services to the extent those services are performed as part of a Federal Work-Study Program as defined under 34 CFR 675 or a substantially similar program of a State or political subdivision thereof.

(C) *Services outside the United States.* The term *hour of service* does not include any hour for services to the extent the compensation for those services constitutes income from sources without the United States (within the meaning of sections 861 through 863 and the regulations thereunder).

(iii) *Service for other applicable large employer members.* In determining hours of service and status as a full-time employee for all purposes under section 4980H, an hour of service for one applicable large employer member is treated as an hour of service for all other applicable large employer members for all periods during which the applicable large employer members are part of the same group of employers forming an applicable large employer.

(25) *Initial measurement period.* The term *initial measurement period* means a period selected by an applicable large employer member of at least three consecutive months but not more than 12 consecutive months used by the applicable large employer as part of the look-back measurement method in § 54.4980H–3(d).

(26) *Limited non-assessment period for certain employees.* References to the *limited non-assessment period for certain employees* refers to the limited period during which an employer will not be subject to an assessable payment under section 4980H(a), and in certain cases section 4980H(b), with respect to an employee as set forth in—

(i) Section 54.4980H–2(b)(5) (regarding the transition rule for an employer's first year as an applicable large employer),

(ii) Section 54.4980H–3(c)(2) (regarding the application of section 4980H for the three full calendar month period beginning with the first full calendar month in which an employee is first otherwise eligible for an offer of coverage under the monthly measurement method),

(iii) Section 54.4980H–3(d)(2)(iii) (regarding the application of section 4980H during the initial three full calendar months of employment for an employee reasonably expected to be a full-time employee at the start date, under the look-back measurement method),

(iv) Section 54.4980H–3(d)(3)(iii) (regarding the application of section 4980H during the initial measurement period to a new variable hour employee, seasonal employee or part-time employee determined to be employed on average at least 30 hours of service per week, under the look-back measurement method),

(v) Section 54.4980H–3(d)(3)(vii) (regarding the application of section 4980H following an employee's change in employment status to a full-time employee during the initial measurement period, under the look-back measurement method), and

(vi) Section 54.4980H–4(c) and § 54.4980H–5(c) (regarding the application of section 4980H to the calendar month in which an employee's start date occurs on a day other than the first day of the calendar month).

(27) *Minimum essential coverage*. The term *minimum essential coverage*, or *MEC*, has the same meaning as provided in section 5000A(f) and any regulations or other guidance thereunder.

(28) *Minimum value*. The term *minimum value* has the same meaning as provided in section 36B(c)(2)(C)(ii) and any regulations or other guidance thereunder.

(29) *Month*. The term *month* means—

(i) A *calendar month* as defined in paragraph (a)(8) of this section, or

(ii) The period that begins on any date following the first day of a calendar month and that ends on the immediately preceding date in the immediately following calendar month (for example, from February 2 to March 1 or from December 15 to January 14).

(30) *New employee*. Under the look-back measurement method, the term *new employee* means an employee who has been employed by an applicable large employer for less than one complete standard measurement period; for treatment of the employee as a new employee or continuing employee under the look-back measurement method following a period for which no hours of service are earned, see the rehire and continuing employee rules at § 54.4980H–3(d)(6). Under the monthly measurement method, the term *new employee* means an employee who either has not previously been employed by the applicable large employer or has previously been employed by the applicable large employer but is treated as a new employee under the rehire and continuing employee rules at § 54.4980H–3(c)(4).

(31) *Ongoing employee*. The term *ongoing employee* means an employee who has been employed by an applicable large employer member for at least one complete standard measurement period. For the treatment of an ongoing employee as a new employee or continuing employee following a period for which no hours of service are earned, see the rehire and continuing employee rules at § 54.4980H–3(d)(6).

(32) *Part-time employee*. The term *part-time employee* means a new employee who the applicable large employer member reasonably expects to be employed on average less than 30 hours of service per week during the initial measurement period, based on the facts and circumstances at the employee's start date. Whether an employer's determination that a new employee is a part-time employee is reasonable is based on the facts and circumstances at the employee's start date. Factors to consider in determining a new employee's full-time employee status are set forth in § 54.4980H–3(d)(2)(ii).

(33) *Period of employment*. The term *period of employment* means the period of time beginning on the first date for which an employee is credited with an hour of service for an applicable large employer (including any member of that applicable large employer) and ending on the last date on which the employee is credited with an hour of service for that applicable large employer, both dates inclusive. An employee may have one or more periods of employment with the same applicable large employer.

(34) *Person*. The term *person* has the same meaning as provided in section 7701(a)(1) and the regulations thereunder.

(35) *Plan year*. A *plan year* must be twelve consecutive months, unless a short plan year of less than twelve consecutive months is permitted for a valid business purpose. A *plan year* is permitted to begin on any day of a year and must end on the preceding day in the immediately following year (for example, a plan year that begins on October 15, 2015, must end on October 14, 2016). A calendar year *plan year* is a period of twelve consecutive months beginning on January 1 and ending on December 31 of the same calendar year. Once established, a plan year is effective for the first plan year and for all subsequent plan years, unless changed, provided that such change will only be recognized if made for a valid business purpose. A change in the plan year is not permitted if a principal purpose of the change in plan year is to circumvent the rules of section 4980H or these regulations.

(36) *Predecessor employer*. [Reserved]

(37) *Qualified health plan*. The term *qualified health plan* means a qualified health plan as defined in Affordable Care Act section 1301(a) (42 U.S.C. 18021(a)), but does not include a catastrophic plan described in Affordable Care Act section 1302(e) (42 U.S.C. 18022(e)).

(38) *Seasonal employee*. The term *seasonal employee* means an employee who is hired into a position for which the customary annual employment is six months or less.

(39) *Seasonal worker*. The term *seasonal worker* means a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including (but not limited to) workers covered by 29 CFR 500.20(s)(1), and retail workers employed exclusively during holiday seasons. Employers may apply a reasonable, good faith interpretation of the term *seasonal worker* and a reasonable good faith interpretation of 29 CFR 500.20(s)(1) (including as applied by analogy to workers and employment positions not otherwise covered under 29 CFR 500.20(s)(1)).

(40) *Section 1411 Certification*. The term *Section 1411 Certification* means the certification received as part of the process established by the Secretary of Health and Human Services under which an employee is certified to the employer under section 1411 of the Affordable Care Act as having enrolled for a calendar month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee.

(41) *Section 4980H(a) applicable payment amount*. The term *section 4980H(a) applicable payment amount* means, with respect to any calendar month, 1/12 of $2,000, adjusted for inflation in accordance with section 4980H(c)(5) and any applicable guidance thereunder.

(42) *Section 4980H(b) applicable payment amount*. The term section *4980H(b) applicable payment amount* means, with respect to any calendar month, 1/12 of $3,000, adjusted for inflation in accordance with section 4980H(c)(5) and any applicable guidance thereunder.

(43) *Self-only coverage*. The term *self-only coverage* means health insurance coverage provided to only one individual, generally the employee.

(44) *Special unpaid leave*. The term *special unpaid leave* means—

(i) Unpaid leave that is subject to the Family and Medical Leave Act of 1993 (FMLA), Public Law 103–3, 29 U.S.C. 2601 et seq.;

(ii) Unpaid leave that is subject to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), Public Law 103–353, 38 U.S.C. 4301 et seq.; or

(iii) Unpaid leave on account of jury duty.

(45) *Stability period*. The term *stability period* means a period selected by an applicable large employer member that immediately follows, and is associated with, a standard measurement period or an initial measurement period (and, if elected by the employer, the administrative period associated with that standard measurement period or initial measurement period), and is used by the applicable large employer member as part of the look-back measurement method in § 54.4980H–3(d).

(46) *Standard measurement period*. The term *standard measurement period* means a period of at least three but not more than 12 consecutive months that is used by an applicable large employer member as part of the look-back measurement method in § 54.4980H–3(d). See

§ 54.4980H–3(d)(1)(ii) for rules on the use of payroll periods that include the beginning and end dates of the measurement period.

(47) *Start date*. The term *start date* means the first date on which an employee is required to be credited with an hour of service with an employer. For rules relating to when, following a period for which an employee does not earn an hour of service, that employee may be treated as a new employee with a new start date rather than a continuing employee, see the rehire and continuing employee rules at § 54.4980H–3(c)(4) and § 54.4980H–3(d)(6).

(48) *United States*. The term *United States* means United States as defined in section 7701(a)(9).

(49) *Variable hour employee*—(i) *In general*. The term *variable hour employee* means an employee if, based on the facts and circumstances at the employee's start date, the applicable large employer member cannot determine whether the employee is reasonably expected to be employed on average at least 30 hours of service per week during the initial measurement period because the employee's hours are variable or otherwise uncertain.

(ii) *Factors*—(A) *In general*. Factors to consider in determining whether it can be determined that the employee is reasonably expected to be (or reasonably expected not to be) employed on average at least 30 hours of service per week during the initial measurement period include, but are not limited to, whether the employee is replacing an employee who was a full-time employee or a variable hour employee, the extent to which the hours of service of employees in the same or comparable positions have actually varied above and below an average of 30 hours of service per week during recent measurement periods, and whether the job was advertised, or otherwise communicated to the new employee or otherwise documented (for example, through a contract or job description) as requiring hours of service that would average at least 30 hours of service per week, less than 30 hours of service per week, or may vary above and below an average of 30 hours of service per week. These factors are only relevant for a particular new employee if the employer has no reason to anticipate that the facts and circumstances related to that new employee will be different. In all cases, no single factor is determinative. For purposes of determining whether an employee is a variable hour employee, the applicable large employer member may not take into account the likelihood that the employee may terminate employment with the applicable large employer (including any member of the applicable large employer) before the end of the initial measurement period.

(B) *Additional factors for an employee hired by an employer for temporary placement at an unrelated entity*. In the case of an individual who, under all the facts and circumstances, is the employee of an entity (referred to solely for purposes of this paragraph (a)(49) as a ''temporary staffing firm'') that hired such individual for temporary placement at an unrelated entity that is not the common law employer, additional factors to consider to determine whether the employee is reasonably expected to be (or reasonably expected not to be) employed by the temporary staffing firm on average at least 30 hours of service per week during the initial measurement period include, but are not limited to, whether other employees in the same position of employment with the temporary staffing firm, as part of their continuing employment, retain the right to reject temporary placements that the temporary staffing firm offers the employee; typically have periods during which no offer of temporary placement is made; typically are offered temporary placements for differing periods of time; and typically are offered temporary placements that do not extend beyond 13 weeks.

(C) *Educational organizations*. An employer that is an educational organization cannot take into account the potential for, or likelihood of, an employment break period in determining its expectation of future hours of service.

(iii) *Application only for look-back measurement method*. The term *variable hour employee* is used as a category of employees under the look-back measurement method and is not relevant to the monthly measurement method.

(50) *Week*. The term *week* means any period of seven consecutive calendar days applied consistently by the applicable large employer member.

(b) *Effective/applicability date*. This section is applicable for periods after December 31, 2014.

[T.D. 9655, 79 FR 8577, Feb. 12, 2014]

§ 54.4980H–2 Applicable large employer and applicable large employer member.

(a) *In general*. Section 4980H applies to an applicable large employer and to all of the applicable large employer members that comprise that applicable large employer.

(b) *Determining applicable large employer status*—(1) *In general*. An employer's status as an applicable large employer for a calendar year is determined by taking the sum of the total number of full-time employees (including any seasonal workers) for each calendar month in the preceding calendar year and the total number of FTEs (including any seasonal workers) for each calendar month in the preceding calendar year, and dividing by 12. The result, if not a whole number, is then rounded to the next lowest whole number. If the result of this calculation is less than 50, the employer is not an applicable large employer for the current calendar year. If the result of this calculation is 50 or more, the employer is an applicable large employer for the current calendar year, unless the seasonal worker exception in paragraph (b)(2) of this section applies.

(2) *Seasonal worker exception*. If the sum of an employer's full-time employees and FTEs exceeds 50 for 120 days or less during the preceding calendar year, and the employees in excess of 50 who were employed during that period of no more than 120 days are seasonal workers, the employer is not considered to employ more than 50 full-time employees (including FTEs) and the employer is not an applicable large employer for the current calendar year. In the case of an employer that was not in existence on any business day during the preceding calendar year, if the employer reasonably expects that the sum of its full-time employees and FTEs for the current calendar year will exceed 50 for 120 days or less during the calendar year, and that the employees in excess of 50 who will be employed during that period of no more than 120 days will be seasonal workers, the employer is not an applicable large employer for the current calendar year. For purposes of this paragraph (b)(2) only, four calendar months may be treated as the equivalent of 120 days. The four calendar months and the 120 days are not required to be consecutive.

(3) *Employers not in existence in preceding calendar year*. An employer not in existence throughout the preceding calendar year is an applicable large employer for the current calendar year if the employer is reasonably expected to employ an average of at least 50 full-time employees (taking into account FTEs) on business days during the current calendar year and it actually employs an average of at least 50 full-time employees (taking into account FTEs) on business days during the calendar year. An employer is treated as not having been in existence throughout the prior calendar year only if the employer was not in existence on any business day in the prior calendar year. See paragraph (b)(2) of this section for the application of the seasonal worker exception to employers not in existence in the preceding calendar year.

(4) *Special rules for government entities, churches, and conventions and associations of churches*. [Reserved]

(5) *Transition rule for an employer's first year as an applicable large employer*. With respect to an employee who was not offered coverage by the employer at any point during the prior calendar year, if the applicable large employer offers coverage to the employee on or before April 1 of the first calendar year for which the employer is an applicable large employer, the employer will not be subject to an assessable payment under section 4980H by reason of its failure to offer coverage to the employee for January through March of that year, provided that this relief applies only with respect to potential liability under section 4980H(b) (for January through March of the first calendar year for which the employer is an applicable large employer) if the coverage offered by April 1 provides minimum value. If the employer does

not offer coverage to the employee by April 1, the employer may be subject to a section 4980H(a) assessable payment with respect January through March of the first calendar year for which the employer is an applicable large employer in addition to any later calendar months for which coverage was not offered. If the employer offers coverage to the employee by April 1 that does not provided minimum value, the employer may be subject to a section 4980H(b) assessable payment with respect to the employee for January through March of the first calendar year for which the employer is an applicable large employer in addition to any later calendar months for which coverage does not provide minimum value or is not affordable. This rule applies only during the first year that an employer is an applicable large employer (and would not apply if, for example, the employer falls below the 50 full-time employee (plus FTE) threshold for a subsequent calendar year and then increases employment and becomes an applicable large employer again).

(c) *Full-time equivalent employees (FTEs)*—(1) *In general*. In determining whether an employer is an applicable large employer, the number of FTEs it employed during the preceding calendar year is taken into account. All employees (including seasonal workers) who were not employed on average at least 30 hours of service per week for a calendar month in the preceding calendar year are included in calculating the employer's FTEs for that calendar month.

(2) *Calculating the number of FTEs*. The number of FTEs for each calendar month in the preceding calendar year is determined by calculating the aggregate number of hours of service for that calendar month for employees who were not full-time employees (but not more than 120 hours of service for any employee) and dividing that number by 120. In determining the number of FTEs for each calendar month, fractions are taken into account; an employer may round the number of FTEs for each calendar month to the nearest one hundredth.

(d) *Examples*. The following examples illustrate the rules of paragraphs (a) through (c) of this section. In these examples, hours of service are computed following the rules set forth in § 54.4980H–3, and references to years refer to calendar years unless otherwise specified. The employers in *Example 2* through *Example 6* are each the sole applicable large employer member of the applicable large employer, as determined under section 414(b), (c), (m), and (o).

Example 1 (Applicable large employer/controlled group). (i) *Facts*. For all of 2015 and 2016, Corporation Z owns 100 percent of all classes of stock of Corporation Y and Corporation X. Corporation Z has no employees at any time in 2015. For every calendar month in 2015, Corporation Y has 40 full-time employees and Corporation X has 60 full-time employees. Corporations Z, Y, and X are a controlled group of corporations under section 414(b).

(ii) *Conclusion*. Because Corporations Z, Y and X have a combined total of 100 full-time employees during 2015, Corporations Z, Y, and X together are an applicable large employer for 2016. Each of Corporations Z, Y and X is an applicable large employer member for 2016.

Example 2 (Applicable large employer with FTEs). (i) *Facts*. During each calendar month of 2015, Employer W has 20 full-time employees each of whom averages 35 hours of service per week, 40 employees each of whom averages 90 hours of service per calendar month, and no seasonal workers.

(ii) *Conclusion*. Each of the 20 employees who average 35 hours of service per week count as one full-time employee for each calendar month. To determine the number of FTEs for each calendar month, the total hours of service of the employees who are not full-time employees (but not more than 120 hours of service per employee) are aggregated and divided by 120. The result is that the employer has 30 FTEs for each calendar month ($40 \times 90 = 3{,}600$, and $3{,}600 \div 120 = 30$). Because Employer W has 50 full-time employees (the sum of 20 full-time employees and 30 FTEs) during each calendar month in 2015, and because the seasonal worker exception is not applicable, Employer W is an applicable large employer for 2016.

Example 3 (Seasonal worker exception). (i) *Facts*. During 2015, Employer V has 40 full-time employees for the entire calendar year, none of whom are seasonal workers. In addition, Employer V also has 80 seasonal workers who are full-time employees and who work for Employer V from September through December 2015. Employer V has no FTEs during 2015.

(ii) *Conclusion*. Before applying the seasonal worker exception, Employer V has 40

full-time employees during each of eight calendar months of 2015, and 120 full-time employees during each of four calendar months of 2015, resulting in an average of 66.67 full-time employees for the year. However, Employer V's workforce exceeded 50 full-time employees (counting seasonal workers) for no more than four calendar months (treated as the equivalent of 120 days) in calendar year 2015, and the number of full-time employees would be less than 50 during those months if seasonal workers were disregarded. Accordingly, because after application of the seasonal worker exception described in paragraph (b)(2) of this section Employer V is not considered to employ more than 50 full-time employees, Employer V is not an applicable large employer for 2016.

Example 4 (Seasonal workers and other FTEs). (i) *Facts.* Same facts as *Example 3,* except that Employer V has 20 FTEs in August, some of whom are seasonal workers.

(ii) *Conclusion.* The seasonal worker exception described in paragraph (b)(2) of this section does not apply if the number of an employer's full-time employees (including seasonal workers) and FTEs exceeds 50 for more than 120 days during the calendar year. Because Employer V has at least 50 full-time employees for a period greater than four calendar months (treated as the equivalent of 120 days) during 2015, the exception described in paragraph (b)(2) of this section does not apply. Employer V averaged 68 full-time employees in 2015: $[(40 \times 7) + (60 \times 1) + (120 \times 4)] \div 12 = 68.33$, and accordingly, Employer V is an applicable large employer for calendar year 2016.

Example 5 (New employer). (i) *Facts.* Corporation S is incorporated on January 1, 2016. On January 1, 2016, Corporation S has three employees. However, prior to incorporation, Corporation S's owners purchased a factory intended to open within two calendar months of incorporation and to employ approximately 100 full-time employees. By March 15, 2016, Corporation S has more than 75 full-time employees.

(ii) *Conclusion.* Because Corporation S can reasonably be expected to employ on average at least 50 full-time employees on business days during 2016, and actually employs an average of at least 50 full-time employees on business days during 2016, Corporation S is an applicable large employer (and an applicable large employer member) for calendar year 2016.

Example 6 (First year as applicable large employer). (i) *Facts.* As of January 1, 2015, Employer R has been in existence for several years and did not average 50 or more full-time employees (including FTEs) on business days during 2014. Employer R averages 50 or more full-time employees on business days during 2015, so that for 2016 Employer R is an applicable large employer, for the first time. For all the calendar months of 2016, Employer R has the same 60 full-time employees. Employer R offered 20 of those full-time employees healthcare coverage during 2015, and offered those same employees coverage providing minimum value for 2016. With respect to the 40 full-time employees who were not offered coverage during 2015, Employer R offers coverage providing minimum value for calendar months April 2016 through December 2016.

(ii) *Conclusion.* For the 40 full-time employees not offered coverage during 2015 and offered coverage providing minimum value for the calendar months April 2016 through December 2016, the failure to offer coverage during the calendar months January 2016 through March 2016 will not result in an assessable payment under section 4980H with respect to those employees for those three calendar months. For those same 40 full-time employees, the offer of coverage during the calendar months April 2016 through December 2016 may result in an assessable payment under section 4980H(b) with respect to any employee for any calendar month for which the offer is not affordable and for which Employer R has received a Section 1411 Certification. For the other 20 full-time employees, the offer of coverage during 2016 may result in an assessable payment under section 4980H(b) for any calendar month if the offer is not affordable and Employer R has received a Section 1411 Certification with respect to the employee who received the offer of coverage. For all calendar months of 2016, Employer R will not be subject to an assessable payment under section 4980H(a).

(e) *Additional guidance.* With respect to an employer's status as an applicable large employer, the Commissioner may prescribe additional guidance of general applicability, published in the Internal Revenue Bulletin (see § 601.601(d)(2)(ii)(b) of this chapter).

(f) *Effective/applicability date.* This section is applicable for periods after December 31, 2014.

[T.D. 9655, 79 FR 8577, Feb. 12, 2014]

§ 54.4980H–3 Determining full-time employees.

(a) *In general.* This section sets forth the rules for determining hours of service and status as a full-time employee for purposes of section 4980H. These regulations provide two methods for determining full-time employee status—the monthly measurement method, set forth in paragraph (c) of this section, and the look-back measurement method, set forth in paragraph

(d) of this section. The monthly measurement method applies for purposes of determining and calculating liability under section 4980H(a) and (b), as well as, with respect to paragraph (c)(1) of this section, determination of applicable large employer status (except with respect to the weekly rule under the monthly measurement method). The look-back measurement method applies solely for purposes of determining and calculating liability under section 4980H(a) and (b) (and not for purposes of determining status as an applicable large employer). See § 54.4980H–1(a)(21) for the definition of full-time employee. The rules set forth in this section prescribe the minimum standards for determining status as a full-time employee for purposes of section 4980H; treatment of additional employees as full-time employees for other purposes does not affect section 4980H liability if those employees are not full-time employees under the look-back measurement method or the monthly measurement method.

(b) *Hours of service*—(1) *In general*. The following rules on the calculation of hours of service apply for purposes of applying both the look-back measurement method and the monthly measurement method.

(2) *Hourly employees calculation*. Under the look-back measurement method and the monthly measurement method, for employees paid on an hourly basis, an employer must calculate actual hours of service from records of hours worked and hours for which payment is made or due.

(3) *Non-hourly employees calculation*—(i) *In general*. Except as otherwise provided, under the look-back measurement method and the monthly measurement method, for employees paid on a non-hourly basis, an employer must calculate hours of service by using one of the following methods:

(A) Using actual hours of service from records of hours worked and hours for which payment is made or due;

(B) Using a days-worked equivalency whereby the employee is credited with eight hours of service for each day for which the employee would be required to be credited with at least one hour of service in accordance with paragraph (b)(2) of this section; or

(C) Using a weeks-worked equivalency whereby the employee is credited with 40 hours of service for each week for which the employee would be required to be credited with at least one hour of service in accordance with paragraph (b)(2) of this section.

(ii) *Change in method*. An employer must use one of the three methods in paragraph (b)(3)(i) of this section for calculating the hours of service for non-hourly employees. An employer is not required to use the same method for all non-hourly employees, and may apply different methods for different categories of non-hourly employees, provided the categories are reasonable and consistently applied. Similarly, an applicable large employer member is not required to apply the same methods as other applicable large employer members of the same applicable large employer for the same or different categories of non-hourly employees, provided that in each case the categories are reasonable and consistently applied by the applicable large employer member. An employer may change the method of calculating the hours of service of non-hourly employees (or of one or more categories of non-hourly employees) for each calendar year.

(iii) *Prohibited use of equivalencies*. The number of hours of service calculated using the days-worked or weeks-worked equivalency must reflect generally the hours actually worked and the hours for which payment is made or due. An employer is not permitted to use the days-worked equivalency or the weeks-worked equivalency if the result is to substantially understate an employee's hours of service in a manner that would cause that employee not to be treated as a full-time employee, or if the result is to understate the hours of service of a substantial number of employees (even if no particular employee's hours of service are understated substantially and even if the understatement would not cause the employee to not be treated as a full-time employee). For example, as to the former, an employer may not use a days-worked equivalency in the case of an employee who generally works three 10-hour days per week, because the

equivalency would substantially understate the employee's hours of service as 24 hours of service per week, which would result in the employee being treated as not a full-time employee.

(c) *Monthly measurement method*—(1) *In general*. Under the monthly measurement method, an applicable large employer member determines each employee's status as a full-time employee by counting the employee's hours of service for each calendar month. See § 54.4980H–1(a)(21) for the definition of full-time employee. This paragraph (c)(1) (except with respect to the weekly rule) applies for purposes of the determination of status as an applicable large employer; paragraphs (c)(2) through (4) of this section do not apply for purposes of the determination of status as an applicable large employer. For rules regarding the use of the look-back measurement method and the monthly measurement method for different categories of employees, see paragraph (e) of this section.

(2) *Employee first otherwise eligible for an offer of coverage*. The rule in this paragraph (c)(2) applies with respect to an employee who, in a calendar month, first becomes otherwise eligible to be offered coverage under a group health plan of an employer using the monthly measurement method with respect to that employee. For purposes of this paragraph (c)(2), an employee is otherwise eligible to be offered coverage under a group health plan for a calendar month if, pursuant to the terms of the plan as in effect for that calendar month, the employee meets all conditions to be offered coverage under the plan for that calendar month, other than the completion of a waiting period, within the meaning of § 54.9801–2, and an employee is first otherwise eligible if the employee has not previously been eligible or otherwise eligible for an offer of coverage under a group health plan of the employer during the employee's period of employment. An employer is not subject to an assessable payment under section 4980H(a) with respect to an employee for each calendar month during the period of three full calendar months beginning with the first full calendar month in which the employee is otherwise eligible for an offer of coverage under a group health plan of the employer, provided that the employee is offered coverage no later than the first day of the first calendar month immediately following the three-month period if the employee is still employed on that day. If the coverage for which the employee is otherwise eligible during the three-month period, and which the employee actually is offered on the day following that three-month period if still employed, provides minimum value, the employer also will not be subject to an assessable payment under section 4980H(b) with respect to that employee for the three-month period. This rule cannot apply more than once per period of employment of an employee. If an employee terminates employment and returns under circumstances that would constitute a rehire as set forth in paragraph (c)(4) of this section, the rule in this paragraph (c)(2) may apply again.

(3) *Use of weekly periods*. With respect to a category of employees for whom an employer uses the monthly measurement method, an employer may determine full-time employee status for a calendar month based on hours of service over a period that:

(i) Begins on the first day of the week that includes the first day of the calendar month, provided that the period over which hours of service are measured does not include the week in which falls the last day of the calendar month (unless that week ends with the last day of the calendar month, in which case it is included); or

(ii) begins on the first day of the week immediately subsequent to the week that includes the first day of the calendar month (unless the week begins on the first day of the calendar month, in which case it is included), provided the period over which hours of service are measured includes the week in which falls the last day of the calendar month.

(4) *Employees rehired after termination of employment or resuming service after other absence*—(i) *Treatment as a new employee after a period of absence for employees of employers other than educational organizations*. Except as provided in paragraph (c)(4)(ii) of this section (related to rules for employers that are educational organizations), an

employee who resumes providing services to (or is otherwise credited with an hour of service for) an applicable large employer after a period during which the individual was not credited with any hours of service may be treated as having terminated employment and having been rehired, and therefore may be treated as a new employee upon the resumption of services only if the employee did not have an hour of service for the applicable large employer for a period of at least 13 consecutive weeks immediately preceding the resumption of services. The rule set forth in this paragraph (c)(4)(i) applies solely for the purpose of determining whether the employee, upon the resumption of services, is treated as a new employee or as a continuing employee, and does not determine whether the employee is treated as a continuing full-time employee (for example, an employee on leave) or a terminated employee for some or all of the period during which no hours of service are credited.

(ii) *Treatment as a new employee after a period of absence for employees of educational organizations.* With respect to an employer that is an educational organization, an employee who resumes providing services to (or is otherwise credited with an hour of service for) an applicable large employer after a period during which the individual was not credited with any hours of service may be treated as having terminated employment and having been rehired, and therefore may be treated as a new employee upon the resumption of services, only if the employee did not have an hour of service for the applicable large employer for a period of at least 26 consecutive weeks immediately preceding the resumption of services. The rule set forth in this paragraph (c)(4)(ii) applies solely for the purpose of determining whether the employee, upon the resumption of services, is treated as a new employee or as a continuing employee, and does not determine whether the employee is treated as a continuing full-time employee (for example, an employee on leave) or a terminated employee for some or all of the period during which no hours of service are credited.

(iii) *Averaging method for special unpaid leave and employment break periods.* The averaging method for periods of special unpaid leave and employment break periods does not apply under the monthly measurement method, regardless of whether the employer is (or is not) an educational organization.

(iv) *Treatment of continuing employee.* The rule set forth in paragraph (c)(2) of this section applies to an employee treated as a continuing employee in the same way that it applies to an employee who has not experienced a period with no hours of service. A continuing employee treated as a full-time employee is treated as offered coverage upon resumption of services if the employee is offered coverage as of the first day that employee is credited with an hour of service, or, if later, as soon as administratively practicable. For this purpose, offering coverage by no later than the first day of the calendar month following resumption of services is deemed to be as soon as administratively practicable.

(v) *Rule of parity.* For purposes of determining the period after which an employee may be treated as having terminated employment and having been rehired, an applicable large employer may choose a period, measured in weeks, of at least four consecutive weeks during which the employee was not credited with any hours of service that exceeds the number of weeks of that employee's period of employment with the applicable large employer immediately preceding the period that is shorter than 13 weeks (for an employee of an educational organization employer, a period that is shorter than 26 weeks).

(vi) *International transfers.* An employer may treat an employee as having terminated employment if the employee transfers to a position at the same applicable large employer (including a different applicable large employer member that is part of the same applicable large employer) if the position is anticipated to continue indefinitely or for at least 12 months and if substantially all of the compensation will constitute income from sources without the United States (within the meaning of sections 861 through 863 and the regulations thereunder). With respect to an employee transferring from

a position that was anticipated to continue indefinitely or for at least 12 months and in which substantially all of the compensation for the hours of service constitutes income from sources without the United States (within the meaning of sections 861 through 863 and the regulations thereunder) to a position at the same applicable large employer (including a different applicable large employer member that is part of the same applicable large employer) with respect to which substantially all of the compensation will constitute U.S. source income, the employer may treat that employee as a new hire to the extent consistent with the rules related to rehired employees as set forth in paragraph (c)(4) of this section.

(5) *Examples*. The following examples illustrate the rules of paragraphs (c)(1) through (4) of this section. In each example, the employer is an applicable large employer with 200 full-time employees (including FTEs) that uses the monthly measurement method to identify full-time employees and offers coverage only to employees who are full-time employees (and their dependents).

Example 1 (Monthly measurement method—employee first otherwise eligible for an offer of coverage). (i) *Facts*. Employer Z uses the monthly measurement method. Employer Z hires Employee A on January 1, 2016. For each calendar month in 2016, Employee A averages 20 hours of service per week and is not eligible (or otherwise eligible) for an offer of coverage under the group health plan of Employer Z. Effective January 1, 2017, Employee A is promoted to a position that is eligible for an offer of coverage under a group health plan of Employer Z, following completion of a 90-day waiting period. For January 2017 through March 2017, Employee A meets all of the conditions for eligibility under the group health plan, other than completion of the waiting period. The coverage that would have been offered to Employee A under the terms of the plan, but for the waiting period, during those three months would have provided minimum value. Effective April 1, 2017, Employer Z offers Employee A coverage that provides minimum value. Employee A averages 40 hours of service per week for each calendar month in 2017.

(ii) *Conclusion*. Because Employer Z offers minimum value coverage to Employee A no later than the first day following the period of three full calendar months beginning with the first full calendar month in which Employee A is otherwise eligible for an offer of coverage under a group health plan of Employer Z, Employer Z is not subject to an assessable payment for January 2017 through March 2017 under section 4980H by reason of its failure to offer coverage to Employee A during those months. For calendar months after March 2017, an offer of minimum value coverage may result in an assessable payment under section 4980H(b) with respect to Employee A for any month for which the offer is not affordable and for which Employer Z has received a Section 1411 Certification. Employer Z is not subject to an assessable payment under section 4980H by reason of its failure to offer coverage to Employee A during each month of 2016 because for each month of 2016, Employee A was not a full-time employee.

Example 2 (Rehire rules under monthly measurement method for employers that are not educational organizations). (i) *Facts*. Same as *Example 1*, except that Employee A has zero hours of service during a nine week period of unpaid leave (that constitutes special unpaid leave) beginning on June 25, 2017, and ending on August 26, 2017. As a result of the nine week period during which Employee A has zero hours of service, Employee A averages less than 30 hours of service per week for July 2017 and August 2017. Employee A averages more than 30 hours of service per week for each month between and including September 2017 through December 2017. Employer Z does not use the rule of parity, set forth in paragraph (c)(4)(v) of this section, and Employer Z is not an educational organization.

(ii) *Conclusion*. Because Employee A resumes providing services for Employer Z after a period during which the employee was not credited with any hours of service of less than 13 consecutive weeks, Employer Z may not treat Employee A as having terminated employment and having been rehired. Therefore, Employer Z may not treat Employee A as a new employee upon the resumption of services, and, accordingly, Employer Z may not again apply the rule set forth in paragraph (c)(2) of this section. Although the nine consecutive weeks of zero hours of service constitute special unpaid leave, the averaging method for periods of special unpaid leave does not apply under the monthly measurement method. Therefore, Employer Z may treat Employee A as a non-full-time employee for July 2017 and August 2017.

Example 3 (Use of weekly rule). (i) *Facts*. Employer Y uses the monthly measurement method in combination with the weekly rule for purposes of determining whether an employee is a full-time employee for a particular calendar month. For purposes of applying the weekly rule, Employer Y uses the period of Sunday through Saturday as a week and includes the week that includes

the first day of a calendar month and excludes the week that includes the last day of a calendar month (except in any case in which the last day of the calendar month occurs on a Saturday). Employer Y measures hours of service for the five weeks from Sunday, December 27, 2015, through Saturday, January 30, 2016, to determine an employee's full-time employee status for January 2016, for the four weeks from Sunday, January 31, 2016, through Saturday, February 27, 2016, to determine an employee's status for February 2016, and the four weeks from Sunday, February 28, 2016, through Saturday, March 26, 2016, to determine an employee's status for March 2016. For January 2016, Employer Y treats an employee as a full-time employee if the employee has at least 150 hours of service (30 hours per week × 5 weeks). For February 2016 and March 2016, Employer Y treats an employee as a full-time employee if the employee has at least 120 hours of service (30 hours per week × 4 weeks).

(ii) *Conclusion*. Employer Y has correctly applied the weekly rule as part of the monthly measurement method for determining each employee's status as a full-time employee for the months January, February, and March 2016.

(d) *Look-back measurement method*—(1) *Ongoing employees*—(i) *In general*. Under the look-back measurement method for ongoing employees, an applicable large employer determines each ongoing employee's full-time employee status by looking back at the standard measurement period. The applicable large employer member determines the months in which the standard measurement period starts and ends, provided that the determination must be made on a uniform and consistent basis for all employees in the same category (see paragraph (d)(1)(v) of this section for a list of permissible categories). For example, if an applicable large employer member chooses a standard measurement period of 12 months, the applicable large employer member could choose to make it the calendar year, a non-calendar plan year, or a different 12-month period, such as one that ends shortly before the start of the plan's annual open enrollment period. If the applicable large employer member determines that an employee was employed on average at least 30 hours of service per week during the standard measurement period, then the applicable large employer member must treat the employee as a full-time employee during a subsequent stability period, regardless of the employee's number of hours of service during the stability period, so long as he or she remains an employee.

(ii) *Use of payroll periods*. For payroll periods that are one week, two weeks, or semi-monthly in duration, an employer is permitted to treat as a measurement period a period that ends on the last day of the payroll period preceding the payroll period that includes the date that would otherwise be the last day of the measurement period, provided that the measurement period begins on the first day of the payroll period that includes the date that would otherwise be the first day of the measurement period. An employer may also treat as a measurement period a period that begins on the first day of the payroll period that follows the payroll period that includes the date that would otherwise be the first day of the measurement period, provided that the measurement period ends on the last day of the payroll period that includes the date that would otherwise be the last day of the measurement period. For example, an employer using the calendar year as a measurement period could exclude the entire payroll period that included January 1 (the beginning of the year) if it included the entire payroll period that included December 31 (the end of that same year), or, alternatively, could exclude the entire payroll period that included December 31 of a calendar year if it included the entire payroll period that included January 1 of that calendar year.

(iii) *Employee determined to be employed an average of at least 30 hours of service per week*. An employee who was employed on average at least 30 hours of service per week during the standard measurement period must be treated as a full-time employee for a stability period that begins immediately after the standard measurement period and any applicable administrative period. The stability period must be at least six consecutive calendar months but no shorter in duration than the standard measurement period.

(iv) *Employee determined not to be employed on average at least 30 hours of service per week*. If an employee was not employed an average of at least 30 hours of service per week during the

standard measurement period, the applicable large employer member may treat the employee as not a full-time employee during the stability period that follows, but is not longer than, the standard measurement period. The stability period must begin immediately after the end of the measurement period and any applicable administrative period.

(v) *Permissible employee categories.* Different applicable large employer members of the same applicable large employer may use measurement periods and stability periods that differ either in length or in their starting or ending dates. In addition, subject to the rules governing the relationship between the length of the measurement period and the stability period, applicable large employer members may use measurement periods and stability periods that differ either in length or in their starting and ending dates for—

(A) Collectively bargained employees and non-collectively bargained employees,

(B) Each group of collectively bargained employees covered by a separate collective bargaining agreement,

(C) Salaried employees and hourly employees, and

(D) Employees whose primary places of employment are in different States.

(vi) *Optional administrative period.* An applicable large employer member may provide for an administrative period that begins immediately after the end of a standard measurement period and that ends immediately before the associated stability period; however, any administrative period between the standard measurement period and the stability period for ongoing employees may neither reduce nor lengthen the measurement period or the stability period. The administrative period following the standard measurement period may last up to 90 days. To prevent this administrative period from creating a period during which coverage is not available, the administrative period must overlap with the prior stability period, so that, during any such administrative period applicable to ongoing employees following a standard measurement period, ongoing employees who are enrolled in coverage because of their status as full-time employees based on a prior measurement period must continue to be covered through the administrative period. Applicable large employer members may use administrative periods that differ in length for the categories of employees identified in paragraph (d)(1)(v) of this section.

(vii) *Change in employment status.* Except as provided in paragraph (f)(2) of this section, if an ongoing employee experiences a change in employment status before the end of a stability period, the change will not affect the application of the classification of the employee as a full-time employee (or not a full-time employee) for the remaining portion of the stability period. For example, if an ongoing employee in a certain position of employment is not treated as a full-time employee during a stability period because the employee's hours of service during the prior measurement period were insufficient for full-time-employee treatment, and the employee experiences a change in employment status that involves an increased level of hours of service, the treatment of the employee as a non-full-time employee during the remainder of the stability period is unaffected. Similarly, if an ongoing employee in a certain position of employment is treated as a full-time employee during a stability period because the employee's hours of service during the prior measurement period were sufficient for full-time-employee treatment, and the employee experiences a change in employment status that involves a lower level of hours of service, the treatment of the employee as a full-time employee during the remainder of the stability period is unaffected.

(viii) Example. The following example illustrates the application of paragraph (d)(1) of this section:

(A) *Facts.* Employer Z is an applicable large employer member and computes hours of service following the rules in this paragraph (d)(1). Employer Z chooses to use a 12-month stability period that begins January 1 and a 12-month standard measurement period that begins October 15. Consistent with the terms of Employer Z's group health plan, only employees classified as full-time employees using the look-back

measurement method are eligible for coverage. Employer Z chooses to use an administrative period between the end of the standard measurement period (October 14) and the beginning of the stability period (January 1) to determine which employees were employed on average 30 hours of service per week during the measurement period, notify them of their eligibility for the plan for the calendar year beginning on January 1 and of the coverage available under the plan, answer questions and collect materials from employees, and enroll those employees who elect coverage in the plan. Previously-determined full-time employees already enrolled in coverage continue to be offered coverage through the administrative period. Employee A and Employee B have been employed by Employer Z for several years, continuously from their start date. Employee A was employed on average 30 hours of service per week during the standard measurement period that begins October 15, 2015, and ends October 14, 2016, and for all prior standard measurement periods. Employee B also was employed on average 30 hours of service per week for all prior standard measurement periods, but averaged less than 30 hours of service per week during the standard measurement period that begins October 15, 2015, and ends October 14, 2016.

(B) *Conclusions.* Because Employee A was employed for the entire standard measurement period that begins October 15, 2015, and ends October 14, 2016, Employee A is an ongoing employee with respect to the stability period running from January 1, 2017, through December 31, 2017. Because Employee A was employed on average 30 hours of service per week during that standard measurement period, Employee A is offered coverage for the entire 2017 stability period (including the administrative period from October 15, 2017, through December 31, 2017). Because Employee A was employed on average 30 hours of service per week during the prior standard measurement period, Employee A is offered coverage for the entire 2016 stability period and, if enrolled, would continue such coverage during the administrative period from October 15, 2016, through December 31, 2016. Because Employee B was employed for the entire standard measurement period that begins October 15, 2015, and ends October 14, 2016, Employee B is also an ongoing employee with respect to the stability period in 2017. Because Employee B was not a full-time employee based on hours of service during this standard measurement period, Employee B is not offered coverage for the stability period in 2017 (including the administrative period from October 15, 2017, through December 31, 2017). However, because Employee B was employed on average 30 hours of service per week during the prior standard measurement period, Employee B is offered coverage through the end of the 2016 stability period and, if enrolled, would continue such coverage during the administrative period from October 15, 2016, through December 31, 2016. Employer Z complies with the standards of paragraph (d)(1) of this section because the standard measurement period is no longer than 12 months, the stability period for ongoing employees who are full-time employees based on hours of service during the standard measurement period is not shorter than the standard measurement period, the stability period for ongoing employees who are not full-time employees based on hours of service during the standard measurement period is no longer than the standard measurement period, and the administrative period is no longer than 90 days.

(2) *New non-variable hour, new non-seasonal and new non-part-time employees*—(i) *In general.* For a new employee who is reasonably expected at the employee's start date to be a full-time employee (and is not a seasonal employee), an applicable large employer member determines such employee's status as a full-time employee based on the employee's hours of service for each calendar month. If the employee's hours of service for the calendar month equal or exceed an average of 30 hours of service per week, the employee is a full-time employee for that calendar month. Once a new employee who is reasonably expected at the employee's start date to be a full-time employee (and is not a seasonal employee) becomes an ongoing employee, the rules

set forth in paragraph (d)(1) of this section apply for determining full-time employee status.

(ii) *Factors for determining full-time employee status.* Whether an employer's determination that a new employee (who is not a seasonal employee) is a full-time employee or is not a full-time employee is reasonable is based on the facts and circumstances at the employee's start date. Factors to consider in determining whether a new employee who is not a seasonal employee is reasonably expected at the employee's start date to be a full-time employee include, but are not limited to, whether the employee is replacing an employee who was (or was not) a full-time employee, the extent to which hours of service of ongoing employees in the same or comparable positions have varied above and below an average of 30 hours of service per week during recent measurement periods, and whether the job was advertised, or otherwise communicated to the new hire or otherwise documented (for example, through a contract or job description), as requiring hours of service that would average 30 (or more) hours of service per week or less than 30 hours of service per week. In all cases, no single factor is determinative. An educational organization employer cannot take into account the potential for, or likelihood of, an employment break period in determining its expectation of future hours of service.

(iii) *Application of section 4980H to initial full three calendar months of employment.* Notwithstanding paragraph (d)(2)(i) of this section, with respect to an employee who is reasonably expected at his or her start date to be a full-time employee (and is not a seasonal employee), the employer will not be subject to an assessable payment under section 4980H(a) for any calendar month of the three-month period beginning with the first day of the first full calendar month of employment if, for the calendar month, the employee is otherwise eligible for an offer of coverage under a group health plan of the employer, provided that the employee is offered coverage by the employer no later than the first day of the fourth full calendar month of employment if the employee is still employed on that day. If the offer of coverage for which the employee is otherwise eligible during the first three full calendar months of employment, and which the employee actually is offered by the first day of the fourth month if still employed, provides minimum value, the employer also will not be subject to an assessable payment under section 4980H(b) with respect to that employee for the first three full calendar months of employment. For purposes of this paragraph (d)(2)(iii), an employee is otherwise eligible to be offered coverage under a group health plan for a calendar month if, pursuant to the terms of the plan as in effect for that calendar month, the employee meets all conditions to be offered coverage under the plan for that calendar month, other than the completion of a waiting period, within the meaning of § 54.9801–2.

(3) *New variable hour employees, new seasonal employees, and new part-time employees*—(i) *In general.* For new variable hour employees, new seasonal employees, and new part-time employees, applicable large employer members are permitted to determine whether the new employee is a full-time employee using an initial measurement period of no less than three consecutive months and no more than 12 consecutive months (as selected by the applicable large employer member) that begins on the employee's start date or on any date up to and including the first day of the first calendar month following the employee's start date (or on the first day of the first payroll period starting on or after the employee's start date, if later, as set forth in paragraph (d)(3)(ii) of this section). The applicable large employer member measures the new employee's hours of service during the initial measurement period and determines whether the employee was employed on average at least 30 hours of service per week during this period. The stability period for such employees must be the same length as the stability period for ongoing employees.

(ii) *Use of payroll periods.* An applicable large employer member may apply the payroll period rule set forth in paragraph (d)(1)(ii) of this section for purposes of determining an initial

measurement period, provided that the initial measurement period must begin on the start date or any date during the period beginning with the employee's start date and ending with the later of the first day of the first calendar month following the employee's start date and the first day of the first payroll period that starts after the employee's start date. As set forth in paragraph (d)(1)(ii) of this section, the use of payroll periods for purposes of determining the initial measurement period applies for payroll periods that are one week, two weeks, or semimonthly in duration.

(iii) *Employees determined to be employed on average at least 30 hours of service per week.* If a new variable hour employee, new seasonal employee, or new part-time employee has on average at least 30 hours of service per week during the initial measurement period, the applicable large employer member must treat the employee as a full-time employee during the stability period that begins after the initial measurement period (and any associated administrative period). The stability period must be a period of at least six consecutive calendar months that is no shorter in duration than the initial measurement period. The stability period must begin immediately after the end of the measurement period and any applicable administrative period. With respect to an employee who has on average at least 30 hours of service per week during the initial measurement period, the employer will not be subject to an assessable payment under section 4980H(a) for any calendar month during the initial measurement period and any associated administrative period if, for the calendar month, the employee is otherwise eligible for an offer of coverage under a group health plan of the employer, provided that the employee is offered coverage by the employer no later than the first day of the associated stability period if the employee is still employed on that day. If the offer of coverage for which the employee is otherwise eligible during the initial measurement period, and which the employee actually is offered by the first day of the stability period if still employed, provides minimum value, the employer also will not be subject to an assessable payment under section 4980H(b) with respect to that employee during the initial measurement period and any associated administrative period. For purposes of this paragraph (d)(3)(iii), an employee is otherwise eligible to be offered coverage under a group health plan for a month if, pursuant to the terms of the plan as in effect for that calendar month, the employee meets all conditions to be offered coverage under the plan for that month, other than the completion of a waiting period, within the meaning of § 54.9801–2.

(iv) *Employees determined not to be employed on average at least 30 hours of service per week.* If a new variable hour employee, new seasonal employee, or new part-time employee does not have on average at least 30 hours of service per week during the initial measurement period, the applicable large employer member may treat the employee as not a full-time employee during the stability period that follows the initial measurement period. Except as provided in paragraph (d)(4)(iv) of this section, the stability period for such employees must not be more than one month longer than the initial measurement period and must not exceed the remainder of the first entire standard measurement period (plus any associated administrative period) for which a variable hour employee, seasonal employee, or part-time employee has been employed. The stability period must begin immediately after the end of the measurement period and any applicable administrative period.

(v) *Permissible differences in measurement or stability periods for different categories of employees.* Subject to the rules governing the relationship between the length of the measurement period and the stability period, with respect to a new variable hour employee, new seasonal employee, or new part-time employee, applicable large employer members may use measurement periods and stability periods that differ either in length or in their starting and ending dates for the categories of employees identified in paragraph (d)(1)(v) of this section.

(vi) *Optional administrative period*—(A) *In general.* Subject to the limits in paragraph (d)(3)(vi)(B) of this section,

an applicable large employer member may apply an administrative period in connection with an initial measurement period and before the start of the stability period. This administrative period must not exceed 90 days in total. For this purpose, the administrative period includes all periods between the start date of a new variable hour employee, new seasonal employee, or new part-time employee and the date the employee is first offered coverage under the applicable large employer member's group health plan, other than the initial measurement period. Thus, for example, if the applicable large employer member begins the initial measurement period on the first day of the first month following a new employee's start date, the period between the employee's start date and the first day of the next month must be taken into account in applying the 90-day limit on the administrative period. Similarly, if there is a period between the end of the initial measurement period and the date the employee is first offered coverage under the plan, that period must be taken into account in applying the 90-day limit on the administrative period. Applicable large employer members may use administrative periods that differ in length for the categories of employees identified in paragraph (d)(1)(v) of this section.

(B) *Limit on combined length of initial measurement period and administrative period.* In addition to the specific limits on the initial measurement period (which must not exceed 12 months) and the administrative period (which must not exceed 90 days), there is a limit on the combined length of the initial measurement period and the administrative period applicable to a new variable hour employee, new seasonal employee, or new part-time employee. Specifically, the initial measurement period and administrative period together cannot extend beyond the last day of the first calendar month beginning on or after the first anniversary of the employee's start date. For example, if an applicable large employer member uses a 12-month initial measurement period for a new variable hour employee, and begins that initial measurement period on the first day of the first calendar month following the employee's start date, the period between the end of the initial measurement period and the offer of coverage to a new variable hour employee who is a full-time employee based on hours of service during the initial measurement period must not exceed one month.

(vii) *Change in employment status during the initial measurement period*—(A) *In general.* If a new variable hour employee, new seasonal employee, or new part-time employee experiences a change in employment status before the end of the initial measurement period such that, if the employee had begun employment in the new position or status, the employee would have reasonably been expected to be employed on average at least 30 hours of service per week (or, if applicable, would not have been a seasonal employee and would have been expected to be employed on average at least 30 hours of service per week), the rules set forth in the remainder of this paragraph (d)(3)(vii) apply. With respect to an employee described in this paragraph (d)(3)(vii) and subject to the rules in the next sentence, the employer will not be subject to an assessable payment under section 4980H for the period before the first day of the fourth full calendar month following the change in employment status (or, if earlier and the employee averages 30 or more hours of service per week during the initial measurement period, the first day of the first month following the end of the initial measurement period (including any optional administrative period associated with the initial measurement period)). An employer will not be subject to an assessable payment under section 4980H(a) with respect to an employee described in this paragraph (d)(3)(vii) for any calendar month during the period described in the prior sentence if, for the calendar month, the employee is otherwise eligible for an offer of coverage under a group health plan of the employer, provided that the employee is offered coverage by the employer no later than the end of the period described in the prior sentence if the employee is still employed on that date; if the offer of coverage for which the employee is otherwise eligible during the period described in the prior sentence,

and which the employee is actually offered by the first day after the end of that period if still employed, provides minimum value, the employer also will not be subject to an assessable payment under section 4980H(b) with respect to that employee during that period. For purposes of this paragraph (d)(3)(vii), an employee is otherwise eligible to be offered coverage under a group health plan for a calendar month if, pursuant to the terms of the plan as in effect for that calendar month, the employee meets all conditions to be offered coverage under the plan for that calendar month, other than the completion of a waiting period, within the meaning of § 54.9801–2.

(B) *Example*. The following example illustrates the provisions of paragraph (d)(3)(vii) of this section. In the following example, the applicable large employer member has 200 full-time employees and offers all of its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan. The coverage is affordable within the meaning of section 36B(c)(2)(C)(i) (or is treated as affordable under one of the affordability safe harbors described in § 54.4980H–5) and provides minimum value.

Example (Change in employment status from variable hour employee to full-time employee). (i) *Facts*. For new variable hour employees, Employer Z uses a 12-month initial measurement period that begins on the start date and applies an administrative period from the end of the initial measurement period through the end of the first calendar month beginning on or after the end of the initial measurement period. For new variable hour employees, Employer Z offers coverage no later than the first day of the fourteenth month after the start date if an employee averages 30 or more hours of service per week during the initial measurement period. Employer Z hires Employee A on May 10, 2015. Employee A's initial measurement period runs from May 10, 2015, through May 9, 2016, with the optional administrative period ending June 30, 2016. At Employee A's May 10, 2015, start date, Employee A is a variable hour employee. On September 15, 2015, Employer Z promotes Employee A to a position that can reasonably be expected to average at least 30 hours of service per week. For October 2015 through December 2015, Employee A is otherwise eligible for an offer of coverage that provides minimum value, and, on January 1, 2016, Employee A is offered coverage by the employer that provides minimum value.

(ii) *Conclusion*. Employer Z will not be subject to an assessable payment under section 4980H(a) with respect to Employee A for October 2015, November 2015, or December 2015, because for each of those months Employee A is otherwise eligible for an offer of coverage and because Employee A is offered coverage by January 1, 2016 (the date that is the earlier of the first day of the fourth calendar month following the change in employment status (January 1, 2016) or the first day of the calendar month after the end of the initial measurement period plus the optional administrative period (July 1, 2016)). Because the coverage offered on January 1, 2016, provides minimum value, Employer Z also will not be subject to an assessable payment under section 4980H(b) with respect to Employee A for October 2015, November 2015, or December 2015.

(4) *Transition from new variable hour employee, new seasonal employee, or new part-time employee to ongoing employee*—(i) *In general*. Once a new variable hour employee, new seasonal employee, or new part-time employee has been employed for an entire standard measurement period, the applicable large employer member must test the employee for full-time employee status, beginning with that standard measurement period, at the same time and under the same conditions as apply to other ongoing employees. Accordingly, for example, an applicable large employer member with a calendar year standard measurement period that also uses a one-year initial measurement period beginning on the employee's start date would test a new employee whose start date is April 12 for full-time employee status first based on the initial measurement period (April 12 of the year including the start date through April 11 of the following year) and again based on the calendar year standard measurement period (if the employee continues in employment for that entire standard measurement period) beginning on January 1 of the year after the start date.

(ii) *Employee determined to be employed an average of at least 30 hours of service per week*. An employee who was employed an average of at least 30 hours of service per week during an initial measurement period or standard measurement period must be treated as a

full-time employee for the entire associated stability period. This is the case even if the employee was employed an average of at least 30 hours of service per week during the initial measurement period but was not employed an average of at least 30 hours of service per week during the overlapping or immediately following standard measurement period. In that case, the applicable large employer member may treat the employee as not a full-time employee only after the end of the stability period associated with the initial measurement period. Thereafter, the applicable large employer member must determine the employee's status as a full-time employee in the same manner as it determines such status in the case of its other ongoing employees as described in paragraph (d)(1) of this section.

(iii) *Employee determined not to be employed an average of at least 30 hours of service per week.* If the employee was not employed an average of at least 30 hours of service per week during the initial measurement period, but was employed at least 30 hours of service per week during the overlapping or immediately following standard measurement period, the employee must be treated as a full-time employee for the entire stability period that corresponds to that standard measurement period (even if that stability period begins before the end of the stability period associated with the initial measurement period). Thereafter, the applicable large employer member must determine the employee's status as a full-time employee in the same manner as it determines such status in the case of its other ongoing employees as described in paragraph (d)(1) of this section.

(iv) *Treatment during periods between stability periods.* If there is a period between the end of the stability period associated with the initial measurement period and the beginning of the stability period associated with the first full standard measurement period during which an employee is employed, the treatment as a full-time employee or not a full-time employee that applies during the stability period associated with the initial measurement period continues to apply until the beginning of the stability period associated with the first full standard measurement period during which the employee is employed.

(5) *Examples.* The following examples illustrate the look-back measurement methods described in paragraphs (d)(1), (d)(3) and (d)(4) of this section. In all of the following examples, the applicable large employer member has 200 full-time employees and offers all of its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan. The coverage is affordable within the meaning of section 36B(c)(2)(C)(i) (or is treated as affordable coverage under one of the affordability safe harbors described in § 54.4980H–5) and provides minimum value. In *Example 1* through *Example 8*, the new employee is a new variable hour employee, and the employer has chosen to use a 12-month standard measurement period for ongoing employees starting October 15 and a 12-month stability period associated with that standard measurement period starting January 1. (Thus, during the administrative period from October 15 through December 31 of each calendar year, the employer continues to offer coverage to employees who qualified for coverage for that entire calendar year based upon having an average of at least 30 hours of service per week during the prior standard measurement period.) In *Example 9* and *Example 10*, the new employee is a new variable hour employee, and the employer uses a six-month standard measurement period, starting each May 1 and November 1, with six-month stability periods associated with those standard measurement periods starting January 1 and July 1. In *Example 12*, *Example 13*, and *Example 14*, the employer is in the trade or business of providing temporary workers to numerous clients that are unrelated to the employer and to one another; the employer is the common law employer of the temporary workers based on all of the facts and circumstances; the employer offers health plan coverage only to full-time employees (including temporary workers who are full-time employees) and their dependents; and the

employer uses a 12-month initial measurement period for new variable hour employees that begins on the start date and applies an administrative period from the end of the initial measurement period through the end of the first calendar month beginning after the end of the initial measurement period.

Example 1 (12-Month initial measurement period followed by 1 + partial month administrative period). (i) *Facts.* For new variable hour employees, Employer Z uses a 12-month initial measurement period that begins on the start date and applies an administrative period from the end of the initial measurement period through the end of the first calendar month beginning on or after the end of the initial measurement period. Employer Z hires Employee A on May 10, 2015. Employee A's initial measurement period runs from May 10, 2015, through May 9, 2016. Employee A has an average of 30 hours of service per week during this initial measurement period. Employer Z offers coverage that provides minimum value to Employee A for a stability period that runs from July 1, 2016, through June 30, 2017. For each calendar month during the period beginning with June 2015 and ending with June 2016, Employee A is otherwise eligible for an offer of coverage with respect to the coverage that is offered to Employee A on July 1, 2016.

(ii) *Conclusion.* Employer Z uses an initial measurement period that does not exceed 12 months; an administrative period totaling not more than 90 days; and a combined initial measurement period and administrative period that does not last beyond the final day of the first calendar month beginning on or after the one-year anniversary of Employee A's start date. Accordingly, Employer Z complies with the standards for the initial measurement period and stability periods for a new variable hour employee. Employer Z will not be subject to an assessable payment under section 4980H(a) with respect to Employee A for any calendar month from June 2015 through June 2016 because, for each month during that period, Employee A is otherwise eligible for an offer of coverage and because coverage is offered no later than the end of the initial measurement period plus the associated administrative period (July 1, 2016). Employer Z will not be subject to an assessable payment under section 4980H(b) with respect to Employee A for any calendar month from June 2015 through June 2016 because the coverage Employer Z offers to Employee A provides minimum value. Employer Z will not be subject to an assessable payment under section 4980H(a) or (b) with respect to Employee A for May 2015 because an applicable large employer member is not subject to an assessable payment under section 4980H with respect to an employee for the calendar month in which falls the employee's start date if the start date is on a date other than the first day of the calendar month. Employer Z must test Employee A again based on the period from October 15, 2015, through October 14, 2016 (Employer Z's first standard measurement period that begins after Employee A's start date).

Example 2 (11-Month initial measurement period followed by 2 + partial month administrative period). (i) *Facts.* Same as *Example 1*, except that Employer Z uses an 11-month initial measurement period that begins on the start date and applies an administrative period from the end of the initial measurement period until the end of the second calendar month beginning after the end of the initial measurement period. Employee A's initial measurement period runs from May 10, 2015, through April 9, 2016. The administrative period associated with Employee A's initial measurement period ends on June 30, 2016. Employee A has an average of 30 hours of service per week during this initial measurement period.

(ii) *Conclusion.* Same as *Example 1.*

Example 3 (11-Month initial measurement period preceded by partial month administrative period and followed by 2-month administrative period). (i) *Facts.* Same as *Example 1*, except that Employer Z uses an 11-month initial measurement period that begins on the first day of the first calendar month beginning after the start date and applies an administrative period that runs from the end of the initial measurement period through the end of the second calendar month beginning on or after the end of the initial measurement period. Employee A's initial measurement period runs from June 1, 2015, through April 30, 2016. The administrative period associated with Employee A's initial measurement period ends on June 30, 2016. Employee A has an average of 30 hours of service per week during this initial measurement period.

(ii) *Conclusion.* Same as *Example 1.*

Example 4 (12-Month initial measurement period preceded by partial month administrative period and followed by 2-month administrative period). (i) *Facts.* For new variable hour employees, Employer Z uses a 12-month initial measurement period that begins on the first day of the first month following the start date and applies an administrative period that runs from the end of the initial measurement period through the end of the second calendar month beginning on or after the end of the initial measurement period. Employer Z hires Employee A on May 10, 2015. Employee A's initial measurement period runs from June 1, 2015, through May 31, 2016. Employee A has an average of 30 hours of service per week during this initial measurement period. Employer Z offers coverage to Employee A for a stability period that

runs from August 1, 2016, through July 31, 2017.

(ii) *Conclusion.* Employer Z does not satisfy the standards for the look-back measurement method in paragraph (d)(3)(vi)(B) of this section because the combination of the initial partial month delay, the 12-month initial measurement period, and the two month administrative period means that the coverage offered to Employee A does not become effective until after the first day of the second calendar month following the first anniversary of Employee A's start date. Accordingly, Employer Z is potentially subject to an assessable payment under section 4980H for each full calendar month during the initial measurement period and associated administrative period.

Example 5 (Continuous full-time employee). (i) *Facts.* Same as *Example 1;* in addition, Employer Z tests Employee A again based on Employee A's hours of service from October 15, 2015, through October 14, 2016 (Employer Z's first standard measurement period that begins after Employee A's start date), determines that Employee A has an average of 30 hours of service per week during that period, and offers Employee A coverage for July 1, 2017, through December 31, 2017. (Employee A already has an offer of coverage for the period of January 1, 2017, through June 30, 2017, because that period is covered by the initial stability period following the initial measurement period, during which Employee A was determined to be a full-time employee.)

(ii) *Conclusion.* Employer Z is not subject to any payment under section 4980H for any calendar month during 2017 with respect to Employee A.

Example 6 (Initially full-time employee, becomes non-full-time employee). (i) *Facts.* Same as *Example 1;* in addition, Employer Z tests Employee A again based on Employee A's hours of service from October 15, 2015, through October 14, 2016 (Employer Z's first standard measurement period that begins after Employee A's start date), and determines that Employee A has an average of 28 hours of service per week during that period. Employer Z continues to offer coverage to Employee A through June 30, 2017 (the end of the stability period based on the initial measurement period during which Employee A was determined to be a full-time employee), but does not offer coverage to Employee A for the period of July 1, 2017, through December 31, 2017.

(ii) *Conclusion.* Employer Z is not subject to any payment under section 4980H for any calendar month during 2017 with respect to Employee A.

Example 7 (Initially non-full-time employee). (i) *Facts.* Same as *Example 1,* except that Employee A has an average of 28 hours of service per week during the initial measurement period (May 10, 2015, through May 9, 2016), and Employer Z does not offer coverage to Employee A for any calendar month in 2016.

(ii) *Conclusion.* From Employee A's start date through the end of 2016, Employer Z is not subject to any payment under section 4980H with respect to Employee A, because Employer Z complies with the standards for the measurement and stability periods for a new variable hour employee with respect to Employee A and because under those standards, Employee A is not a full-time employee for any month during 2016.

Example 8 (Initially non-full-time employee, becomes full-time employee). (i) *Facts.* Same as *Example 7;* in addition, Employer Z tests Employee A again based on Employee A's hours of service from October 15, 2015, through October 14, 2016 (Employer Z's first standard measurement period that begins after Employee A's start date), determines that Employee A has an average of 30 hours of service per week during this standard measurement period, and offers coverage to Employee A for 2017.

(ii) *Conclusion.* Employer Z is not subject to any payment under section 4980H for any calendar month during 2017 with respect to Employee A.

Example 9 (Initially full-time employee). (i) *Facts.* For new variable hour employees, Employer Y uses a six-month initial measurement period that begins on the start date and applies an administrative period that runs from the end of the initial measurement period through the end of the first full calendar month beginning after the end of the initial measurement period. Employer Y hires Employee B on May 10, 2015. Employee B's initial measurement period runs from May 10, 2015, through November 9, 2015, during which Employee B has an average of 30 hours of service per week. Employer Y offers coverage that provides minimum value to Employee B for a stability period that runs from January 1, 2016, through June 30, 2016. For each calendar month during the period from June 2015 through December 2015, Employee B is otherwise eligible for an offer of coverage with respect to the coverage that is offered to Employee B on January 1, 2016.

(ii) *Conclusion.* Employer Y uses an initial measurement period that does not exceed 12 months; an administrative period totaling not more than 90 days; and a combined initial measurement period and administrative period that does not extend beyond the final day of the first calendar month beginning on or after the one-year anniversary of Employee B's start date. Employer Y complies with the standards for the measurement and stability periods for a new variable hour employee with respect to Employee B. Employer Y is not subject to an assessable payment under section 4980H(a) with respect to Employee B for any calendar month from June 2015 through December 2015 because, for each month during that period, Employee B

is otherwise eligible for an offer of coverage and because Employee B is offered coverage no later than the end of the initial measurement period plus the associated administrative period (January 1, 2016). Employer Y is not subject to an assessable payment under section 4980H(b) with respect to Employee B for any calendar month from June 2015 through December 2015 because the coverage Employer Y offers to Employee B no later than January 1, 2016, provides minimum value. Employer Y is not subject to an assessable payment under section 4980H(a) or (b) with respect to Employee B for May 2015 because an applicable large employer member is not subject to an assessable payment under section 4980H with respect to an employee for the calendar month in which falls the employee's start date if the start date is on a date other than the first day of the calendar month. Employer Y must test Employee B again based on Employee B's hours of service during the period from November 1, 2015, through April 30, 2016 (Employer Y's first standard measurement period that begins after Employee B's start date).

Example 10 (Initially full-time employee, becomes non-full-time employee). (i) *Facts.* Same as *Example 9;* in addition, Employer Y tests Employee B again based on Employee B's hours of service during the period from November 1, 2015, through April 30, 2016 (Employer Y's first standard measurement period that begins after Employee B's start date), during which period Employee B has an average of 28 hours of service per week. Employer Y continues to offer coverage to Employee B through June 30, 2016 (the end of the initial stability period based on the initial measurement period during which Employee B has an average of 30 hours of service per week), but does not offer coverage to Employee B from July 1, 2016, through December 31, 2016.

(ii) *Conclusion.* Employer Y is not subject to any payment under section 4980H with respect to Employee B for any calendar month during 2016.

Example 11 (Seasonal employee, 12-month initial measurement period; 1 + partial month administrative period). (i) *Facts.* Employer X offers health plan coverage only to full-time employees (and their dependents). Employer X uses a 12-month initial measurement period for new seasonal employees that begins on the start date and applies an administrative period from the end of the initial measurement period through the end of the first calendar month beginning after the end of the initial measurement period. Employer X hires Employee C, a ski instructor, on November 15, 2015, with an anticipated season during which Employee C will work running through March 15, 2016. Employee C's initial measurement period runs from November 15, 2015, through November 14, 2016.

(ii) *Conclusion.* Employer X determines that Employee C is a seasonal employee because Employee C is hired into a position for which the customary annual employment is six months or less. Accordingly, Employer X may treat Employee C as a seasonal employee during the initial measurement period.

Example 12 (Variable hour employee; temporary staffing firm). (i) *Facts.* Employer W hires Employee D on January 1, 2015, in a position under which Employer W will offer assignments to Employee D to provide services in temporary placements at clients of Employer W, and employees of Employer W in the same position as Employee D, as part of their continuing employment, retain the right to reject an offer of placement. Employees of Employer W in the same position of employment as Employee D typically perform services for a particular client for 40 hours of service per week for a period of less than 13 weeks, and for each employee there are typically periods in a calendar year during which Employer W does not have an assignment to offer the employee. At the time Employee D is hired by Employer W, Employer W has no reason to anticipate that Employee D's position of employment will differ from the typical employee in the same position.

(ii) *Conclusion.* Employer W cannot determine whether Employee D is reasonably expected to average at least 30 hours of service per week for the 12-month initial measurement period. Accordingly, Employer W may treat Employee D as a variable hour employee during the initial measurement period.

Example 13 (Variable hour employee; temporary staffing firm). (i) *Facts.* Employer V hires Employee E on January 1, 2015, in a position under which Employer V will offer assignments to Employee E to provide services in temporary placements at clients of Employer V. Employees of Employer V in the same position of employment as Employee E typically are offered assignments of varying hours of service per week (so that some weeks of the assignment typically result in more than 30 hours of service per week and other weeks of the assignment typically result in less than 30 hours of service per week). Although a typical employee in the same position of employment as Employee E rarely fails to have an offer of an assignment for any period during the calendar year, employees of Employer V in the same position of employment, as part of their continuing employment, retain the right to reject an offer of placement, and typically refuse one or more offers of placement and do not perform services for periods ranging from four to twelve weeks during a calendar year. At the time Employee E is hired by Employer V, Employer V has no reason to anticipate that Employee E's position of employment

will differ from the typical employee in the same position.

(ii) *Conclusion.* Employer V cannot determine whether Employee E is reasonably expected to average at least 30 hours of service per week for the 12-month initial measurement period. Accordingly, Employer V may treat Employee E as a variable hour employee during the initial measurement period.

Example 14 (Variable hour employee; temporary staffing firm). (i) *Facts.* Employer T hires Employee F on January 1, 2015, in a position under which Employer T will offer assignments to Employee F to provide services in temporary placements at clients of Employer T. Employees of Employer T in the same position typically are offered assignments of 40 or more hours of service per week for periods expected to last for periods of three months to 12 months, subject to a request for renewal by the client. Employees of Employer T in similar positions to Employee F are typically offered and take new positions immediately upon cessation of a placement. At the time Employee F is hired by Employer T, Employer T has no reason to anticipate that Employee F's position of employment will differ from the typical employee in the same position.

(ii) *Conclusion.* Employer T must assume that Employee F will be employed by Employer T and available for an offer of temporary placement for the entire initial measurement period. Under that assumption, Employer T would reasonably determine that Employee F is reasonably expected to average at least 30 hours of service per week for the 12-month initial measurement period. Accordingly, Employer T may not treat Employee F as a variable hour employee during the initial measurement period.

Example 15 (Variable hour employee). (i) *Facts.* Employee G is hired on an hourly basis by Employer S to fill in for employees who are absent and to provide additional staffing at peak times. Employer S expects that Employee G will average 30 hours of service per week or more for Employee G's first few months of employment, while assigned to a specific project, but also reasonably expects that the assignments will be of unpredictable duration, that there will be periods of unpredictable duration between assignments, that the hours per week required by subsequent assignments will vary, and that Employee G will not necessarily be available for all assignments.

(ii) *Conclusion.* Employer S cannot determine whether Employee G is reasonably expected to average at least 30 hours of service per week for the initial measurement period. Accordingly, Employer S may treat Employee G as a variable hour employee during the initial measurement period.

Example 16 (Period between initial stability period and standard stability period). (i) *Facts.* Employer R uses an 11-month initial measurement period for new variable hour, new seasonal, and new part-time employees with an administrative period that lasts from the end of the initial measurement period through the last day of the first calendar month beginning on or after the first anniversary of the employee's start date. Employer R uses a standard measurement period of October 15 through October 14, and an administrative period of October 15 through December 31. Employee H is hired as a variable hour employee on October 20, 2015, with an initial measurement period of October 20, 2015, through September 19, 2016, and an administrative period lasting through November 30, 2016. Employee H is a full-time employee based on the hours of service in the initial measurement period, and Employee H's stability period for the initial measurement period is December 1, 2016, through November 30, 2017. Employee H's first full standard measurement period begins on October 15, 2016, with an associated stability period beginning on January 1, 2018. The standard measurement period beginning on October 15, 2015, does not apply to Employee H because Employee H is not hired until October 20, 2015.

(ii) *Conclusion.* For the period after the stability period associated with the initial measurement period and before the stability period associated with Employee H's first full standard measurement period (that is December 1, 2017, through December 31, 2017), Employer R must treat Employee H as a full-time employee because the treatment as a full-time employee (or not a full-time employee) that applies during the stability period associated with the initial measurement period continues to apply until the beginning of the stability period associated with the first full standard measurement period during which the employee is employed.

(6) *Employees rehired after termination of employment or resuming service after other absence*—(i) *Treatment as a new employee after a period of absence for employees of employers other than educational organizations*—(A) *In general.* The rules in this paragraph (d)(6)(i) apply to employers that are not educational organizations. For rules relating to employers that are educational organizations, see paragraph (d)(6)(ii) of this section. An employee who resumes providing services to (or is otherwise credited with an hour of service for) an applicable large employer that is not an educational organization after a period during which the employee was not credited with any hours of service may be treated as having terminated employment and having been

rehired, and therefore may be treated as a new employee upon the resumption of services, only if the employee did not have an hour of service for the applicable large employer for a period of at least 13 consecutive weeks immediately preceding the resumption of services. The rule set forth in this paragraph (d)(6)(i) applies solely for the purpose of determining whether the employee, upon the resumption of services, is treated as a new employee or as a continuing employee, and does not determine whether the employee is treated as a continuing full-time employee or a terminated employee during the period during which no hours of service are credited.

(B) *Averaging method for special unpaid leave.* For purposes of applying the look-back measurement method described in paragraph (d) of this section to an employee who is not treated as a new employee under paragraph (d)(6)(i) of this section, the employer determines the employee's average hours of service for a measurement period by computing the average after excluding any special unpaid leave during that measurement period and by using that average as the average for the entire measurement period. Alternatively, for purposes of determining the employee's average hours of service for the measurement period, the employer may choose to treat the employee as credited with hours of service for any periods of special unpaid leave during that measurement period at a rate equal to the average weekly rate at which the employee was credited with hours of service during the weeks in the measurement period that are not part of a period of special unpaid leave. There is no limit on the number of hours of service required to be excluded or credited (as the case may be) with respect to special unpaid leave. For purposes of this paragraph (d)(6)(i)(B), in computing the average weekly rate, employers are permitted to use any reasonable method if applied on a consistent basis. In addition, if an employee's average weekly rate under this paragraph (d)(6)(i)(B) is computed for a measurement period and that measurement period is shorter than six months, the six-month period ending with the close of the measurement period is used to compute the average hours of service.

(C) *Averaging rules for employment break periods for employers other than educational organizations.* The averaging rule for employment break periods described in paragraph (d)(6)(ii)(B) of this section applies only to educational organizations and does not apply to other employers.

(ii) *Treatment as a new employee after a period of absence for employees of employers that are educational organizations*—(A) *In general.* The rules of this paragraph (d)(6)(ii) apply only to employers that are educational institutions. An employee who resumes providing services to (or is otherwise credited with an hour of service for) an applicable large employer that is an educational organization after a period during which the employee was not credited with any hours of service may be treated as having terminated employment and having been rehired, and therefore may be treated as a new employee upon the resumption of services, only if the employee did not have an hour of service for the applicable large employer for a period of at least 26 consecutive weeks immediately preceding the resumption of services. The rule set forth in this paragraph (d)(6)(ii)(A) applies solely for the purpose of determining whether the employee, upon the resumption of services, is treated as a new employee or as a continuing employee, and does not determine whether the employee is treated as a continuing full-time employee or a terminated employee during the period during which no hours of service are credited.

(B) *Averaging method for special unpaid leave and employment break periods.* For purposes of applying the look-back measurement method described in paragraph (d) of this section to an employee who is not treated as a new employee under paragraph (d)(6)(ii)(A) of this section, an educational organization employer determines the employee's average hours of service for a measurement period by computing the average after excluding any special unpaid leave and any employment break period during that measurement period and by using that average as the average for the entire measurement period.

Alternatively, for purposes of determining the employee's average hours of service for the measurement period, the employer may choose to treat the employee as credited with hours of service for any periods of special unpaid leave and any employment break period during that measurement period at a rate equal to the average weekly rate at which the employee was credited with hours of service during the weeks in the measurement period that are not part of a period of special unpaid leave or an employment break period. Notwithstanding the preceding two sentences, no more than 501 hours of service during employment break periods in a calendar year are required to be excluded (under the first sentence) or credited (under the second sentence) by an educational organization, provided that this 501-hour limit does not apply to hours of service required to be excluded or credited in respect of special unpaid leave. In applying the preceding sentence, an employer that uses the method described in the first sentence of this paragraph (d)(6)(ii)(B) determines the number of hours excluded by multiplying the average weekly rate for the measurement period (determined as in the second sentence of this paragraph (d)(6)(ii)(B)) by the number of weeks in the employment break period. For purposes of this paragraph (d)(6)(ii)(B), in computing the average weekly rate, employers are permitted to use any reasonable method if applied on a consistent basis. In addition, if an employee's average weekly rate under this paragraph (d)(6)(ii)(B) is being computed for a measurement period and that measurement period is shorter than six months, the six-month period ending with the close of the measurement period is used to compute the average hours of service.

(iii) *Treatment of continuing employee.* Under the look-back measurement method, an employee treated as a continuing employee retains, upon resumption of services, the status that employee had with respect to the application of any stability period (for example, if the continuing employee returns during a stability period in which the employee is treated as a full-time employee, the employee is treated as a full-time employee upon return and through the end of that stability period). For purposes of the preceding sentence, a continuing employee treated as a full-time employee is treated as offered coverage upon resumption of services if the employee is offered coverage as of the first day that employee is credited with an hour of service, or, if later, as soon as administratively practicable. For this purpose, offering coverage by no later than the first day of the calendar month following resumption of services is deemed to be as soon as administratively practicable. If a continuing employee returns during a stability period in which the employee is treated as a full-time employee and the employer previously made the employee an offer of coverage with respect to the entire stability period and the employee declined the offer, the employer will continue to be treated as having offered coverage for that stability period and the employer need not make a new offer of coverage for the remainder of the ongoing stability period due to the employee's resumption of services.

(iv) *Rule of parity.* For purposes of determining the period after which an employee may be treated as having terminated employment and having been rehired, an applicable large employer may choose a period, measured in weeks, of at least four consecutive weeks during which the employee was not credited with any hours of service that exceeds the number of weeks of that employee's period of employment with the applicable large employer immediately preceding the period and that is shorter than 13 weeks (for an employee of an educational organization employer, a period that is shorter than 26 weeks). For purposes of the preceding sentence, the duration of the immediately preceding period of employment is determined after application to that period of employment of the averaging methods described in paragraphs (d)(6)(i)(B) and (d)(6)(ii)(B) of this section (relating to employment break periods and special unpaid leave), if applicable.

(v) *International transfers.* An employer may treat an employee as having terminated employment if the employee transfers to a position at the

same applicable large employer (including a different applicable large employer member that is part of the same applicable large employer) if the position is anticipated to continue indefinitely or for at least 12 months and if substantially all of the compensation will constitute income from sources without the United States (within the meaning of sections 861 through 863 and the regulations thereunder). With respect to an employee transferring from a position that was anticipated to continue indefinitely or for at least 12 months and in which substantially all of the compensation for the hours of service constitutes income from sources without the United States (within the meaning of sections 861 through 863 and the regulations thereunder) to a position at the same applicable large employer (including a different applicable large employer member that is part of the same applicable large employer) with respect to which substantially all of the compensation will constitute U.S. source income, the employer may treat that employee as a new hire to the extent consistent with the rules related to rehired employees in paragraph (d)(6) of this section.

(vi) *Anti-abuse rule.* For purposes of this paragraph (d)(6), any hour of service is disregarded if the hour of service is credited, or the services giving rise to the crediting of the hour of service are requested or required of the employee, for a purpose of avoiding or undermining the application of the employee rehire rules under paragraph (d)(6) of this section, or the application of the averaging method for employment break periods under paragraph (d)(6)(ii)(B) of this section. For example, if an employee of an educational organization would otherwise have a period with no hours of service to which the rules under paragraph (d)(6)(ii)(B) of this section would apply, but for the employer's request or requirement that the employee perform one or more hours of service for a purpose of avoiding the application of those rules, any such hours of service for the week are disregarded, and the rules under paragraph (d)(6)(ii)(B) of this section will apply.

(vii) *Examples.* The following examples illustrate the provisions of paragraph (d)(6) of this section. All employers in these examples are applicable large employer members with 200 full-time employees (including full-time equivalent employees), each is in a different applicable large employer group, and each determines full-time employee status under the look-back measurement method. None of the periods during which an employee is not credited with an hour of service for an employer involve special unpaid leave or the employee being credited with hours of service for any applicable large employer member in the same applicable large employer as the employer.

Example 1. (i) *Facts.* As of April 1, 2015, Employee A has been an employee of Employer Z (which is not an educational organization) for 10 years. On April 1, 2015, Employee A terminates employment and is not credited with an hour of service until June 1, 2015, when Employer Z rehires Employee A and Employee A continues as an employee through December 31, 2015, which is the close of the measurement period as applied by Employer Z.

(ii) *Conclusion.* Because the period for which Employee A is not credited with any hours of service is not longer than Employee A's prior period of employment and is less than 13 weeks, Employee A is not treated as having terminated employment and been rehired for purposes of determining whether Employee A is treated as a new employee upon resumption of services. Therefore, Employee A's hours of service prior to termination are required to be taken into account for purposes of the measurement period, and Employee A's period with no hours of service is taken into account as a period of zero hours of service during the measurement period.

Example 2. (i) *Facts.* Same facts as *Example 1,* except that Employee A is rehired on December 1, 2015.

(ii) *Conclusion.* Because the period during which Employee A is not credited with an hour of service for Employer Z exceeds 13 weeks, Employee A is treated as having terminated employment on April 1, 2015, and having been rehired as a new employee on December 1, 2015, for purposes of determining Employee A's full-time employee status. Because Employee A is treated as a new employee, Employee A's hours of service prior to termination are not taken into account for purposes of the measurement period, and the period between termination and rehire with no hours of service is not taken into account in the new measurement period that begins after the employee is rehired.

Example 3. (i) *Facts.* Employee B is employed by Employer Y, an educational organization. Employee B is employed for 38 hours of service per week on average from September 7, 2014, through May 23, 2015, and then does not provide services (and is not otherwise credited with an hour of service) during the summer break when the school is generally not in session. Employee B resumes providing services for Employer Y on September 7, 2015, when the new school year begins.

(ii) *Conclusion.* Because the period from May 24, 2015 through September 5, 2015 (a total of 15 weeks), during which Employee B is not credited with an hour of service does not exceed 26 weeks, and also does not exceed the number of weeks of Employee B's immediately preceding period of employment, Employee B is not treated as having terminated employment on May 24, 2015, and having been rehired on September 6, 2015. Also, for purposes of determining Employee B's average hours of service per week for the measurement period, Employee B is credited, under the averaging method for employment break periods applicable to educational organizations, as having an average of 38 hours of service per week for the 15 weeks between May 24, 2015 and September 5, 2015, during which Employee B otherwise was credited with no hours of service. However, Employer Y is not required to credit more than 501 hours of service for the employment break period (15 weeks × 38 hours = 570 hours).

Example 4. (i) *Facts.* Same facts as *Example 3*, except that Employee B does not resume providing services for Employer Y until December 5, 2015.

(ii) *Conclusion.* Because the period from May 24, 2015 through December 5, 2015, exceeds 26 weeks, Employee B may be treated as having terminated employment on May 24, 2015, and having been rehired on December 5, 2015. Because Employee B is treated as a new employee on December 5, 2015, Employee B's hours of service prior to termination are not taken into account for purposes of the measurement period, and the period between termination and rehire with no hours of service is not taken into account in the new measurement period that begins after Employee B is rehired. The averaging method for employment break periods applicable to educational organizations does not apply because Employee B is treated as a new employee rather than a continuing employee as of the date of resumption of services.

(e) *Use of the look-back measurement method and the monthly measurement method for different categories of employees.* Different applicable large employer members of the same applicable large employer may use different methods of determining full-time employee status (that is, either the monthly measurement method or the look-back measurement method). In addition, an applicable large employer member may use either the monthly measurement method or the look-back measurement method for each of the categories of employees set forth in paragraphs (d)(1)(v) and (d)(3)(v) of this section, and is not required to use the same method for all categories.

(f) *Changes in employment status resulting in a change in full-time employee determination method*—(1) *Change in employment status from a position to which a look-back measurement method applies to a position to which the monthly measurement method applies, or vice versa*—(i) *Change from look-back measurement method to monthly measurement method.* For an employee transferring from a position under which the look-back measurement method is used to determine the employee's status as a full-time employee, to a position under which the monthly measurement method is used to determine the employee's status as a full-time employee, the following rules apply:

(A) For an employee who at the time of the change of position is in a stability period under which the employee is treated as a full-time employee, the employer must continue to treat the employee as a full-time employee through the end of the stability period;

(B) For an employee who at the time of the change of position is in a stability period under which the employee is not treated as a full-time employee, the employer may continue to treat the employee as not a full-time employee through the end of the stability period, or may apply the monthly measurement method set forth in paragraph (c) of this section through the end of the stability period beginning with any calendar month including the calendar month in which the change in employment status occurs or any subsequent calendar month;

(C) For the stability period associated with the measurement period during which the change in employment status occurs, the employer must treat the employee as a full-time employee for any calendar month during which the employee either would be treated

as a full-time employee under the stability period that would have applied based on the measurement period in which the change in employment status occurred or would be treated as a full-time employee under the monthly measurement method; and

(D) For any calendar month subsequent to the stability period identified in paragraph (f)(1)(i)(C) of this section, the monthly measurement method applies for determination of the employee's status as a full-time employee.

(ii) *Change from monthly measurement method to look-back measurement method.* For an employee who is transferring from a position under which the monthly measurement method is used to determine the employee's status as a full-time employee, to a position under which a look-back measurement method is used to determine the employee's status as a full-time employee, the following rules apply:

(A) For the remainder of the applicable stability period during which the change in employment status occurs, the employer must continue to use the monthly measurement method to determine the employee's status as a full-time employee unless the employee's hours of service prior to the change in employment status would have resulted in the employee being treated as a full-time employee during the stability period in which the change in employment status occurs, in which case the employer must treat the employee as a full-time employee for that stability period;

(B) For the applicable stability period following the measurement period during which the change in employment status occurs, the employer must treat the employee as a full-time employee for any calendar month during which the employee either would be treated as a full-time employee based on the measurement period during which the change in employment status occurs or would be treated as a full-time employee under the monthly measurement method; and

(C) For any calendar month subsequent to the stability period identified in paragraph (f)(1)(ii)(B) of this section, the look-back measurement method applies for determination of the employee's status as a full-time employee.

(iii) *Examples.* The following examples illustrate the rules of this paragraph (f). In each example, the employer is an applicable large employer with 200 full-time employees (including FTEs). For each example, the employer uses the monthly measurement method for determining whether a salaried employee is a full-time employee, and the look-back measurement method for determining whether an hourly employee is a full-time employee with a measurement period from October 15 through October 14 of the following calendar year, and a stability period from January 1 through December 31. In each case, the relevant employee has been employed continuously for several years.

Example 1 (Look-back measurement method to monthly measurement method). Employee A is an hourly employee. Based on Employee A's hours of service from October 15, 2015, through October 14, 2016, Employee A is treated as a full-time employee from January 1, 2017, through December 31, 2017. On July 1, 2017, Employee A transfers from a position as an hourly employee to a position as a salaried employee. For the months July 2017 through December 2017, Employee A must be treated as a full-time employee. Employee A is employed for hours of service from October 15, 2016, through October 14, 2017, such that under the applicable look-back measurement method Employee A would be treated as a full-time employee for the period of January 1, 2018, through December 31, 2018. Accordingly, Employee A must be treated as a full-time employee for the calendar year 2018. For calendar year 2019, the determination of whether Employee A is a full-time employee is made under the monthly measurement method.

Example 2 (Look-back measurement method to monthly measurement method). Same facts as *Example 1,* except that based on Employee A's hours of service from October 15, 2015, through October 14, 2016, Employee A is not treated as a full-time employee from January 1, 2017, through December 31, 2017. For the months July 2017 through December 2017, Employer Z may either treat Employee A as not a full-time employee or apply the monthly measurement method to determine Employee A's status as a full-time employee. Employee A is employed for hours of service from October 15, 2016, through October 14, 2017, such that under the applicable look-back measurement method Employee A would be treated as a full-time employee for the period of January 1, 2018, through December 31, 2018. Employee A must be treated as a full-time employee for the calendar year

2018. For calendar year 2019, the determination of whether Employee A is a full-time employee is made under the monthly measurement method.

Example 3 (Look-back measurement method to monthly measurement method). Same facts as *Example 1*, except that Employee A is employed for hours of service from October 15, 2016, through October 14, 2017, such that under the applicable look-back measurement method Employee A would not be treated as a full-time employee for the period of January 1, 2018, through December 31, 2018. For the calendar year 2018, Employer Z must treat Employee A as a full-time employee only for calendar months during which Employee A would be a full-time employee under the monthly measurement method. For calendar year 2019, the determination of whether Employee A is a full-time employee is made under the monthly measurement method.

Example 4 (Monthly measurement method to look-back measurement method). Employee B is a salaried employee of Employer Y. On July 1, 2017, Employee B transfers to an hourly employee position. Based on Employee B's hours of service from October 15, 2015, through October 14, 2016, Employee B would have been treated as a full-time employee for the stability period from January 1, 2017, through December 31, 2017, had the look-back measurement method applicable to hourly employees applied to Employee B for the entire stability period. For the calendar months January 2017 through June 2017 (prior to Employee B's change to hourly employee status), Employee B's status as a full-time employee is determined using the monthly measurement method. For the calendar months July 2017 through December 2017, Employer Y must treat Employee B as a full-time employee because Employee B would have been treated as a full-time employee during that portion of the stability period had the look-back measurement method applied to Employee B for that entire stability period. Employee B is employed for hours of service from October 15, 2016, through October 14, 2017, such that under the applicable look-back measurement method Employee B would be treated as a full-time employee for the period January 1, 2018, through December 31, 2018. Accordingly, Employee B must be treated as a full-time employee for the calendar year 2018. For calendar year 2019, the determination of whether Employee B is a full-time employee is made under the applicable look-back measurement method.

Example 5 (Monthly measurement method to look-back measurement method). Same facts as *Example 4*, except that based on Employee B's hours of service from October 15, 2015, through October 14, 2016, Employee B would not have been treated as a full-time employee from January 1, 2017, through December 31, 2017. For the calendar months of 2017, Employer Y applies the monthly measurement method to determine Employee B's status as a full-time employee. Employee B is employed for hours of service from October 15, 2016, through October 14, 2017, such that under the applicable look-back measurement method Employee B would be treated as a full-time employee for the period January 1, 2018, through December 31, 2018. Accordingly, Employee B must be treated as a full-time employee for the calendar year 2018. For calendar year 2019, the determination of whether Employee B is a full-time employee is made under the applicable look-back measurement method.

Example 6 (Monthly measurement method to look-back measurement method). Same facts as *Example 4*, except that Employee B is employed for hours of service from October 15, 2016, through October 14, 2017, such that under the applicable look-back measurement method Employee B would not be treated as a full-time employee for the period of January 1, 2018, through December 31, 2018. For the calendar year 2018, Employer Y must treat Employee B as a full-time employee only for calendar months during which Employee B would be a full-time employee under the monthly measurement method.

(2) *Special rule for certain employees to whom minimum value coverage has been continuously offered*—(i) *In general.* Notwithstanding the rules in paragraphs (e) and (f) of this section, an employer using the look-back measurement method to determine the full-time employee status of an employee may apply the monthly measurement method to that employee beginning on the first day of the fourth full calendar month following the calendar month in which the employee experiences a change in employment status such that, if the employee had begun employment in the new position or status, the employee would have reasonably been expected not to be employed on average at least 30 hours of service per week (for example, the employee has changed to a part-time position of only 20 hours of service per week). This rule only applies with respect to an employee to whom the applicable large employer member offered minimum value coverage by the first day of the calendar month following the employee's initial three full calendar months of employment through the calendar

month in which the change in employment status described in this paragraph (f)(2) occurs, and only if the employee actually averages less than 30 hours of service per week for each of the three full calendar months following the change in employment status. For the three full calendar months between the employee's change in employment status and the application of the monthly measurement method, the employee's full-time employee status is determined based on the employee's status during the applicable stability period(s). Under this rule, an employer may apply the monthly measurement method to an employee even if the employer does not apply the monthly measurement method to the other employees in the same category of employees under paragraph (d)(1)(v) or (d)(3)(v) of this section (for example, under this method an employer could apply the monthly measurement method to an hourly employee, even if the employer uses the look-back measurement method to determine full-time employee status of all other hourly employees). The employer may continue to apply the monthly measurement method through the end of the first full measurement period (and any associated administrative period) that would have applied had the employee remained under the applicable look-back measurement method.

(ii) *Examples*. The following examples illustrate the rule of paragraphs (f)(2) of this section. In each example, the employer is an applicable large employer with 200 full-time employees (including FTEs).

Example 1 (New variable hour employee, no delay in coverage, becomes non-full-time employee). (i) *Facts*. Employer Z, an applicable large employer, uses the look-back measurement method to determine the full-time employee status for all of its employees. On May 10, 2015, Employer Z hired Employee A who is a variable hour employee. Although Employee A is a new variable hour employee, so that Employer Z could wait until the end of an initial measurement period to offer coverage to Employee A without an assessable payment under section 4980H with respect to Employee A, Employer Z offers coverage that provides minimum value to Employee A on September 1, 2015. For its ongoing employees, Employer Z has chosen to use a 12-month standard measurement period starting October 15 and a 12-month stability period associated with that standard measurement period starting January 1. Employee A continues in employment with Employer Z for over five years and averages more than 30 hours of service per week for all measurement periods through the measurement period ending October 14, 2020. On February 12, 2021, Employee A experiences a change in position of employment with Employer Z to a position under which Employer Z reasonably expects Employee A to average less than 30 hours of service per week. For the calendar months after February 2021, Employee A averages less than 30 hours of service per week. Employer Z offered Employee A coverage that provided minimum value continuously from September 1, 2015, through May 31, 2021. Effective June 1, 2021, Employer Z elects to apply the monthly measurement method to determine Employee A's status as a full-time employee for the remainder of the stability period ending December 31, 2021, and the calendar year 2022 (which is through the end of the first full measurement period following the change in employment status plus the associated administrative period). Applying the stability period beginning January 1, 2021, Employer Z treats Employee A as a full-time employee for each calendar month from January 2021 through May 2021. Applying the monthly measurement method, for each calendar month from June 2021 through December 2022, Employer Z treats Employee A as not a full-time employee.

(ii) *Conclusion*. Because Employer Z offered coverage that provided minimum value to Employee A from no later than the first day of the fourth full calendar month following Employee A's start date through the calendar month in which the change in employment status occurred, and because Employee A did not average 30 hours of service per week for any of the three calendar months immediately following Employee A's change in employment status to an employee not reasonably expected to average 30 hours of service per week, Employer Z may use the monthly measurement method to determine the full-time employee status of Employee A beginning on the first day of the fourth month following the change in employment status (June 1, 2021) through the end of the first full measurement period (plus any associated administrative period) immediately following the change in employment status (December 31, 2022). Because Employee A did not average at least 30 hours of service per week for any calendar month from June 2021 through December 2022, Employer Z has properly treated Employee A as not a full-time employee for those calendar months.

Example 2 (New full-time employee, no delay in coverage, becomes non-full-time employee). (i) *Facts*. Same facts as *Example 1*, except that

at Employee A's start date, Employer Z reasonably expects that Employee A will average at least 30 hours of service per week. Accordingly, Employer Z offers coverage to Employee A beginning on September 1, 2015, and offers coverage continuously to Employee A for all calendar months through May 2021.

(ii) *Conclusion*. Same as *Example 1*.

(g) *Nonpayment or late payment of premiums*. An applicable large employer member will not be treated as failing to offer to a full-time employee (and his or her dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan for an employee whose coverage under the plan is terminated during the coverage period solely due to the employee failing to make a timely payment of the employee portion of the premium. This treatment continues only through the end of the coverage period (typically the plan year). For this purpose, the rules in § 54.4980B–8, Q&A–5(a), (c), (d) and (e) apply under this section to the payment for coverage with respect to a full-time employee in the same manner that they apply to payment for COBRA continuation coverage under § 54.4980B–8.

(h) *Additional guidance*. With respect to the determination of full-time employee status, including determination of hours of service, the Commissioner may prescribe additional guidance of general applicability, published in the Internal Revenue Bulletin (see § 601.601(d)(2)(ii)(b) of this chapter).

(i) *Effective/applicability date*. This section is applicable for periods after December 31, 2014.

[T.D. 9655, 79 FR 8577, Feb. 12, 2014]

§ 54.4980H–4 Assessable payments under section 4980H(a).

(a) *In general*. If an applicable large employer member fails to offer to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan for any calendar month, and the applicable large employer member has received a Section 1411 Certification with respect to at least one full-time employee, an assessable payment is imposed. For the calendar month, the applicable large employer member will owe an assessable payment equal to the product of the section 4980H(a) applicable payment amount and the number of full-time employees of the applicable large employer member (other than employees in a limited non-assessment period for certain employees and as adjusted in accordance with paragraph (e) of this section). For purposes of this paragraph (a), an applicable large employer member is treated as offering such coverage to its full-time employees (and their dependents) for a calendar month if, for that month, it offers such coverage to all but five percent (or, if greater, five) of its full-time employees (provided that an employee is treated as having been offered coverage only if the employer also offers coverage to that employee's dependents). For purposes of the preceding sentence, an employee in a limited non-assessment period for certain employees is not included in the calculation.

(b) *Offer of coverage*—(1) *In general*. An applicable large employer member will not be treated as having made an offer of coverage to a full-time employee for a plan year if the employee does not have an effective opportunity to elect to enroll in the coverage at least once with respect to the plan year, or does not have an effective opportunity to decline to enroll if the coverage offered does not provide minimum value or requires an employee contribution for any calendar month of more than 9.5 percent of a monthly amount determined as the federal poverty line for a single individual for the applicable calendar year, divided by 12. For this purpose, the applicable federal poverty line is the federal poverty line for the 48 contiguous states and the District of Columbia. Whether an employee has an effective opportunity to enroll or to decline to enroll is determined based on all the relevant facts and circumstances, including adequacy of notice of the availability of the offer of coverage, the period of time during which acceptance of the offer of coverage may be made, and any other conditions on the offer. An employee's election of coverage from a prior year that continues for the next plan year unless the employee affirmatively

elects to opt out of the plan constitutes an offer of coverage for purposes of section 4980H.

(2) *Offer of coverage on behalf of another entity.* For purposes of section 4980H, an offer of coverage by one applicable large employer member to an employee for a calendar month is treated as an offer of coverage by all applicable large employer members for that calendar month. In addition, an offer of coverage made to an employee on behalf of a contributing employer under a multiemployer or single employer Taft-Hartley plan or multiple employer welfare arrangement (MEWA) is treated as made by the employer. For an offer of coverage to an employee performing services for an employer that is a client of a staffing firm, in cases in which the staffing firm is not the common law employer of the individual and the staffing firm makes an offer of coverage to the employee on behalf of the client employer under a plan established or maintained by the staffing firm, the offer is treated as made by the client employer for purposes of section 4980H only if the fee the client employer would pay to the staffing firm for an employee enrolled in health coverage under the plan is higher than the fee the client employer would pay the staffing firm for the same employee if that employee did not enroll in health coverage under the plan.

(c) *Partial calendar month.* If an applicable large employer member fails to offer coverage to a full-time employee for any day of a calendar month, that employee is treated as not offered coverage during that entire month, regardless of whether the employer uses the payroll period rule set forth in § 54.4980H–3(d)(1)(ii) or the weekly rule set forth in § 54.4980H–3(c)(3) to determine full-time employee status for the calendar month. However, in a calendar month in which the employment of a full-time employee terminates, if the employee would have been offered coverage for the entire calendar month had the employee been employed for the entire calendar month, the employee is treated as having been offered coverage for that entire calendar month. In addition, an applicable large employer member is not subject to an assessable payment under section 4980H with respect to an employee for the calendar month in which the employee's start date occurs if the start date is on a date other than the first day of the calendar month, and, in addition, with respect to the calendar month in which the start date occurs, such an employee is not included for purposes of the calculation of any potential liability under section 4980H(a).

(d) *Application to applicable large employer member.* The liability for an assessable payment under section 4980H(a) for a calendar month with respect to a full-time employee applies solely to the applicable large employer member that was the employer of that employee for that calendar month. For an employee who was an employee of more than one applicable large employer member of the same applicable large employer during a calendar month, the liability for the assessable payment under section 4980H(a) for a calendar month applies to the applicable large employer member for whom the employee has the greatest number of hours of service for that calendar month (if the employee has an equal number of hours of service for two or more applicable large employer members of the same applicable large employer for the calendar month, those applicable large employer members can treat one of those members as the employer of that employee for that calendar month for purposes of this section, and if the members do not select one member, or select in an inconsistent manner, the IRS will select a member to be treated as the employer of that employee for purposes of the assessable payment determination). For a calendar month, an applicable large employer member may be liable for an assessable payment under section 4980H(a) or under section 4980H(b), but will not be liable for an assessable payment under both section 4980H(a) and section 4980H(b).

(e) *Allocated reduction of 30 full-time employees.* For purposes of the liability calculation under paragraph (a) of this section, with respect to each calendar month, an applicable large employer member's number of full-time employees is reduced by that member's allocable share of 30. The applicable large

employer member's allocation is equal to 30 allocated ratably among all members of the applicable large employer on the basis of the number of full-time employees employed by each applicable large employer member during the calendar month (after application of the rules of paragraph (d) of this section addressing employees who work for more than one applicable large employer member during a calendar month). If an applicable large employer member's total allocation is not a whole number, the allocation is rounded to the next highest whole number. This rounding rule may result in the aggregate reduction for the entire group of applicable large employer members exceeding 30.

(f) *Example*. The following example illustrates the provisions of paragraphs (a) and (e) of this section.

Example. (i) *Facts*. Applicable large employer member Z and applicable large employer member Y are the two members of an applicable large employer. Applicable large employer member Z employs 40 full-time employees in each calendar month of 2017. Applicable large employer member Y employs 35 full-time employees in each calendar month of 2017. Assume that for 2017, the applicable payment amount for a calendar month is $2,000 divided by 12. Applicable large employer member Z does not sponsor an eligible employer-sponsored plan for any calendar month of 2017, and receives a Section 1411 Certification for 2017 with respect to at least one of its full-time employees. Applicable large employer member Y sponsors an eligible employer-sponsored plan under which all of its full-time employees are eligible for minimum essential coverage.

(ii) *Conclusion*. Pursuant to section 4980H(a) and this section, applicable large employer member Z is subject to an assessable payment under section 4980H(a) for 2017 of $48,000, which is equal to 24 × $2,000 (40 full-time employees reduced by 16 (its allocable share of the 30-employee offset ((40/75) × 30 = 16)) and then multiplied by $2,000). Applicable large employer member Y is not subject to an assessable payment under section 4980H(a) for 2017.

(g) *Additional guidance*. With respect to assessable payments under section 4980H(a), the Commissioner may prescribe additional guidance of general applicability, published in the Internal Revenue Bulletin (see § 601.601(d)(2)(ii)(b) of this chapter).

(h) *Effective/applicability date*. This section is applicable for periods after December 31, 2014.

[T.D. 9655, 79 FR 8577, Feb. 12, 2014]

§ 54.4980H–5 Assessable payments under section 4980H(b).

(a) *In general*. If an applicable large employer member offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan for any calendar month (including an offer of coverage to all but five percent or less (or, if greater, five or less) of its full-time employees (provided that an employee is treated as having been offered coverage only if the employer also offers coverage to that employee's dependents)) and the applicable large employer member has received a Section 1411 Certification with respect to one or more full-time employees of the applicable large employer member, then there is imposed on the applicable large employer member an assessable payment equal to the product of the number of full-time employees of the applicable large employer member for which it has received a Section 1411 Certification (minus the number of those employees in a limited non-assessment period for certain employees and the number of other employees who were offered the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan that satisfied minimum value and met one or more of the affordability safe harbors described in paragraph (e) of this section) and the section 4980H(b) applicable payment amount. Notwithstanding the foregoing, the aggregate amount of assessable payment determined under this paragraph (a) with respect to all employees of an applicable large employer member for any calendar month may not exceed the product of the section 4980H(a) applicable payment amount and the number of full-time employees of the applicable large employer member during that calendar month (reduced by the applicable large employer member's ratable allocation of the 30 employee reduction under § 54.4980H–4(e)).

(b) *Offer of coverage*. For purposes of this section, the same rules with respect to an offer of coverage for purposes of section 4980H(a) apply. See § 54.4980H–4.

(c) *Partial calendar month*. If an applicable large employer member fails to offer coverage to a full-time employee for any day of a calendar month, that employee is treated as not offered coverage during that entire month, regardless of whether the employer uses the payroll period rule set forth in § 54.4980H–3(d)(1)(ii) or the weekly rule set forth in § 54.4980H–3(c)(3) to determine full-time employee status for the calendar month. However, in a calendar month in which a full-time employee's employment terminates, if the employee would have been offered coverage if the employee had been employed for the entire month, the employee is treated as having been offered coverage during that month. Also, an applicable large employer member is not subject to an assessable payment under section 4980H with respect to an employee for the calendar month in which the employee's start date occurs if the start date is on a date other than the first day of the calendar month.

(d) *Applicability to applicable large employer member*. The liability for an assessable payment under section 4980H(b) for a calendar month with respect to a full-time employee applies solely to the applicable large employer member that was the employer of that employee for that calendar month. For an employee who was a full-time employee of more than one applicable large employer member during that calendar month, the liability for the assessable payment under section 4980H(b) for a calendar month applies to the applicable large employer member for whom the employee has the greatest number of hours of service for that calendar month (if the employee has an equal number of hours of service for two or more applicable large employer members for the calendar month, those applicable large employer members can treat one of those members as the employer of that employee for that calendar month for purposes of this paragraph (d), and if the members do not select one member, or select in an inconsistent manner, the IRS will select a member to be treated as the employer of that employee for purposes of the assessable payment determination). For a calendar month, an applicable large employer member may be liable for an assessable payment under section 4980H(a) or under section 4980H(b), but will not be liable for an assessable payment under both section 4980H(a) and section 4980H(b).

(e) *Affordability*—(1) *In general*. An employee who is offered coverage by an applicable large employer member may be eligible for an applicable premium tax credit or cost-sharing reduction if that offer of coverage is not affordable within the meaning of section 36B(c)(2)(C)(i) and the regulations thereunder.

(2) *Affordability safe harbors for section 4980H(b) purposes*. The affordability safe harbors set forth in paragraph (e)(2)(ii) through (iv) of this section apply solely for purposes of section 4980H(b), so that an applicable large employer member that offers minimum essential coverage providing minimum value will not be subject to an assessable payment under section 4980H(b) with respect to any employee receiving the applicable premium tax credit or cost-sharing reduction for a period for which the coverage is determined to be affordable under the requirements of an affordability safe harbor. This rule applies even if the applicable large employer member's offer of coverage that meets the requirements of an affordability safe harbor is not affordable for a particular employee under section 36B(c)(2)(C)(i) and an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to that employee.

(i) *Conditions of using an affordability safe harbor*. An applicable large employer member may use one or more of the affordability safe harbors described in this paragraph (e)(2) only if the employer offers its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan that provides minimum value with respect to the self-only coverage offered to the employee. Use of any of the safe harbors is optional for an applicable large employer member,

and an applicable large employer member may choose to apply the safe harbors for any reasonable category of employees, provided it does so on a uniform and consistent basis for all employees in a category. Reasonable categories generally include specified job categories, nature of compensation (hourly or salary), geographic location, and similar bona fide business criteria. An enumeration of employees by name or other specific criteria having substantially the same effect as an enumeration by name is not considered a reasonable category.

(ii) *Form W–2 safe harbor*—(A) *Full-year offer of coverage.* An employer will not be subject to an assessable payment under section 4980H(b) with respect to a full-time employee if that employee's required contribution for the calendar year for the employer's lowest cost self-only coverage that provides minimum value during the entire calendar year (excluding COBRA or other continuation coverage except with respect to an active employee eligible for continuation coverage) does not exceed 9.5 percent of that employee's Form W–2 wages from the employer (and any other member of the same applicable large employer that also pays wages to that employee) for the calendar year. Application of this safe harbor is determined after the end of the calendar year and on an employee-by-employee basis, taking into account the Form W–2 wages and the required employee contribution for that year. In addition, to qualify for this safe harbor, the employee's required contribution must remain a consistent amount or percentage of all Form W–2 wages during the calendar year (or during the plan year for plans with non-calendar year plan years) so that an applicable large employer member is not permitted to make discretionary adjustments to the required employee contribution for a pay period. A periodic contribution that is based on a consistent percentage of all Form W–2 wages may be subject to a dollar limit specified by the employer.

(B) *Adjustment for partial-year offer of coverage.* For an employee not offered coverage for an entire calendar year, the Form W–2 safe harbor is applied by adjusting the Form W–2 wages to reflect the period for which coverage was offered, then determining whether the employee's required contribution for the employer's lowest cost self-only coverage that provides minimum value, totaled for the periods during which coverage was offered, does not exceed 9.5 percent of the adjusted amount of Form W–2 wages. To adjust Form W–2 wages for this purpose, the Form W–2 wages are multiplied by a fraction equal to the number of calendar months for which coverage was offered over the number of calendar months in the employee's period of employment with the employer during the calendar year. For this purpose, if coverage is offered during at least one day during the calendar month, or the employee is employed for at least one day during the calendar month, the entire calendar month is counted in determining the applicable fraction.

(iii) *Rate of pay safe harbor.* An applicable large employer member satisfies the rate of pay safe harbor with respect to an hourly employee for a calendar month if the employee's required contribution for the calendar month for the applicable large employer member's lowest cost self-only coverage that provides minimum value does not exceed 9.5 percent of an amount equal to 130 hours multiplied by the lower of the employee's hourly rate of pay as of the first day of the coverage period (generally the first day of the plan year) or the employee's lowest hourly rate of pay during the calendar month. An applicable large employer member satisfies the rate of pay safe harbor with respect to a non-hourly employee for a calendar month if the employee's required contribution for the calendar month for the applicable large employer member's lowest cost self-only coverage that provides minimum value does not exceed 9.5 percent of the employee's monthly salary, as of the first day of the coverage period (instead of 130 multiplied by the hourly rate of pay); provided that if the monthly salary is reduced, including due to a reduction in work hours, the safe harbor is not available, and, solely for purposes of this paragraph (e)(2)(iii), an applicable large employer member may

use any reasonable method for converting payroll periods to monthly salary. For this purpose, if coverage is offered during at least one day during the calendar month, the entire calendar month is counted both for purposes of determining the assumed income for the calendar month and for determining the employee's share of the premium for the calendar month.

(iv) *Federal poverty line safe harbor*. An applicable large employer member satisfies the federal poverty line safe harbor with respect to an employee for a calendar month if the employee's required contribution for the calendar month for the applicable large employer member's lowest cost self-only coverage that provides minimum value does not exceed 9.5 percent of a monthly amount determined as the federal poverty line for a single individual for the applicable calendar year, divided by 12. For this purpose, if coverage is offered during at least one day during the calendar month, the entire calendar month is counted both for purposes of determining the monthly amount for the calendar month and for determining the employee's share of the premium for the calendar month. For this purpose, the applicable federal poverty line is the federal poverty line for the State in which the employee is employed.

(v) *Examples*. The following examples illustrate the application of the affordability safe harbors described in this paragraph (e)(2). In each example, each employer is an applicable large employer member with 200 full-time employees (including full-time equivalent employees).

Example 1 (Form W–2 wages safe harbor). (i) *Facts*. Employee A is employed by Employer Z consistently from January 1, 2015, through December 31, 2015. In addition, Employer Z offers Employee A and his dependents minimum essential coverage during that period that provides minimum value. The employee contribution for self-only coverage is $100 per calendar month, or $1,200 for the calendar year. For 2015, Employee A's Form W–2 wages with respect to employment with Employer Z are $24,000.

(ii) *Conclusion*. Because the employee contribution for 2015 is less than 9.5 percent of Employee A's Form W–2 wages for 2015, the coverage offered is treated as affordable with respect to Employee A for 2015 ($1,200 is 5 percent of $24,000).

Example 2 (Form W–2 wages safe harbor). (i) *Facts*. Employee B is employed by Employer Y from January 1, 2015, through September 30, 2015. In addition, Employer Y offers Employee B and his dependents minimum essential coverage during that period that provides minimum value. The employee contribution for self-only coverage is $100 per calendar month, or $900 for Employee B's period of employment. For 2015, Employee B's Form W–2 wages with respect to employment with Employer Y are $18,000. For purposes of applying the affordability safe harbor, the Form W–2 wages are multiplied by 9/9 (9 calendar months of coverage offered over 9 months of employment during the calendar year) or 1. Accordingly, affordability is determined by comparing the adjusted Form W–2 wages ($18,000) to the employee contribution for the period for which coverage was offered ($900).

(ii) *Conclusion*. Because the employee contribution for 2015 is less than 9.5 percent of Employee B's adjusted Form W–2 wages for 2015, the coverage offered is treated as affordable with respect to Employee B for 2015 ($900 is 5 percent of $18,000).

Example 3 (Form W–2 wages safe harbor). (i) *Facts*. Employee C is employed by Employer X from May 15, 2015, through December 31, 2015. In addition, Employer X offers Employee C and her dependents minimum essential coverage during the period from August 1, 2015, through December 31, 2015, that provides minimum value. The employee contribution for self-only coverage is $100 per calendar month, or $500 for Employee C's period of employment. For 2015, Employee C's Form W–2 wages with respect to employment with Employer X are $15,000. For purposes of applying the affordability safe harbor, the Form W–2 wages are multiplied by 5/8 (5 calendar months of coverage offered over 8 months of employment during the calendar year). Accordingly, affordability is determined by comparing the adjusted Form W–2 wages ($9,375 or $15,000 × 5/8) to the employee contribution for the period for which coverage was offered ($500).

(ii) *Conclusion*. Because the employee contribution of $500 is less than 9.5 percent of $9,375 (Employee C's adjusted Form W–2 wages for 2015), the coverage offered is treated as affordable with respect to Employee C for 2015 ($500 is 5.33 percent of $9,375).

Example 4 (Rate of pay safe harbor). (i) *Facts*. Employer W offers its full-time employees and their dependents minimum essential coverage that provides minimum value. For the 2016 calendar year, Employer W is using the rate of pay safe harbor to establish premium contribution amounts for full-time employees paid at a rate of $7.25 per hour (the minimum wage in Employer W's jurisdiction) for each calendar month of the entire 2016 calendar year. Employer W can apply the affordability safe harbor by using

an assumed monthly income amount that is based on an assumed 130 hours of service multiplied by $7.25 per hour ($942.50 per calendar month). To satisfy the safe harbor, Employer W would set the employee monthly contribution amount at a rate that does not exceed 9.5 percent of the assumed monthly income of $942.50. Employer W sets the employee contribution for self-only coverage at $85 per calendar month for 2016.

(ii) *Conclusion.* Because $85 is less than 9.5 percent of the employee's assumed monthly income at a $7.25 rate of pay, the coverage offered is treated as affordable under the rate of pay safe harbor for each calendar month of 2016 ($85 is 9.01 percent of $942.50).

Example 5 (Rate of pay safe harbor). (i) *Facts.* Employee E is employed by Employer V from May 1, 2015, through December 31, 2015. Employer V offers Employee E and her dependents minimum essential coverage from May 1, 2015, through December 31, 2015, that provides minimum value. The employee contribution for self-only coverage is $100 per calendar month. From May 1, 2015, through October 31, 2015, Employee E is paid at a rate of $10 per hour. From November 1, 2015, through December 31, 2015, Employee E is paid at a rate of $12 per hour. For purposes of applying the affordability safe harbor for the calendar months May 2015 through October 2015, Employer V may assume that Employee E earned $1,300 per calendar month (130 hours of service multiplied by $10 (which is the lower of the employee's hourly rate of pay at the beginning of the coverage period ($10) and the lowest hourly rate of pay for the calendar month ($10)). Accordingly, affordability is determined by comparing the assumed income ($1,300 per month) to the employee contribution ($100 per calendar month). For the calendar months November 2015 through December 2015, Employer V may assume that Employee E earned $1,300 per calendar month (130 hours of service multiplied by $10 (which is the lower of the employee's hourly rate of pay at the beginning of the coverage period ($10) and the lowest hourly rate of pay for the calendar month ($12)). Accordingly, affordability is determined by comparing the assumed income ($1,300 per month) to the employee contribution ($100 per calendar month).

(ii) *Conclusion.* Because $100 is less than 9.5 percent of Employee E's assumed monthly income for each calendar month from May 2015 through December 2015, the coverage offered is treated as affordable with respect to Employee E for May 2015 through December 2015 ($100 is 7.69 percent of $1,300).

Example 6 (Federal poverty line safe harbor). (i) *Facts.* Employee F is employed by Employer T from January 1, 2015, through December 31, 2015. In addition, Employer T offers Employee F and his dependents minimum essential coverage during that period that provides minimum value. Employer T uses the look-back measurement method. Under that measurement method as applied by Employer T, Employee F is treated as a full-time employee for the entire calendar year 2015. Employee F is regularly credited with 35 hours of service per week but is credited with only 20 hours of service during the month of March 2015 and only 15 hours of service during the month of August 2015. Assume for this purpose that the federal poverty line for 2015 for an individual is $11,670. With respect to Employee F, Employer T sets the monthly employee contribution for employee single-only coverage for each calendar month of 2015 at $92.39 (9.5 percent of $11,670, divided by 12).

(ii) *Conclusion.* Regardless of Employee F's actual wages for any calendar month in 2015, including the months of March 2015 and August 2015, when Employee F has lower wages because of significantly lower hours of service, the coverage under the plan is treated as affordable with respect to Employee F, because the employee contribution does not exceed 9.5 percent of the federal poverty line.

(f) *Additional guidance.* With respect to assessable payments under section 4980H(b), including the determination of whether an offer of coverage is affordable for purposes of section 4980H, the Commissioner may prescribe additional guidance of general applicability, published in the Internal Revenue Bulletin (see § 601.601(d)(2)(ii)(b) of this chapter).

(g) *Effective/applicability date.* This section is applicable for periods after December 31, 2014.

[T.D. 9655, 79 FR 8577, Feb. 12, 2014]

§ 54.4980H–6 Administration and procedure.

(a) *In general.* [Reserved]

(b) *Effective/applicability date.* This section is applicable for periods after December 31, 2014.

[T.D. 9655, 79 FR 8577, Feb. 12, 2014]

§ 54.6011–1 General requirement of return, statement, or list.

(a) *Minimum funding standards or excess contributions for self-employed individuals and section 403(b)(7)(A) custodial accounts.* Any employer or individual liable for tax under section 4971, 4972 or 4973(a)(2) (for a custodial account under section 403(b)(7)(A)) shall file an annual return on Form 5330 and shall include therein the information required by such form and the instructions issued with respect thereto.

(b) *Tax on prohibited transactions.* Every disqualified person (as defined in section 4975(e)(2)) liable for the tax imposed under section 4975(a) with respect to a prohibited transaction shall file an annual return on Form 5330 and shall include therein the information required by such form and the instructions issued with respect thereto. The annual return on Form 5330 shall be filed with respect to each prohibited transaction and for each taxable year (or part thereof) of the disqualified person in the taxable period (as defined in section 4975(f)(2)) beginning on the date on which such prohibited transaction occurs.

(c) *Entity manager tax on prohibited tax shelter transactions*—(1) *In general.* Any entity manager of a tax-exempt entity described in section 4965(c)(4), (c)(5), (c)(6), or (c)(7) who is liable for tax under section 4965(a)(2) shall file a return on Form 5330, ''Return of Excise Taxes Related to Employee Benefit Plans,'' on or before the 15th day of the fifth month following the close of such entity manager's taxable year during which the entity entered into the prohibited tax shelter transaction, and shall include therein the information required by such form and the instructions issued with respect thereto.

(2) *Transition rule.* A Form 5330, ''Return of Excise Taxes Related to Employee Benefit Plans,'' for an excise tax under section 4965 that was due on or before October 4, 2007, will be deemed to have been filed on the due date if it was filed by October 4, 2007, and if the section 4965 tax that was required to be reported on that Form 5330 was paid by October 4, 2007.

(d) *Effective/applicability date.* Paragraph (c) of this section is applicable on July 6, 2007.

[T.D. 7838, 47 FR 44249, Oct. 7, 1982, as amended by T.D. 9334, 72 FR 36873, July 6, 2007; T.D. 9492, 75 FR 38708, July 6, 2010; 75 FR 46845, Aug. 4, 2010]

§ 54.6011–1T General requirement of return, statement, or list (temporary).

(a) *Tax on reversions of qualified plan assets to employer.* Every employer liable for the tax imposed under section 4980(a) with respect to an employer reversion (as defined in section 4980(c)(2)) shall file a quarterly return on Form 5330 and shall include therein the information required by such form and the instructions issued with respect thereto. The quarterly return on Form 5330 shall be filed with respect to employer reversions from each qualified plan (as defined in section 4980(c)(1)).

(b) [Reserved]

[T.D. 8133, 52 FR 10563, Apr. 2, 1987, as amended by T.D. 9334, 72 FR 36873, July 6, 2007; 72 FR 45895, Aug. 16, 2007; T.D. 9492, 75 FR 38709, July 6, 2010]

§ 54.6011–2 General requirement of return, statement, or list.

Effective for any Form 8928 that is due on or after January 1, 2010, any person liable for tax under section 4980B, 4980D, 4980E, or 4980G of the Code shall file a return with respect to the tax on Form 8928. The return must include the information required by Form 8928 and the instructions issued with respect to it.

[T.D. 9457, 74 FR 45999, Sept. 8, 2009]

§ 54.6011–4 Requirement of statement disclosing participation in certain transactions by taxpayers.

(a) *In general.* If a transaction is identified as a *listed transaction* or a *transaction of interest* as defined in § 1.6011–4 of this chapter by the Commissioner in published guidance (see § 601.601(d)(2)(ii)(*b*) of this chapter), and the listed transaction or transaction of interest involves an excise tax under chapter 43 of subtitle D of the Internal Revenue Code (relating to qualified pension, etc., plans) the transaction must be disclosed in the manner stated in such published guidance.

(b) *Effective/applicability date.* This section applies to listed transactions entered into on or after January 1, 2003. This section applies to transactions of interest entered into on or after November 2, 2006.

[T.D. 9350, 72 FR 43154, Aug. 3, 2007]

§ 54.6060–1 Reporting requirements for tax return preparers.

(a) *In general.* A person that employs one or more tax return preparers to prepare a return or claim for refund under Chapter 43 of subtitle D of the Internal Revenue Code, other than for

the person, at any time during a return period, shall satisfy the record keeping and inspection requirements in the manner stated in § 1.6060–1 of this chapter.

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

[T.D. 9436, 73 FR 78458, Dec. 22, 2008]

§ 54.6061–1 Signing of returns and other documents.

Effective for any Form 8928 that is due on or after January 1, 2010, any return, statement, or other document required to be made with respect to a tax imposed by section 4980B, 4980D, 4980E, or 4980G of the Code or the regulations under section 4980B, 4980D, 4980E, or 4980G must be signed by the person required to file the return, statement, or other document, or by the persons required or duly authorized to sign in accordance with the regulations, forms, or instructions prescribed with respect to such return, statement, or document. An individual's signature on such return, statement, or other document shall be prima facie evidence that the individual is authorized to sign the return, statement, or other document.

[T.D. 9457, 74 FR 46000, Sept. 8, 2009]

§ 54.6071–1 Time for filing returns.

(a) *Returns under section 4980B.* (1) *Due date for filing of return by employers or other persons responsible for benefits under a group health plan.* If the person liable for the excise tax is an employer or other person responsible for providing or administering benefits under a group health plan (such as an insurer or a third party administrator), the return required by § 54.6011–2 must be filed on or before the due date for filing the person's income tax return and must reflect the portion of the noncompliance period for each failure under section 4980B that falls during the person's taxable year. An extension to file the person's income tax return does not extend the date for filing Form 8928.

(2) *Due date for filing of return by multiemployer plans.* If the person liable for the excise tax is a multiemployer plan, the return required by § 54.6011–2 must be filed on or before the last day of the seventh month following the end of the plan's plan year. The filing of Form 8928 by a plan must reflect the portion of the noncompliance period for each failure under section 4980B that falls during the plan's plan year.

(b) *Returns under section 4980D.* (1) *Due date for filing of return by employers.* If the person liable for the excise tax is an employer, the return required by § 54.6011–2 must be filed on or before the due date for filing the employer's income tax return and must reflect the portion of the noncompliance period for each failure under chapter 100 that falls during the employer's taxable year. An extension to file the employer's income tax return does not extend the date for filing Form 8928.

(2) *Due date for filing of return by multiemployer plans or multiple employer health plans.* If the person liable for the excise tax is a multiemployer plan or a specified multiple employer health plan, the return required by § 54.6011–2 must be filed on or before the last day of the seventh month following the end of the plan's plan year. The filing of Form 8928 by a plan must reflect the portion of the noncompliance period for each failure under chapter 100 that falls during the plan's plan year.

(c) *Returns under section 4980E.* Any employer who is liable for the excise tax under section 4980E must report this tax by filing the return required by § 54.6011–2 on or before the 15th day of the fourth month following the calendar year in which the noncomparable contributions were made.

(d) *Returns under section 4980G.* Any employer who is liable for the excise tax under section 4980E must report this tax by filing the return required by § 54.6011–2 on or before the 15th day of the fourth month following the calendar year in which the noncomparable contributions were made. *See* Q & A–4 of § 54.4980G–1 for the rules on computation of the excise tax under section 4980G.

(e) *Effective/applicability date:* The rules in this section are effective for any Form 8928 that is due on or after January 1, 2010.

[T.D. 9457, 74 FR 46000, Sept. 8, 2009]

§ 54.6081–1 Automatic extension of time for filing returns for certain excise taxes under Chapter 43.

(a) *In general.* An employer, other person or health plan that is required to file a return on Form 8928, ''Return of Certain Excise Taxes Under Chapter 43 of the Internal Revenue Code,'' will be allowed an automatic 6-month extension of time to file the return after the date prescribed for filing the return if the employer, other person or health plan files an application under this section in accordance with paragraph (b) of this section.

(b) *Requirements.* To satisfy this paragraph (b), an employer, other person or health plan must—

(1) Submit a complete application on Form 7004, ''Application for Automatic Extension of Time To File Certain Business Income Tax, Information, and Other Returns,'' or in any other manner prescribed by the Commissioner;

(2) File the application on or before the date prescribed for filing the return with the Internal Revenue Service office designated in the application's instructions; and

(3) Remit the amount of the properly estimated unpaid tax liability on or before the date prescribed for payment.

(c) *No extension of time for the payment of tax.* An automatic extension of time for filing a return granted under paragraph (a) of this section will not extend the time for payment of any tax due on such return.

(d) *Termination of automatic extension.* The Commissioner may terminate an automatic extension at any time by mailing to the employer, other person, or health plan a notice of termination at least 10 days prior to the termination date designated in such notice. The Commissioner must mail the notice of termination to the address shown on the Form 7004 or to the estate or trust's last known address. For further guidance regarding the definition of last known address, *see* § 301.6212–2 of this chapter.

(e) *Penalties. See* section 6651 for failure to file a pension excise tax return or failure to pay the amount shown as tax on the return.

(f) *Effective/applicability date.* This section is applicable for applications for an automatic extension of time to file a return due under chapter 43, filed on or after June 24, 2011.

[T.D. 9531, 76 FR 36999, June 24, 2011]

§ 54.6091–1 Place for filing excise tax returns under section 4980B, 4980D, 4980E, or 4980G.

Effective for any Form 8928 that is due on or after January 1, 2010, the return required by § 54.6011–2 must be filed at the place specified in the forms and instructions provided by the Internal Revenue Service.

[T.D. 9457, 74 FR 46000, Sept. 8, 2009]

§ 54.6107–1 Tax return preparer must furnish copy of return or claims for refund to taxpayer and must retain a copy or record.

(a) *In general.* A person who is a signing tax return preparer of any return or claim for refund of tax under Chapter 43 of subtitle D of the Internal Revenue Code, shall furnish a completed copy of the return or claim for refund to the taxpayer, and retain a completed copy or record in the manner stated in § 1.6107–1 of this chapter.

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

[T.D. 9436, 73 FR 78458, Dec. 22, 2008]

§ 54.6109–1 Tax return preparers furnishing identifying numbers for returns or claims for refund filed.

(a) *In general.* Each tax return or claim for refund of tax under Chapter 43 of subtitle D prepared by one or more signing tax return preparers must include the identifying number of the preparer required by § 1.6695–1(b) of this chapter to sign the return or claim for refund in the manner stated in § 1.6109–2 of this chapter.

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

[T.D. 9436, 73 FR 78458, Dec. 22, 2008]

§ 54.6151–1 Time and place for paying of tax shown on returns.

Effective for any Form 8928 that is due on or after January 1, 2010, the tax shown on any return which is imposed under section 4980B, 4980D, 4980E or

4980G shall, without assessment or notice and demand, be paid to the internal revenue officer with whom the return is filed at the time and place for filing such return (determined without regard to any extension of time for filing the return). For provisions relating to the time and place for filing such return, *see* §§ 54.6071–1 and 54.6091–1.

[T.D. 9457, 74 FR 46000, Sept. 8, 2009]

§ 54.6694–1 Section 6694 penalties applicable to tax return preparer.

(a) *In general.* For general definitions regarding section 6694 penalties applicable to preparers of tax returns or claims for refund of tax under Chapter 43 of subtitle D, see § 1.6694–1 of this chapter.

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

[T.D. 9436, 73 FR 78458, Dec. 22, 2008]

§ 54.6694–2 Penalties for understatement due to an unreasonable position.

(a) *In general.* A person who is a tax return preparer of any return or claim for refund of tax under Chapter 43 of subtitle D of the Internal Revenue Code (Code) shall be subject to penalties under section 6694(a) of the Code in the manner stated in § 1.6694–2 of this chapter.

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

[T.D. 9436, 73 FR 78458, Dec. 22, 2008]

§ 54.6694–3 Penalty for understatement due to willful, reckless, or intentional conduct.

(a) *In general.* A person who is a tax return preparer of any return or claim for refund of excise tax under chapter 43 of subtitle D of the Internal Revenue Code (Code) shall be subject to penalties under section 6694(b) of the Code in the manner stated in § 1.6694–3 of this chapter.

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

[T.D. 9436, 73 FR 78458, Dec. 22, 2008]

§ 54.6694–4 Extension of period of collection when tax return preparer pays 15 percent of a penalty for understatement of taxpayer's liability and certain other procedural matters.

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

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

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

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

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

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

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

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

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

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

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

§ 54.7701–1 Tax return preparer.

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

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

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

§ 54.9801–1 Basis and scope.

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

(b) *Scope*. A group health plan or health insurance issuer offering group health insurance coverage may provide greater rights to participants and beneficiaries than those set forth in the portability and market reform sections of this part 54. This part 54 sets forth minimum requirements for group health plans and group health insurance issuers offering group health insurance coverage concerning certain consumer protections of the Health Insurance Portability and Accountability Act (HIPAA), including special enrollment periods and the prohibition against discrimination based on a health factor, as amended by the Patient Protection and Affordable Care Act (Affordable Care Act). Other consumer protection provisions, including other protections provided by the Affordable Care Act and the Mental Health Parity and Addiction Equity Act, are set forth in this part 54.

(c) *Similar requirements under the Employee Retirement Income Security Act and the Public Health Service Act*. Sections 701, 702, 703, 711, 712, 732, and 733 of the Employee Retirement Income Security Act of 1974 and sections 2701, 2702, 2704, 2705, 2721, and 2791 of the Public Health Service Act impose requirements similar to those imposed under Chapter 100 of Subtitle K with respect to health insurance issuers offering group health insurance coverage. See 29 CFR part 2590 and 45 CFR parts 144, 146, and 148. See also part B of title XXVII of the Public Health Service Act and 45 CFR part 148 for other rules applicable to health insurance offered in the individual market (defined in § 54.9801–2).

[T.D. 9166, 69 FR 78746, Dec. 30, 2004, as amended by T.D. 9299, 71 FR 75056, Dec. 13, 2006; T.D. 9427, 73 FR 62419, Oct. 20, 2008; T.D. 9464, 74 FR 51678, Oct. 7, 2009; T.D. 9656, 79 FR 10303, Feb. 24, 2014]

§ 54.9801–1T Basis and scope (temporary).

(a) *Statutory basis*. This section and §§ 54.9801–2 through 54.9801–6, 54.9802–1, 54.9802–2, 54.9802–3T, 54.9802–4, 54.9811–1, 54.9812–1, 54.9815–1251, 54.9815–2704, 54.9815–2705, 54.9815–2708, 54.9815–2711, 54.9815–2712, 54.9815–2713, 54.9815–2713A, 54.9815–2714, 54.9815–2715, 54.9815–2715A1, 54.9815–2715A2, 54.9815–2715A3, 54.9815–2719, 54.9815–2715A, 54.9816–1 through 9816–7, 54.9831–1, and 54.9833–1 implement Chapter 100 of Subtitle K of the Internal Revenue Code of 1986.

(b) *Scope*. A group health plan or health insurance issuer offering group health insurance coverage may provide greater rights to participants and beneficiaries than those set forth in the portability and market reform sections of this part. This part sets forth minimum requirements for group health plans and group health insurance issuers offering group health insurance coverage concerning certain consumer protections of the Health Insurance Portability and Accountability Act (HIPAA), including special enrollment periods and the prohibition against discrimination based on a health factor, as amended by the Patient Protection and Affordable Care Act (Affordable Care Act). Other consumer protection provisions, including other protections

provided by the Affordable Care Act, the Mental Health Parity and Addiction Equity Act, and the No Surprises Act are set forth in this part.

(c) *Similar requirements under the Employee Retirement Income Security Act and the Public Health Service Act.* Sections 701, 702, 703, 711, 712, 716, 717, 732, and 733 of the Employee Retirement Income Security Act of 1974 and sections 2701, 2702, 2704, 2705, 2721, 2791, 2799A–1, and 2799A–2 of the Public Health Service Act impose requirements similar to those imposed under Chapter 100 of Subtitle K with respect to health insurance issuers offering group health insurance coverage. *See* 29 CFR part 2590 and 45 CFR parts 144, 146, 148, and 149. See also part B of Title XXVII of the Public Health Service Act and 45 CFR parts 148 and 149 for other rules applicable to health insurance offered in the individual market (defined in § 54.9801–2).

[T.D. 9951, 86 FR 36947, July 13, 2021]

§ 54.9801–2 Definitions.

Unless otherwise provided, the definitions in this section govern in applying the provisions of sections 9801 through 9815 and 9831 through 9833.

Affiliation period means a period of time that must expire before health insurance coverage provided by an HMO becomes effective, and during which the HMO is not required to provide benefits.

COBRA definitions:

(1) *COBRA* means title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(2) *COBRA continuation coverage* means coverage, under a group health plan, that satisfies an applicable COBRA continuation provision.

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

(4) *Exhaustion of COBRA continuation coverage* means that an individual's COBRA continuation coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). An individual is considered to have exhausted COBRA continuation coverage if such coverage ceases—

(i) Due to the failure of the employer or other responsible entity to remit premiums on a timely basis;

(ii) When the individual no longer resides, lives, or works in the service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other COBRA continuation coverage available to the individual; or

(iii) When the individual incurs a claim that would meet or exceed a lifetime limit on all benefits and there is no other COBRA continuation coverage available to the individual.

Condition means a *medical condition*.

Creditable coverage means *creditable coverage* within the meaning of § 54.9801–4(a).

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

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

Enroll means to become covered for benefits under a group health plan (that is, when coverage becomes effective), without regard to when the individual may have completed or filed any forms that are required in order to become covered under the plan. For this purpose, an individual who has health coverage under a group health plan is enrolled in the plan regardless of whether the individual elects coverage, the individual is a dependent who becomes covered as a result of an election by a participant, or the individual becomes covered without an election.

Enrollment date 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 § 54.9831(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 the term in § 54.9802–3T(a)(3).

Group health insurance coverage means health insurance coverage offered in connection with a group health plan. Individual health insurance coverage reimbursed by the arrangements described in 29 CFR 2510.3–1(l) is not offered in connection with a group health plan, and is not group health insurance coverage, provided all the conditions in 29 CFR 2510.3–1(l) are satisfied.

Group health plan or *plan* means a *group health plan* within the meaning of § 54.9831–1(a).

Group market means the market for health insurance coverage offered in connection with a group health plan. (However, certain very small plans may be treated as being in the *individual market*, rather than the group market; see the definition of individual market in this section.)

Health insurance coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance. However, benefits described in § 54.9831(c)(2) are not treated as benefits consisting of medical care.

Health insurance issuer or *issuer* means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance (within the meaning of section 514(b)(2) of ERISA). Such term does not include a group health plan.

Health maintenance organization or *HMO* means—

(1) A federally qualified health maintenance organization (as defined in section 1301(a) of the PHS Act);

(2) An organization recognized under State law as a health maintenance organization; or

(3) A similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

Individual health insurance coverage means health insurance coverage offered to individuals in the individual market, but does not include short-term, limited-duration insurance. Individual health insurance coverage can include dependent coverage.

Individual market means the market for health insurance coverage offered to individuals other than in connection with a group health plan. Unless a State elects otherwise in accordance with section 2791(e)(1)(B)(ii) of the PHS Act, such term also includes coverage offered in connection with a group health plan that has fewer than two participants who are current employees on the first day of the plan year.

Issuer means a *health insurance issuer*.

Late 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 § 54.9801–6.) 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 has the meaning given such term by section 213(d), determined without regard to section 213(d)(1)(C) and so much of section 213(d)(1)(D) as

relates to qualified long-term care insurance.

Medical condition or *condition* means any condition, whether physical or mental, including, but not limited to, any condition resulting from illness, injury (whether or not the injury is accidental), pregnancy, or congenital malformation. However, genetic information is not a condition.

Participant means *participant* within the meaning of section 3(7) of ERISA.

Placement, or being placed, for adoption means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person ends upon the termination of such legal obligation.

Plan year means the year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is—

(1) The deductible or limit year used under the plan;

(2) If the plan does not impose deductibles or limits on a yearly basis, then the plan year is the policy year;

(3) If the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, then the plan year is the employer's taxable year; or

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

Preexisting condition exclusion means a limitation or exclusion of benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan or group or individual health insurance coverage (or other coverage provided to Federally eligible individuals pursuant to 45 CFR part 148), whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any limitation or exclusion of benefits (including a denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan, or group or individual health insurance coverage (or other coverage provided to Federally eligible individuals pursuant to 45 CFR part 148), such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

Public health plan means *public health plan* within the meaning of § 54.9801–4(a)(1)(ix).

Public Health Service Act (PHS Act) means the Public Health Service Act (42 U.S.C. 201, *et seq.*).

Short-term, limited-duration insurance means health insurance coverage provided pursuant to a contract with an issuer that:

(1) Has an expiration date specified in the contract that is less than 12 months after the original effective date of the contract and, taking into account renewals or extensions, has a duration of no longer than 36 months in total;

(2) With respect to policies having a coverage start date before January 1, 2019, displays prominently in the contract and in any application materials provided in connection with enrollment in such coverage in at least 14 point type the language in the following Notice 1, excluding the heading ''Notice 1,'' with any additional information required by applicable state law:

NOTICE 1:

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage. Also, this coverage is not ''minimum essential

coverage.'' If you don't have minimum essential coverage for any month in 2018, you may have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

(3) With respect to policies having a coverage start date on or after January 1, 2019, displays prominently in the contract and in any application materials provided in connection with enrollment in such coverage in at least 14 point type the language in the following Notice 2, excluding the heading ''Notice 2,'' with any additional information required by applicable state law:

NOTICE 2:

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.

(4) If a court holds the 36-month maximum duration provision set forth in paragraph (1) of this definition or its applicability to any person or circumstances invalid, the remaining provisions and their applicability to other people or circumstances shall continue in effect.

Significant break in coverage means a *significant break in coverage* within the meaning of § 54.9801–4(b)(2)(iii).

Special enrollment means enrollment in a group health plan under the rights described in § 54.9801–6 or in group health insurance coverage under the rights described in 29 CFR 2590.701–6 or 45 CFR 146.117.

State health benefits risk pool means a *State health benefits risk pool* within the meaning of § 54.9801–4(a)(1)(vii).

Travel insurance means insurance coverage for personal risks incident to planned travel, which may include, but is not limited to, interruption or cancellation of trip or event, loss of baggage or personal effects, damages to accommodations or rental vehicles, and sickness, accident, disability, or death occurring during travel, provided that the health benefits are not offered on a stand-alone basis and are incidental to other coverage. For this purpose, the term travel insurance does not include major medical plans that provide comprehensive medical protection for travelers with trips lasting 6 months or longer, including, for example, those working overseas as an expatriate or military personnel being deployed.

Waiting period means *waiting period* within the meaning of § 54.9815–2708(b).

[T.D. 9166, 69 FR 78746, Dec. 30, 2004, as amended by T.D. 9299, 71 FR 75056, Dec. 13, 2006; T.D. 9427, 73 FR 62420, Oct. 20, 2008; T.D. 9464, 74 FR 51678, Oct. 7, 2009; T.D. 9491, 75 FR 37222, June 28, 2010; T.D. 9656, 79 FR 10304, Feb. 24, 2014; T.D. 9744, 80 FR 72238, Nov. 18, 2015; T.D. 9791, 81 FR 75324, Oct. 31, 2016; T.D. 9837, 83 FR 38241, Aug. 3, 2018; T.D. 9867, 84 FR 28987, June 20, 2019]

§ 54.9801–2T Definitions (temporary).

Unless otherwise provided, the definitions in this section and § 54.9801–2 govern in applying the provisions of sections 9801 through 9825 and 9831 through 9834.

Affiliation period means a period of time that must expire before health insurance coverage provided by an HMO becomes effective, and during which the HMO is not required to provide benefits.

COBRA definitions:

(1) *COBRA* means title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(2) *COBRA continuation coverage* means coverage, under a group health plan, that satisfies an applicable COBRA continuation provision.

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

(4) *Exhaustion of COBRA continuation coverage* means that an individual's COBRA continuation coverage ceases for any reason other than either failure of the individual to pay premiums on a

timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). An individual is considered to have exhausted COBRA continuation coverage if such coverage ceases—

(i) Due to the failure of the employer or other responsible entity to remit premiums on a timely basis;

(ii) When the individual no longer resides, lives, or works in the service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other COBRA continuation coverage available to the individual; or

(iii) When the individual incurs a claim that would meet or exceed a lifetime limit on all benefits and there is no other COBRA continuation coverage available to the individual.

Condition means a *medical condition*.

Creditable coverage means *creditable coverage* within the meaning of § 54.9801–4(a).

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

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

Enroll means to become covered for benefits under a group health plan (that is, when coverage becomes effective), without regard to when the individual may have completed or filed any forms that are required in order to become covered under the plan. For this purpose, an individual who has health coverage under a group health plan is enrolled in the plan regardless of whether the individual elects coverage, the individual is a dependent who becomes covered as a result of an election by a participant, or the individual becomes covered without an election.

Enrollment date 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 § 54.9831(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 the term in § 54.9802–3T(a)(3).

Group health insurance coverage means health insurance coverage offered in connection with a group health plan. Individual health insurance coverage reimbursed by the arrangements described in 29 CFR 2510.3–1(l) is not offered in connection with a group health plan, and is not group health insurance coverage, provided all the conditions in 29 CFR 2510.3–1(l) are satisfied.

Group health plan or *plan* means a *group health plan* within the meaning of § 54.9831–1(a).

Group market means the market for health insurance coverage offered in connection with a group health plan. (However, certain very small plans may be treated as being in the *individual market*, rather than the group market; see the definition of individual market in this section.)

Health insurance coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance. However, benefits described in § 54.9831(c)(2) are not treated as benefits consisting of medical care.

Health insurance issuer or *issuer* means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance (within the meaning of section 514(b)(2)

of ERISA). Such term does not include a group health plan.

Health maintenance organization or *HMO* means—

(1) A federally qualified health maintenance organization (as defined in section 1301(a) of the PHS Act);

(2) An organization recognized under State law as a health maintenance organization; or

(3) A similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

Individual health insurance coverage means health insurance coverage offered to individuals in the individual market, but does not include short-term, limited-duration insurance. Individual health insurance coverage can include dependent coverage.

Individual market means the market for health insurance coverage offered to individuals other than in connection with a group health plan. Unless a State elects otherwise in accordance with section 2791(e)(1)(B)(ii) of the PHS Act, such term also includes coverage offered in connection with a group health plan that has fewer than two participants who are current employees on the first day of the plan year.

Issuer means a *health insurance issuer*.

Late 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 §54.9801–6.) 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 has the meaning given such term by section 213(d), determined without regard to section 213(d)(1)(C) and so much of section 213(d)(1)(D) as relates to qualified long-term care insurance.

Medical condition or *condition* means any condition, whether physical or mental, including, but not limited to, any condition resulting from illness, injury (whether or not the injury is accidental), pregnancy, or congenital malformation. However, genetic information is not a condition.

Participant means *participant* within the meaning of section 3(7) of ERISA.

Placement, or being placed, for adoption means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person ends upon the termination of such legal obligation.

Plan year means the year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is—

(1) The deductible or limit year used under the plan;

(2) If the plan does not impose deductibles or limits on a yearly basis, then the plan year is the policy year;

(3) If the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, then the plan year is the employer's taxable year; or

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

Preexisting condition exclusion means a limitation or exclusion of benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan or group or individual health insurance coverage (or other coverage provided to federally eligible individuals pursuant to 45 CFR part 148), whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting

condition exclusion includes any limitation or exclusion of benefits (including a denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan, or group or individual health insurance coverage (or other coverage provided to federally eligible individuals pursuant to 45 CFR part 148), such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

Public health plan means *public health plan* within the meaning of § 54.9801–4(a)(1)(ix).

Public Health Service Act (PHS Act) means the Public Health Service Act (42 U.S.C. 201, *et seq.*).

Short-term, limited-duration insurance means health insurance coverage provided pursuant to a contract with an issuer that:

(1) Has an expiration date specified in the contract that is less than 12 months after the original effective date of the contract and, taking into account renewals or extensions, has a duration of no longer than 36 months in total;

(2) With respect to policies having a coverage start date before January 1, 2019, displays prominently in the contract and in any application materials provided in connection with enrollment in such coverage in at least 14 point type the language in the following Notice 1, excluding the heading ''Notice 1,'' with any additional information required by applicable state law:

NOTICE 1

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage. Also, this coverage is not ''minimum essential coverage.'' If you don't have minimum essential coverage for any month in 2018, you may have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

(3) With respect to policies having a coverage start date on or after January 1, 2019, displays prominently in the contract and in any application materials provided in connection with enrollment in such coverage in at least 14 point type the language in the following Notice 2, excluding the heading ''Notice 2,'' with any additional information required by applicable state law:

NOTICE 2

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.

(4) If a court holds the 36-month maximum duration provision set forth in paragraph (1) of this definition or its applicability to any person or circumstances invalid, the remaining provisions and their applicability to other people or circumstances shall continue in effect.

Significant break in coverage means a *significant break in coverage* within the meaning of § 54.9801–4(b)(2)(iii).

Special enrollment means enrollment in a group health plan under the rights described in § 54.9801–6 or in group health insurance coverage under the rights described in 29 CFR 2590.701–6 or 45 CFR 146.117.

State health benefits risk pool means a *State health benefits risk pool* within the meaning of § 54.9801–4(a)(1)(vii).

Travel insurance means insurance coverage for personal risks incident to planned travel, which may include, but is not limited to, interruption or cancellation of trip or event, loss of baggage or personal effects, damages to accommodations or rental vehicles, and sickness, accident, disability, or death occurring during travel, provided that the health benefits are not offered on a stand-alone basis and are incidental to other coverage. For this purpose, the term travel insurance does not include major medical plans that provide comprehensive medical protection for travelers with trips lasting 6 months or longer, including, for example, those working overseas as an expatriate or military personnel being deployed.

Waiting period means *waiting period* within the meaning of § 54.9815–2708(b).

[T.D. 9951, 86 FR 36948, July 13, 2021]

§ 54.9801–3 Limitations on preexisting condition exclusion period.

(a) *Preexisting condition exclusion defined.* (1) A *preexisting condition exclusion* means a *preexisting condition exclusion* within the meaning of § 54.9801–2.

(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 under the policy.

(ii) *Conclusion.* In this *Example 1,* the exclusion of benefits for any prosthesis if the body part was lost before the effective date of coverage is a preexisting condition exclusion because it operates to exclude benefits for a condition based on the fact that the condition was present before the effective date of coverage under the policy. 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 limit benefits for a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is 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 treatment of heart conditions. However, the plan does not cover those same items and services when used for treatment of congenital heart conditions.

(ii) *Conclusion.* In this *Example 6,* the exclusion of coverage for treatment of congenital heart conditions is a preexisting condition exclusion because it operates to exclude benefits relating to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is prohibited.

Example 7. (i) *Facts.* A group health plan generally provides coverage for medically necessary items and services. However, the plan excludes coverage for the treatment of cleft palate.

(ii) *Conclusion*. In this *Example 7*, the exclusion of coverage for treatment of cleft palate is not a preexisting condition exclusion because the exclusion applies regardless of when the condition arose relative to the effective date of coverage. The plan provision, therefore, is not prohibited. (But see 45 CFR 147.150, which may require coverage of cleft palate as an essential health benefit for health insurance coverage in the individual or small group market, depending on the essential health benefits benchmark plan as defined in 45 CFR 156.20).

Example 8. (i) *Facts*. A group health plan provides coverage for treatment of cleft palate, but only if the individual being treated has been continuously covered under the plan from the date of birth.

(ii) *Conclusion*. In this *Example 8*, the exclusion of coverage for treatment of cleft palate for individuals who have not been covered under the plan from the date of birth operates to exclude benefits in relation to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is prohibited.

(b) *General rules*. *See* section 2704 of the Public Health Service Act, incorporated into section 9815 of the Code, and its implementing regulations for rules prohibiting the imposition of a preexisting condition exclusion.

[T.D. 9166, 69 FR 78746, Dec. 30, 2004, as amended by T.D. 9491, 75 FR 37223, June 28, 2010; T.D. 9656, 79 FR 10304, Feb. 24, 2014; T.D. 9744, 80 FR 72238, Nov. 18, 2015]

§ 54.9801–4 Rules relating to creditable coverage.

(a) *General rules*—(1) *Creditable coverage*. For purposes of this section, except as provided in paragraph (a)(2) of this section, the term *creditable coverage* means coverage of an individual under any of the following:

(i) A group health plan as defined in § 54.9831–1(a).

(ii) Health insurance coverage as defined in § 54.9801–2 (whether or not the entity offering the coverage is subject to Chapter 100 of Subtitle K, and without regard to whether the coverage is offered in the group market, the individual market, or otherwise).

(iii) Part A or B of title XVIII of the Social Security Act (Medicare).

(iv) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).

(v) Title 10 U.S.C. Chapter 55 (medical and dental care for members and certain former members of the uniformed services, and for their dependents; for purposes of title 10 U.S.C. Chapter 55, *uniformed services* means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service).

(vi) A medical care program of the Indian Health Service or of a tribal organization.

(vii) A State health benefits risk pool. For purposes of this section, a *State health benefits risk pool* means—

(A) An organization qualifying under section 501(c)(26);

(B) A qualified high risk pool described in section 2744(c)(2) of the PHS Act; or

(C) Any other arrangement sponsored by a State, the membership composition of which is specified by the State and which is established and maintained primarily to provide health coverage for individuals who are residents of such State and who, by reason of the existence or history of a medical condition—

(*1*) Are unable to acquire medical care coverage for such condition through insurance or from an HMO, or

(*2*) Are able to acquire such coverage only at a rate which is substantially in excess of the rate for such coverage through the membership organization.

(viii) A health plan offered under title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program).

(ix) A public health plan. For purposes of this section, a public health plan means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

(x) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(xi) Title XXI of the Social Security Act (State Children's Health Insurance Program).

(2) *Excluded coverage*. Creditable coverage does not include coverage of solely excepted benefits (described in § 54.9831–1).

(b) *Counting creditable coverage rules superseded by prohibition on preexisting condition exclusion*. *See* section 2704 of the Public Health Service Act, incorporated into section 9815 of the Code, and its implementing regulations for rules prohibiting the imposition of a preexisting condition exclusion.

[T.D. 9166, 69 FR 78746, Dec. 30, 2004, as amended by T.D. 9656, 79 FR 10304, Feb. 24, 2014]

§ 54.9801–5 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* section 2704 of the Public Health Service Act, incorporated into section 9815 of the Code, and its implementing regulations for rules prohibiting the imposition of a preexisting condition exclusion.

(b) *Applicability*. The provisions of this section apply beginning December 31, 2014.

[T.D. 9656, 79 FR 10305, Feb. 24, 2014]

§ 54.9801–6 Special enrollment periods.

(a) *Special enrollment for certain individuals who lose coverage*—(1) *In general*. A group health plan is required to permit current employees and dependents (as defined in § 54.9801–2) who are described in paragraph (a)(2) of this section to enroll for coverage under the terms of the plan if the conditions in paragraph (a)(3) of this section are satisfied. The special enrollment rights under this paragraph (a) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan. (See section 701(f)(1) of ERISA and section 2701(f)(1) of the PHS Act, under which this obligation is also imposed on a health insurance issuer offering group health insurance coverage.)

(2) *Individuals eligible for special enrollment*—(i) *When employee loses coverage*. A current employee and any dependents (including the employee's spouse) each are eligible for special enrollment in any benefit package under the plan (subject to plan eligibility rules conditioning dependent enrollment on enrollment of the employee) if—

(A) The employee and the dependents are otherwise eligible to enroll in the benefit package;

(B) When coverage under the plan was previously offered, the employee had coverage under any group health plan or health insurance coverage; and

(C) The employee satisfies the conditions of paragraph (a)(3)(i), (ii), or (iii) of this section and, if applicable, paragraph (a)(3)(iv) of this section.

(ii) *When dependent loses coverage*—(A) A dependent of a current employee (including the employee's spouse) and the employee each are eligible for special enrollment in any benefit package under the plan (subject to plan eligibility rules conditioning dependent enrollment on enrollment of the employee) if—

(*1*) The dependent and the employee are otherwise eligible to enroll in the benefit package;

(*2*) When coverage under the plan was previously offered, the dependent had coverage under any group health plan or health insurance coverage; and

(*3*) The dependent satisfies the conditions of paragraph (a)(3)(i), (ii), or (iii) of this section and, if applicable, paragraph (a)(3)(iv) of this section.

(B) However, the plan is not required to enroll any other dependent unless that dependent satisfies the criteria of this paragraph (a)(2)(ii), or the employee satisfies the criteria of paragraph (a)(2)(i) of this section.

(iii) *Examples*. The rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) *Facts*. Individual *A* works for Employer *X*. *A*, *A*'s spouse, and *A*'s dependent children are eligible but not enrolled for coverage under X's group health plan. *A*'s spouse works for Employer *Y* and at the time coverage was offered under X's plan, *A* was enrolled in coverage under *Y*'s plan. Then, *A* loses eligibility for coverage under *Y*'s plan.

(ii) *Conclusion*. In this *Example 1*, because *A* satisfies the conditions for special enrollment under paragraph (a)(2)(i) of this section, *A*, *A*'s spouse, and *A*'s dependent children are eligible for special enrollment under *X*'s plan.

Example 2. (i) *Facts.* Individual *A* and *A*'s spouse are eligible but not enrolled for coverage under Group Health Plan *P* maintained by *A*'s employer. When *A* was first presented with an opportunity to enroll *A* and *A*'s spouse, they did not have other coverage. Later, *A* and *A*'s spouse enroll in Group Health Plan *Q* maintained by the employer of *A*'s spouse. During a subsequent open enrollment period in *P*, *A* and *A*'s spouse did not enroll because of their coverage under *Q*. They then lose eligibility for coverage under *Q*.

(ii) *Conclusion.* In this *Example 2,* because *A* and *A*'s spouse were covered under *Q* when they did not enroll in *P* during open enrollment, they satisfy the conditions for special enrollment under paragraphs (a)(2)(i) and (ii) of this section. Consequently, *A* and *A*'s spouse are eligible for special enrollment under *P*.

Example 3. (i) *Facts.* Individual *B* works for Employer *X*. *B* and *B*'s spouse are eligible but not enrolled for coverage under *X*'s group health plan. *B*'s spouse works for Employer *Y* and at the time coverage was offered under *X*'s plan, *B*'s spouse was enrolled in self-only coverage under *Y*'s group health plan. Then, *B*'s spouse loses eligibility for coverage under *Y*'s plan.

(ii) *Conclusion.* In this *Example 3,* because *B*'s spouse satisfies the conditions for special enrollment under paragraph (a)(2)(ii) of this section, both *B* and *B*'s spouse are eligible for special enrollment under *X*'s plan.

Example 4. (i) *Facts.* Individual *A* works for Employer *X*. *X* maintains a group health plan with two benefit packages—an HMO option and an indemnity option. Self-only and family coverage are available under both options. *A* enrolls for self-only coverage in the HMO option. *A*'s spouse works for Employer *Y* and was enrolled for self-only coverage under *Y*'s plan at the time coverage was offered under *X*'s plan. Then, *A*'s spouse loses coverage under *Y*'s plan. *A* requests special enrollment for *A* and *A*'s spouse under the plan's indemnity option.

(ii) *Conclusion.* In this *Example 4*, because *A*'s spouse satisfies the conditions for special enrollment under paragraph (a)(2)(ii) of this section, both *A* and *A*'s spouse can enroll in either benefit package under *X*'s plan. Therefore, if *A* requests enrollment in accordance with the requirements of this section, the plan must allow *A* and *A*'s spouse to enroll in the indemnity option.

(3) *Conditions for special enrollment*—(i) *Loss of eligibility for coverage.* In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph (a)(3)(i) are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). Loss of eligibility under this paragraph (a)(3)(i) does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Loss of eligibility for coverage under this paragraph (a)(3)(i) includes (but is not limited to)—

(A) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;

(B) In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);

(C) In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual; and

(D) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in § 54.9802–1(d)) that includes the individual.

(ii) *Termination of employer contributions.* In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph (a)(3)(ii) are satisfied at the time employer contributions towards the employee's or

dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent.

(iii) *Exhaustion of COBRA continuation coverage.* In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions of this paragraph (a)(3)(iii) are satisfied at the time the COBRA continuation coverage is exhausted. For purposes of this paragraph (a)(3)(iii), an individual who satisfies the conditions for special enrollment of paragraph (a)(3)(i) of this section, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions of this paragraph (a)(3)(iii). (*Exhaustion of COBRA continuation coverage* is defined in § 54.9801–2.)

(iv) *Written statement.* A plan may require an employee declining coverage (for the employee or any dependent of the employee) to state in writing whether the coverage is being declined due to other health coverage only if, at or before the time the employee declines coverage, the employee is provided with notice of the requirement to provide the statement (and the consequences of the employee's failure to provide the statement). If a plan requires such a statement, and an employee does not provide it, the plan is not required to provide special enrollment to the employee or any dependent of the employee under this paragraph (a)(3). A plan must treat an employee as having satisfied the plan requirement permitted under this paragraph (a)(3)(iv) if the employee provides a written statement that coverage was being declined because the employee or dependent had other coverage; a plan cannot require anything more for the employee to satisfy the plan's requirement to provide a written statement. (For example, the plan cannot require that the statement be notarized.)

(v) The rules of this paragraph (a)(3) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *D* enrolls in a group health plan maintained by Employer *Y*. At the time *D* enrolls, *Y* pays 70 percent of the cost of employee coverage and *D* pays the rest. *Y* announces that beginning January 1, *Y* will no longer make employer contributions towards the coverage. Employees may maintain coverage, however, if they pay the total cost of the coverage.

(ii) *Conclusion.* In this *Example 1,* employer contributions towards *D*'s coverage ceased on January 1 and the conditions of paragraph (a)(3)(ii) of this section are satisfied on this date (regardless of whether *D* elects to pay the total cost and continue coverage under *Y*'s plan).

Example 2. (i) *Facts.* A group health plan provides coverage through two options—Option 1 and Option 2. Employees can enroll in either option only within 30 days of hire or on January 1 of each year. Employee *A* is eligible for both options and enrolls in Option 1. Effective July 1 the plan terminates coverage under Option 1 and the plan does not create an immediate open enrollment opportunity into Option 2.

(ii) *Conclusion.* In this *Example 2, A* has experienced a loss of eligibility for coverage that satisfies paragraph (a)(3)(i) of this section, and has satisfied the other conditions for special enrollment under paragraph (a)(2)(i) of this section. Therefore, if *A* satisfies the other conditions of this paragraph (a), the plan must permit *A* to enroll in Option 2 as a special enrollee. (*A* may also be eligible to enroll in another group health plan, such as a plan maintained by the employer of *A*'s spouse, as a special enrollee.) The outcome would be the same if Option 1 was terminated by an issuer and the plan made no other coverage available to *A*.

Example 3. (i) *Facts.* Individual *C* is covered under a group health plan maintained by Employer *X*. While covered under *X*'s plan, *C* was eligible for but did not enroll in a plan maintained by Employer *Z*, the employer of *C*'s spouse. *C* terminates employment with *X* and loses eligibility for coverage under *X*'s plan. *C* has a special enrollment right to enroll in *Z*'s plan, but *C* instead elects COBRA continuation coverage under *X*'s plan. *C* exhausts COBRA continuation coverage under *X*'s plan and requests special enrollment in *Z*'s plan.

(ii) *Conclusion.* In this *Example 3, C* has satisfied the conditions for special enrollment under paragraph (a)(3)(iii) of this section, and has satisfied the other conditions for special enrollment under paragraph (a)(2)(i) of this section. The special enrollment right that *C* had into *Z*'s plan immediately after the loss of eligibility for coverage under *X*'s plan was an offer of coverage under *Z*'s plan. When *C* later exhausts COBRA coverage under *X*'s plan, *C* has a second special enrollment right in *Z*'s plan.

(4) *Applying for special enrollment and effective date of coverage.* (i) A plan or issuer must allow an employee a period

of at least 30 days after an event described in paragraph (a)(3) of this section 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 that makes coverage available with respect to dependents is required to permit individuals described in paragraph (b)(2) of this section to be enrolled for coverage in a benefit package under the terms of the plan. Paragraph (b)(3) of this section describes the required special enrollment period and the date by which coverage must begin. The special enrollment rights under this paragraph (b) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan. (*See* 29 CFR 2590.701–6(b) and 45 CFR 146.117(b), under which this obligation is also imposed on a health insurance issuer offering group health insurance coverage.)

(2) *Individuals eligible for special enrollment.* An individual is described in this paragraph (b)(2) if the individual is otherwise eligible for coverage in a benefit package under the plan and if the individual is described in paragraph (b)(2)(i), (ii), (iii), (iv), (v), or (vi) of this section.

(i) *Current employee only.* A current employee is described in this paragraph (b)(2)(i) if a person becomes a dependent of the individual through marriage, birth, adoption, or placement for adoption.

(ii) *Spouse of a participant only.* An individual is described in this paragraph (b)(2)(ii) if either—

(A) The individual becomes the spouse of a participant; or

(B) The individual is a spouse of a participant and a child becomes a dependent of the participant through birth, adoption, or placement for adoption.

(iii) *Current employee and spouse.* A current employee and an individual who is or becomes a spouse of such an employee, are described in this paragraph (b)(2)(iii) if either—

(A) The employee and the spouse become married; or

(B) The employee and spouse are married and a child becomes a dependent of the employee through birth, adoption, or placement for adoption.

(iv) *Dependent of a participant only.* An individual is described in this paragraph (b)(2)(iv) if the individual is a dependent (as defined in § 54.9801–2) of a participant and the individual has become a dependent of the participant through marriage, birth, adoption, or placement for adoption.

(v) *Current employee and a new dependent.* A current employee and an individual who is a dependent of the employee, are described in this paragraph (b)(2)(v) if the individual becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.

(vi) *Current employee, spouse, and a new dependent.* A current employee, the employee's spouse, and the employee's dependent are described in this paragraph (b)(2)(vi) if the dependent becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.

(3) *Applying for special enrollment and effective date of coverage*—(i) *Request.* A plan must allow an individual a period of at least 30 days after the date of the marriage, birth, adoption, or placement for adoption (or, if dependent coverage is not generally made available at the time of the marriage, birth, adoption, or placement for adoption, a period of at least 30 days after the date the plan makes dependent coverage generally available) to request enrollment (for the individual or the individual's dependent).

(ii) *Reasonable procedures for special enrollment.* [Reserved]

(iii) *Date coverage must begin*—(A) *Marriage.* In the case of marriage, coverage must begin no later than the first day of the first calendar month beginning after the date the plan (or any issuer offering health insurance coverage under the plan) receives the request for special enrollment.

(B) *Birth, adoption, or placement for adoption.* Coverage must begin in the case of a dependent's birth on the date

of birth and in the case of a dependent's adoption or placement for adoption no later than the date of such adoption or placement for adoption (or, if dependent coverage is not made generally available at the time of the birth, adoption, or placement for adoption, the date the plan makes dependent coverage available).

(4) *Examples*. The rules of this paragraph (b) are illustrated by the following examples:

Example 1. (i) *Facts*. An employer maintains a group health plan that offers all employees employee-only coverage, employee-plus-spouse coverage, or family coverage. Under the terms of the plan, any employee may elect to enroll when first hired (with coverage beginning on the date of hire) or during an annual open enrollment period held each December (with coverage beginning the following January 1). Employee *A* is hired on September 3. *A* is married to *B*, and they have no children. On March 15 in the following year a child *C* is born to *A* and *B*. Before that date, *A* and *B* have not been enrolled in the plan.

(ii) *Conclusion*. In this *Example 1*, the conditions for special enrollment of an employee with a spouse and new dependent under paragraph (b)(2)(vi) of this section are satisfied. If *A* satisfies the conditions of paragraph (b)(3) of this section for requesting enrollment timely, the plan will satisfy this paragraph (b) if it allows *A* to enroll either with employee-only coverage, with employee-plus-spouse coverage (for *A* and *B*), or with family coverage (for *A*, *B*, and *C*). The plan must allow whatever coverage is chosen to begin on March 15, the date of *C*'s birth.

Example 2. (i) *Facts*. Individual *D* works for Employer *X*. *X* maintains a group health plan with two benefit packages—an HMO option and an indemnity option. Self-only and family coverage are available under both options. *D* enrolls for self-only coverage in the HMO option. Then, a child, *E*, is placed for adoption with *D*. Within 30 days of the placement of *E* for adoption, *D* requests enrollment for *D* and *E* under the plan's indemnity option.

(ii) *Conclusion*. In this *Example 2*, *D* and *E* satisfy the conditions for special enrollment under paragraphs (b)(2)(v) and (b)(3) of this section. Therefore, the plan must allow *D* and *E* to enroll in the indemnity coverage, effective as of the date of the placement for adoption.

(c) *Notice of special enrollment*. At or before the time an employee is initially offered the opportunity to enroll in a group health plan, the plan must furnish the employee with a notice of special enrollment that complies with the requirements of this paragraph (c).

(1) *Description of special enrollment rights*. The notice of special enrollment must include a description of special enrollment rights. The following model language may be used to satisfy this requirement:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within [insert "30 days" or any longer period that applies under the plan] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within [insert "30 days" or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact [insert the name, title, telephone number, and any additional contact information of the appropriate plan representative].

(2) *Additional information that may be required*. The notice of special enrollment must also include, if applicable, the notice described in paragraph (a)(3)(iv) of this section (the notice required to be furnished to an individual declining coverage if the plan requires the reason for declining coverage to be in writing).

(d) *Treatment of special enrollees*—(1) If an individual requests enrollment while the individual is entitled to special enrollment under either paragraph (a) or (b) of this section, the individual is a special enrollee, even if the request for enrollment coincides with a late enrollment opportunity under the plan. Therefore, the individual cannot be treated as a late enrollee.

(2) Special enrollees must be offered all the benefit packages available to similarly situated individuals who enroll when first eligible. For this purpose, any difference in benefits or cost-

sharing requirements for different individuals constitutes a different benefit package. In addition, a special enrollee cannot be required to pay more for coverage than a similarly situated individual who enrolls in the same coverage when first eligible.

(3) The rules of this section are illustrated by the following example:

Example 2. (i) *Facts.* Employer *Y* maintains a group health plan that has an enrollment period for late enrollees every November 1 through November 30 with coverage effective the following January 1. On October 18, Individual *B* loses coverage under another group health plan and satisfies the requirements of paragraphs (a)(2), (3), and (4) of this section. *B* submits a completed application for coverage on November 2.

(ii) *Conclusion.* In this *Example, B* is a special enrollee. Therefore, even though *B*'s request for enrollment coincides with an open enrollment period, *B*'s coverage is required to be made effective no later than December 1 (rather than the plan's January 1 effective date for late enrollees).

[T.D. 9166, 69 FR 78746, Dec. 30, 2004, as amended by T.D. 9656, 79 FR 10305, Feb. 24, 2014]

§ 54.9802–1 Prohibiting discrimination against participants and beneficiaries based on a health factor.

(a) *Health factors.* (1) The term *health factor* means, in relation to an individual, any of the following health status-related factors:

(i) Health status;

(ii) Medical condition (including both physical and mental illnesses), as defined in § 54.9801–2;

(iii) Claims experience;

(iv) Receipt of health care;

(v) Medical history;

(vi) Genetic information, as defined in § 54.9802–3T.

(vii) Evidence of insurability; or

(viii) Disability.

(2) Evidence of insurability includes—

(i) Conditions arising out of acts of domestic violence; and

(ii) Participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities.

(3) The decision whether health coverage is elected for an individual (including the time chosen to enroll, such as under special enrollment or late enrollment) is not, itself, within the scope of any health factor. (However, under § 54.9801–6, a plan must treat special enrollees the same as similarly situated individuals who are enrolled when first eligible.)

(b) *Prohibited discrimination in rules for eligibility*—(1) *In general.* (i) A group health plan, 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);

(F) Benefits (including rules relating to covered benefits, benefit restrictions, and cost-sharing mechanisms such as coinsurance, copayments, and deductibles), as described in paragraphs (b)(2) and (3) of this section;

(G) Continued eligibility; and

(H) Terminating coverage (including disenrollment) of any individual under the plan.

(iii) The rules of this paragraph (b)(1) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan that is available to all employees who enroll within the first 30 days

of their employment. However, employees who do not enroll within the first 30 days cannot enroll later unless they pass a physical examination.

(ii) *Conclusion*. In this *Example 1*, the requirement to pass a physical examination in order to enroll in the plan is a rule for eligibility that discriminates based on one or more health factors and thus violates this paragraph (b)(1).

Example 2. (i) *Facts*. Under an employer's group health plan, employees who enroll during the first 30 days of employment (and during special enrollment periods) may choose between two benefit packages: An indemnity option and an HMO option. However, employees who enroll during late enrollment are permitted to enroll only in the HMO option and only if they provide evidence of good health.

(ii) *Conclusion*. In this *Example 2*, the requirement to provide evidence of good health in order to be eligible for late enrollment in the HMO option is a rule for eligibility that discriminates based on one or more health factors and thus violates this paragraph (b)(1). However, if the plan did not require evidence of good health but limited late enrollees to the HMO option, the plan's rules for eligibility would not discriminate based on any health factor, and thus would not violate this paragraph (b)(1), because the time an individual chooses to enroll is not, itself, within the scope of any health factor.

Example 3. (i) *Facts*. Under an employer's group health plan, all employees generally may enroll within the first 30 days of employment. However, individuals who participate in certain recreational activities, including motorcycling, are excluded from coverage.

(ii) *Conclusion*. In this *Example 3*, excluding from the plan individuals who participate in recreational activities, such as motorcycling, is a rule for eligibility that discriminates based on one or more health factors and thus violates this paragraph (b)(1).

Example 4. (i) *Facts*. A group health plan applies for a group health policy offered by an issuer. As part of the application, the issuer receives health information about individuals to be covered under the plan. Individual *A* is an employee of the employer maintaining the plan. *A* and *A*'s dependents have a history of high health claims. Based on the information about *A* and *A*'s dependents, the issuer excludes *A* and *A*'s dependents from the group policy it offers to the employer.

(ii) *Conclusion*. See *Example 4* in 29 CFR 2590.702(b)(1) and 45 CFR 146.121(b)(1) for a conclusion that the exclusion by the issuer of *A* and *A*'s dependents from coverage is a rule for eligibility that discriminates based on one or more health factors and violates rules under 29 CFR 2590.702(b)(1) and 45 CFR 146.121(b)(1) similar to the rules under this paragraph (b)(1). (If the employer is a small employer under 45 CFR 144.103 (generally, an employer with 50 or fewer employees), the issuer also may violate 45 CFR 146.150, which requires issuers to offer all the policies they sell in the small group market on a guaranteed available basis to all small employers and to accept every eligible individual in every small employer group.) If the plan provides coverage through this policy and does not provide equivalent coverage for *A* and *A*'s dependents through other means, the plan violates this paragraph (b)(1).

(2) *Application to benefits*—(i) *General rule*—(A) Under this section, a group health plan is not required to provide coverage for any particular benefit to any group of similarly situated individuals.

(B) However, benefits provided under a plan must be uniformly available to all similarly situated individuals (as described in paragraph (d) of this section). Likewise, any restriction on a benefit or benefits must apply uniformly to all similarly situated individuals and must not be directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries (determined based on all the relevant facts and circumstances). Thus, for example, a plan may limit or exclude benefits in relation to a specific disease or condition, limit or exclude benefits for certain types of treatments or drugs, or limit or exclude benefits based on a determination of whether the benefits are experimental or not medically necessary, but only if the benefit limitation or exclusion applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. In addition, a plan 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 outweighing evidence to the contrary, the plan violates this paragraph (b)(2)(i).

Example 3. (i) A group health plan applies for a group health policy offered by an issuer. Individual *C* is covered under the plan and has an adverse health condition. As part of the application, the issuer receives health information about the individuals to be covered, including information about *C*'s adverse health condition. The policy form offered by the issuer generally provides benefits for the adverse health condition that *C* has, but in this case the issuer offers the plan a policy modified by a rider that excludes benefits for *C* for that condition. The exclusionary rider is made effective the first day of the next plan year.

(ii) *Conclusion.* See *Example 3* in 29 CFR 2590.702(b)(2)(i) and 45 CFR 146.121(b)(2)(i) for a conclusion that the issuer violates rules under 29 CFR 2590.702(b)(2)(i) and 45 CFR 146.121(b)(2)(i) similar to the rules under this paragraph (b)(2)(i) because benefits for *C*'s condition are available to other individuals in the group of similarly situated individuals that includes *C* but are not available to *C*. Thus, the benefits are not uniformly available to all similarly situated individuals. Even though the exclusionary rider is made effective the first day of the next plan year, because the rider does not apply to all similarly situated individuals, the issuer violates the rules under 29 CFR 2590.702(b)(2)(i) and 45 CFR 146.121(b)(2)(i). If the plan provides coverage through this policy and does not provide equivalent coverage for *C* through other means, the plan violates this paragraph (b)(2)(i).

Example 4. (i) *Facts.* A group health plan has a $2,000 lifetime limit for the treatment of temporomandibular joint syndrome (TMJ). The limit is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 4*, the limit does not violate this paragraph (b)(2)(i) because $2,000 of benefits for the treatment of TMJ are available uniformly to all similarly situated individuals and a plan may limit benefits covered in relation to a specific disease or condition if the limit applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries. (However, applying a lifetime limit on TMJ may violate PHS Act section 2711 and its implementing regulations, if TMJ coverage is an essential health 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 PHS Act section 2711 and its implementing regulations 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 may vary benefits, including cost-sharing mechanisms (such as a deductible, copayment, or coinsurance), based on whether an individual has met the standards of a wellness program that satisfies the requirements of paragraph (f) of this section.

(iii) *Specific rule relating to source-of-injury exclusions*—(A) If a group health plan generally provides benefits for a type of injury, the plan may not deny benefits otherwise provided for treatment of the injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions). This rule applies in the case of an injury resulting from a medical condition even if the condition is not diagnosed before the injury.

(B) The rules of this paragraph (b)(2)(iii) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan generally provides medical/surgical benefits, including benefits for hospital stays, that are medically necessary. However, the plan excludes benefits for self-inflicted injuries or injuries sustained in connection with attempted suicide. Because of depression, Individual *D* attempts suicide. As a result, *D* sustains injuries and is hospitalized for treatment of the injuries. Under the exclusion, the plan denies *D* benefits for treatment of the injuries.

(ii) *Conclusion.* In this *Example 1,* the suicide attempt is the result of a medical condition (depression). Accordingly, the denial of benefits for the treatments of *D*'s injuries violates the requirements of this paragraph (b)(2)(iii) because the plan provision excludes benefits for treatment of an injury resulting from a medical condition.

Example 2. (i) *Facts.* A group health plan provides benefits for head injuries generally. The plan also has a general exclusion for any injury sustained while participating in any of a number of recreational activities, including bungee jumping. However, this exclusion does not apply to any injury that results from a medical condition (nor from domestic violence). Participant *E* sustains a head injury while bungee jumping. The injury did not result from a medical condition (nor from domestic violence). Accordingly, the plan denies benefits for *E*'s head injury.

(ii) *Conclusion.* In this *Example 2,* the plan provision that denies benefits based on the source of an injury does not restrict benefits based on an act of domestic violence or any medical condition. Therefore, the provision is permissible under this paragraph (b)(2)(iii) and does not violate this section. (However, if the plan did not allow *E* to enroll in the plan (or applied different rules for eligibility to *E*) because *E* frequently participates in bungee jumping, the plan would violate paragraph (b)(1) of this section.)

(c) *Prohibited discrimination in premiums or contributions*—(1) *In general*—(i) A group health plan may not require an individual, as a condition of enrollment or continued enrollment under the plan, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual (described in paragraph (d) of this section) enrolled in the plan based on any health factor that relates to the individual or a dependent of the individual.

(ii) Discounts, rebates, payments in kind, and any other premium differential mechanisms are taken into account in determining an individual's premium or contribution rate. (For rules relating to cost-sharing mechanisms, see paragraph (b)(2) of this section (addressing benefits).)

(2) *Rules relating to premium rates*—(i) *Group rating based on health factors not restricted under this section.* Nothing in this section restricts the aggregate amount that an employer may be charged for coverage under a group health plan. But *see* § 54.9802–3T(b), which prohibits adjustments in group premium or contribution rates based on genetic information.

(ii) *List billing based on a health factor prohibited.* However, a group health plan may not quote or charge an employer (or an individual) a different premium for an individual in a group of similarly situated individuals based on a health factor. (But see paragraph (g) of this section permitting favorable treatment of individuals with adverse health factors.)

(iii) *Examples.* The rules of this paragraph (c)(2) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan and purchases coverage from a health insurance issuer. In order to determine the premium rate for the upcoming plan year, the issuer reviews the claims experience of individuals covered under the plan. The issuer finds that Individual F had significantly higher claims experience than similarly situated individuals in the plan. The issuer quotes the plan a higher per-participant rate because of F's claims experience.

(ii) *Conclusion.* See *Example 1* in 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) for a conclusion that the issuer does not violate the provisions of 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) similar to the provisions of this paragraph (c)(2) because the issuer blends the rate so that the employer is not quoted a higher rate for F than for a similarly situated individual based on F's claims experience. (However, those examples conclude that if the issuer used genetic information in computing the group rate, it would violate 29 CFR 2590.702–1(b) or 45 CFR 146.122(b).)

Example 2. (i) *Facts.* Same facts as *Example 1*, except that the issuer quotes the employer a higher premium rate for *F*, because of *F*'s claims experience, than for a similarly situated individual.

(ii) *Conclusion.* See *Example 2* in 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) for a conclusion that the issuer violates provisions of 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) similar to the provisions of this paragraph (c)(2). Moreover, even if the plan purchased the policy based on the quote but did not require a higher participant contribution for *F* than for a similarly situated individual, see *Example 2* in 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) for a conclusion that the issuer would still violate 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) (but in such a case the plan would not violate this paragraph (c)(2)).

(3) *Exception for wellness programs.* Notwithstanding paragraphs (c)(1) and (2) of this section, a plan may vary the amount of premium or contribution it requires similarly situated individuals to pay based on whether an individual has met the standards of a wellness program that satisfies the requirements of paragraph (f) of this section.

(d) *Similarly situated individuals.* The requirements of this section apply only within a group of individuals who are treated as similarly situated individuals. A plan may treat participants as a group of similarly situated individuals separate from beneficiaries. In addition, participants may be treated as two or more distinct groups of similarly situated individuals and beneficiaries may be treated as two or more distinct groups of similarly situated individuals in accordance with the rules of this paragraph (d). Moreover, if individuals have a choice of two or more benefit packages, individuals choosing one benefit package may be treated as one or more groups of similarly situated individuals distinct from individuals choosing another benefit package.

(1) *Participants.* Subject to paragraph (d)(3) of this section, a plan may treat participants as two or more distinct groups of similarly situated individuals if the distinction between or among the groups of participants is based on a bona fide employment-based classification consistent with the employer's usual business practice. Whether an employment-based classification is bona fide is determined on the basis of all the relevant facts and circumstances. Relevant facts and circumstances include whether the employer uses the classification for purposes independent of qualification for

health coverage (for example, determining eligibility for other employee benefits or determining other terms of employment). Subject to paragraph (d)(3) of this section, examples of classifications that, based on all the relevant facts and circumstances, may be bona fide include full-time versus part-time status, different geographic location, membership in a collective bargaining unit, date of hire, length of service, current employee versus former employee status, and different occupations. However, a classification based on any health factor is not a bona fide employment-based classification, unless the requirements of paragraph (g) of this section are satisfied (permitting favorable treatment of individuals with adverse health factors).

(2) *Beneficiaries*—(i) Subject to paragraph (d)(3) of this section, a plan may treat beneficiaries as two or more distinct groups of similarly situated individuals if the distinction between or among the groups of beneficiaries is based on any of the following factors:

(A) A bona fide employment-based classification of the participant through whom the beneficiary is receiving coverage;

(B) Relationship to the participant (for example, as a spouse or as a dependent child);

(C) Marital status;

(D) With respect to children of a participant, age or student status; or

(E) Any other factor if the factor is not a health factor.

(ii) Paragraph (d)(2)(i) of this section does not prevent more favorable treatment of individuals with adverse health factors in accordance with paragraph (g) of this section.

(3) *Discrimination directed at individuals*. Notwithstanding paragraphs (d)(1) and (2) of this section, if the creation or modification of an employment or coverage classification is directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries, the classification is not permitted under this paragraph (d), unless it is permitted under paragraph (g) of this section (permitting favorable treatment of individuals with adverse health factors). Thus, if an employer modified an employment-based classification to single out, based on a health factor, individual participants and beneficiaries and deny them health coverage, the new classification would not be permitted under this section.

(4) *Examples*. The rules of this paragraph (d) are illustrated by the following examples:

Example 1. (i) *Facts*. An employer sponsors a group health plan for full-time employees only. Under the plan (consistent with the employer's usual business practice), employees who normally work at least 30 hours per week are considered to be working full-time. Other employees are considered to be working part-time. There is no evidence to suggest that the classification is directed at individual participants or beneficiaries.

(ii) *Conclusion*. In this *Example 1*, treating the full-time and part-time employees as two separate groups of similarly situated individuals is permitted under this paragraph (d) because the classification is bona fide and is not directed at individual participants or beneficiaries.

Example 2. (i) *Facts*. Under a group health plan, coverage is made available to employees, their spouses, and their 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) *Nonconfinement provisions*—(i) *General rule.* Under the rules of paragraphs (b) and (c) of this section, a plan may not establish a rule for eligibility (as described in paragraph (b)(1)(ii) of this section) or set any individual's premium or contribution rate based on whether an individual is confined to a hospital or other health care institution. In addition, under the rules of paragraphs (b) and (c) of this section, a plan may not establish a rule for eligibility or set any individual's premium or contribution rate based on an individual's ability to engage in normal life activities, except to the extent permitted under paragraphs (e)(2)(ii) and (3) of this section (permitting plans, under certain circumstances, to distinguish among employees based on the performance of services).

(ii) *Examples.* The rules of this paragraph (e)(1) are illustrated by the following examples:

Example 1. (i) *Facts.* Under a group health plan, coverage for employees and their dependents generally becomes effective on the first day of employment. However, coverage for a dependent who is confined to a hospital or other health care institution does not become effective until the confinement ends.

(ii) *Conclusion.* In this *Example 1,* the plan violates this paragraph (e)(1) because the plan delays the effective date of coverage for dependents based on confinement to a hospital or other health care institution.

Example 2. (i) *Facts.* In previous years, a group health plan has provided coverage through a group health insurance policy offered by Issuer *M.* However, for the current year, the plan provides coverage through a group health insurance policy offered by Issuer *N.* Under Issuer *N*'s policy, items and services provided in connection with the confinement of a dependent to a hospital or other health care institution are not covered if the confinement is covered under an extension of benefits clause from a previous health insurance issuer.

(ii) *Conclusion.* See *Example 2* in 29 CFR 2590.702(e)(1) and 45 CFR 146.121(e)(1) for a conclusion that Issuer *N* violates provisions of 29 CFR 2590.702(e)(1) and 45 CFR 146.121(e)(1) similar to the provisions of this paragraph (e)(1) because the group health insurance coverage restricts benefits based on whether a dependent is confined to a hospital or other health care institution that is covered under an extension of benefits from a previous issuer. See *Example 2* in 29 CFR 2590.702(e)(1) and 45 CFR 146.121(e)(1) for the additional conclusions that under State law Issuer *M* may also be responsible for providing benefits to such a dependent; and that in a case in which Issuer *N* has an obligation under 29 CFR 2590.702(e)(1) or 45 CFR 146.121(e)(1) to provide benefits and Issuer *M* has an obligation under State law to provide benefits, any State laws designed to prevent more than 100% reimbursement, such as

State coordination-of-benefits laws, continue to apply.

(2) *Actively-at-work and continuous service provisions*—(i) *General rule*—(A) Under the rules of paragraphs (b) and (c) of this section and subject to the exception for the first day of work described in paragraph (e)(2)(ii) of this section, a plan may not establish a rule for eligibility (as described in paragraph (b)(1)(ii) of this section) or set any individual's premium or contribution rate based on whether an individual is actively at work (including whether an individual is continuously employed), unless absence from work due to any health factor (such as being absent from work on sick leave) is treated, for purposes of the plan, as being actively at work.

(B) The rules of this paragraph (e)(2)(i) are illustrated by the following examples:

Example 1. (i) *Facts.* Under a group health plan, an employee generally becomes eligible to enroll 30 days after the first day of employment. However, if the employee is not actively at work on the first day after the end of the 30-day period, then eligibility for enrollment is delayed until the first day the employee is actively at work.

(ii) *Conclusion.* In this *Example 1,* the plan violates this paragraph (e)(2) (and thus also violates paragraph (b) of this section). However, the plan would not violate paragraph (e)(2) or (b) of this section if, under the plan, an absence due to any health factor is considered being actively at work.

Example 2. (i) *Facts.* Under a group health plan, coverage for an employee becomes effective after 90 days of continuous service; that is, if an employee is absent from work (for any reason) before completing 90 days of service, the beginning of the 90-day period is measured from the day the employee returns to work (without any credit for service before the absence).

(ii) *Conclusion.* In this Example 2, the plan violates this paragraph (e)(2) (and thus also paragraph (b) of this section) because the 90-day continuous service requirement is a rule for eligibility based on whether an individual is actively at work. However, the plan would not violate this paragraph (e)(2) or paragraph (b) of this section if, under the plan, an absence due to any health factor is not considered an absence for purposes of measuring 90 days of continuous service. (In addition, any eligibility provision that is time-based must comply with the requirements of PHS Act section 2708 and its implementing regulations.)

(ii) *Exception for the first day of work*—(A) Notwithstanding the general rule in paragraph (e)(2)(i) of this section, a plan may establish a rule for eligibility that requires an individual to begin work for the employer sponsoring the plan (or, in the case of a multiemployer plan, to begin a job in covered employment) before coverage becomes effective, provided that such a rule for eligibility applies regardless of the reason for the absence.

(B) The rules of this paragraph (e)(2)(ii) are illustrated by the following examples:

Example 1. (i) *Facts.* Under the eligibility provision of a group health plan, coverage for new employees becomes effective on the first day that the employee reports to work. Individual *H* is scheduled to begin work on August 3. However, *H* is unable to begin work on that day because of illness. *H* begins working on August 4, and *H*'s coverage is effective on August 4.

(ii) *Conclusion.* In this *Example 1,* the plan provision does not violate this section. However, if coverage for individuals who do not report to work on the first day they were scheduled to work for a reason unrelated to a health factor (such as vacation or bereavement) becomes effective on the first day they were scheduled to work, then the plan would violate this section.

Example 2. (i) *Facts.* Under a group health plan, coverage for new employees becomes effective on the first day of the month following the employee's first day of work, regardless of whether the employee is actively at work on the first day of the month. Individual *J* is scheduled to begin work on March 24. However, *J* is unable to begin work on March 24 because of illness. *J* begins working on April 7 and *J*'s coverage is effective May 1.

(ii) *Conclusion.* In this *Example 2,* the plan provision does not violate this section. However, as in *Example 1,* if coverage for individuals absent from work for reasons unrelated to a health factor became effective despite their absence, then the plan would violate this section.

(3) *Relationship to plan provisions defining similarly situated individuals*—(i) Notwithstanding the rules of paragraphs (e)(1) and (2) of this section, a plan may establish rules for eligibility or set any individual's premium or contribution rate in accordance with the rules relating to similarly situated individuals in paragraph (d) of this section. Accordingly, a plan may distinguish in rules for eligibility under the

plan between full-time and part-time employees, between permanent and temporary or seasonal employees, between current and former employees, and between employees currently performing services and employees no longer performing services for the employer, subject to paragraph (d) of this section. However, other Federal or State laws (including the COBRA continuation provisions and the Family and Medical Leave Act of 1993) may require an employee or the employee's dependents to be offered coverage and set limits on the premium or contribution rate even though the employee is not performing services.

(ii) The rules of this paragraph (e)(3) are illustrated by the following examples:

Example 1. (i) *Facts.* Under a group health plan, employees are eligible for coverage if they perform services for the employer for 30 or more hours per week or if they are on paid leave (such as vacation, sick, or bereavement leave). Employees on unpaid leave are treated as a separate group of similarly situated individuals in accordance with the rules of paragraph (d) of this section.

(ii) *Conclusion.* In this *Example 1,* the plan provisions do not violate this section. However, if the plan treated individuals performing services for the employer for 30 or more hours per week, individuals on vacation leave, and individuals on bereavement leave as a group of similarly situated individuals separate from individuals on sick leave, the plan would violate this paragraph (e) (and thus also would violate paragraph (b) of this section) because groups of similarly situated individuals cannot be established based on a health factor (including the taking of sick leave) under paragraph (d) of this section.

Example 2. (i) *Facts.* To be eligible for coverage under a bona fide collectively bargained group health plan in the current calendar quarter, the plan requires an individual to have worked 250 hours in covered employment during the three-month period that ends one month before the beginning of the current calendar quarter. The distinction between employees working at least 250 hours and those working less than 250 hours in the earlier three-month period is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries.

(ii) *Conclusion.* In this *Example 2,* the plan provision does not violate this section because, under the rules for similarly situated individuals allowing full-time employees to be treated differently than part-time employees, employees who work at least 250 hours in a three-month period can be treated differently than employees who fail to work 250 hours in that period. The result would be the same if the plan permitted individuals to apply excess hours from previous periods to satisfy the requirement for the current quarter.

Example 3. (i) *Facts.* Under a group health plan, coverage of an employee is terminated when the individual's employment is terminated, in accordance with the rules of paragraph (d) of this section. Employee *B* has been covered under the plan. *B* experiences a disabling illness that prevents *B* from working. *B* takes a leave of absence under the Family and Medical Leave Act of 1993. At the end of such leave, *B* terminates employment and consequently loses coverage under the plan. (This termination of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation.)

(ii) *Conclusion.* In this *Example 3,* the plan provision terminating *B*'s coverage upon *B*'s termination of employment does not violate this section.

Example 4. (i) *Facts.* Under a group health plan, coverage of an employee is terminated when the employee ceases to perform services for the employer sponsoring the plan, in accordance with the rules of paragraph (d) of this section. Employee *C* is laid off for three months. When the layoff begins, *C*'s coverage under the plan is terminated. (This termination of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation coverage.)

(ii) *Conclusion.* In this *Example 4,* the plan provision terminating *C*'s coverage upon the cessation of *C*'s performance of services does not violate this section.

(f) *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, § 54.9815–2713T 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* § 54.9802–3T 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 but does not require the individual to attain or maintain a specific health outcome. Examples include walking, diet, or exercise programs, which some individuals may be unable to participate in or complete (or have difficulty participating in or completing) due to a health factor, such as severe asthma, pregnancy, or a recent surgery. *See* paragraph (f)(3) of this section for requirements applicable to activity-only wellness programs.

(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 reward. This alternative pathway, however, does not mean that the overall program, which has an outcome-based component, is not an outcome-based wellness program. That is, if a measurement, test, or screening is used as

part of an initial standard and individuals who meet the standard are granted the reward, the program is considered an outcome-based wellness program. For example, if a wellness program tests individuals for specified medical conditions or risk factors (including biometric screening such as testing for high cholesterol, high blood pressure, abnormal body mass index, or high glucose level) and provides a reward 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 additional steps (such as meeting with a health coach, taking a health or fitness course, adhering to a health improvement action plan, complying with a walking or exercise program, or complying with a health care provider's plan of care) to obtain the same reward, the program is an outcome-based wellness program. *See* paragraph (f)(4) of this section for requirements applicable to outcome-based wellness programs.

(2) *Requirement for participatory wellness programs.* A participatory wellness program, as described in paragraph (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 situated 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 paragraph (f)(1)(iv) 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 activity-only 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)(3)(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.

(iv) *Uniform availability and reasonable alternative standards.* The full reward under the activity-only wellness program must be available to all similarly situated individuals.

(A) Under this paragraph (f)(3)(iv), a reward under an activity-only wellness program is not available to all similarly situated individuals for a period unless the program meets both of the following requirements:

(*1*) 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 unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

(*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:

(*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 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 rules:

(*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 inadvisable 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 rules 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.

(ii) *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 recommendations of 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 unreasonably difficult due to a medical condition to comply with this walking program (and 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 is.)'' Participant *E* is unable to achieve a BMI that is 26 or lower within the plan's timeframe and receives notification that complies with paragraph (f)(4)(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) of this section (including the requirement of paragraph (f)(3)(iv) 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 participant 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 compliance 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 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)(iii), (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 provisions 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 $2,600 ($600 + $2,000 = $2,600), 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 from establishing more favorable rules for eligibility (described in paragraph (b)(1) of this section) for individuals with an adverse health factor, such as disability, than for individuals without the adverse health factor. Moreover, nothing in this section prevents a plan from charging a higher premium or contribution with respect to individuals with an adverse health factor if they would not be eligible for the coverage were it not for the adverse health factor. (However, other laws, including State insurance laws, may set or limit premium rates; these laws are not affected by this section.)

(ii) The rules of this paragraph (g)(1) are illustrated by the following examples:

Example 1. (i) *Facts*. An employer sponsors a group health plan that generally is available to employees, spouses of employees, and dependent children until age 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 employees a higher premium during the extended period of coverage.

Example 3. (i) *Facts.* To comply with the requirements of a COBRA continuation provision, a group health plan generally makes COBRA continuation coverage available for a maximum period of 18 months in connection with a termination of employment but makes the coverage available for a maximum period of 29 months to certain disabled individuals and certain members of the disabled individual's family. Although the plan generally requires payment of 102 percent of the applicable premium for the first 18 months of COBRA continuation coverage, the plan requires payment of 150 percent of the applicable premium for the disabled individual's COBRA continuation coverage during the disability extension if the disabled individual would not be entitled to COBRA continuation coverage but for the disability.

(ii) *Conclusion.* In this *Example 3*, the plan provision allowing extended COBRA continuation coverage for disabled individuals satisfies this paragraph (g)(1) (and thus does not violate this section). In addition, the plan is permitted, under this paragraph (g)(1), to charge the disabled individuals a higher premium for the extended coverage if the individuals would not be eligible for COBRA continuation coverage were it not for the disability. (Similarly, if the plan provided an extended period of coverage for disabled individuals pursuant to State law or plan provision rather than pursuant to a COBRA continuation coverage provision, the plan could likewise charge the disabled individuals a higher premium for the extended coverage.)

(2) *In premiums or contributions*—(i) Nothing in this section prevents a group health plan from charging individuals a premium or contribution that is less than the premium (or contribution) for similarly situated individuals if the lower charge is based on an adverse health factor, such as disability.

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

Example. (i) *Facts.* Under a group health plan, employees are generally required to pay $50 per month for employee-only coverage and $125 per month for family coverage under the plan. However, employees who are disabled receive coverage (whether employee-only or family coverage) under the plan free of charge.

(ii) *Conclusion.* In this *Example*, the plan provision waiving premium payment for disabled employees is permitted under this paragraph (g)(2) (and thus does not violate this section).

(h) *No effect on other laws.* Compliance with this section is not determinative of compliance with any provision of ERISA (including the COBRA continuation provisions) or any other State or Federal law, such as the Americans with Disabilities Act. Therefore, although the rules of this section would not prohibit a plan from treating one group of similarly situated individuals differently from another (such as providing different benefit packages to current and former employees), other Federal or State laws may require that two separate groups of similarly situated individuals be treated the same for certain purposes (such as making the same benefit package available to COBRA qualified beneficiaries as is made available to active employees). In addition, although this section generally does not impose new disclosure obligations on plans, this section does not affect any other laws, including those that require accurate disclosures and prohibit intentional misrepresentation.

(i) *Applicability dates*. This section applies for plan years beginning on or after July 1, 2007.

[T.D. 9298, 71 FR 75030, Dec. 13, 2006; 72 FR 7929, Feb. 22, 2007, as amended by T.D. 9464, 74 FR 51678, Oct. 7, 2009; T.D. 9620, 78 FR 33176, June 3, 2013; T.D. 9656, 79 FR 10305, Feb. 24, 2014]

§ 54.9802–2 Special rules for certain church plans.

(a) *Exception for certain church plans*—(1) *Church plans in general*. A church plan described in paragraph (b) of this section is not treated as failing to meet the requirements of section 9802 or § 54.9802–1 solely because the plan requires evidence of good health for coverage of individuals under plan provisions described in paragraph (b)(2) or (3) of this section.

(2) *Health insurance issuers*. See sections 2702 and 2721(b)(1)(B) of the Public Health Service Act (42 U.S.C. 300gg–2 and 300gg–21(b)(1)(B)) and 45 CFR 146.121, which require health insurance issuers providing health insurance coverage under a church plan that is a group health plan to comply with nondiscrimination requirements similar to those that church plans are required to comply with under section 9802 and § 54.9802–1 except that those nondiscrimination requirements do not include an exception for health insurance issuers comparable to the exception for church plans under section 9802(c) and this section.

(b) *Church plans to which this section applies*—(1) *Church plans with certain coverage provisions in effect on July 15, 1997*. This section applies to any church plan (as defined in section 414(e)) for a plan year if, on July 15, 1997 and at all times thereafter before the beginning of the plan year, the plan contains either the provisions described in paragraph (b)(2) of this section or the provisions described in paragraph (b)(3) of this section.

(2) *Plan provisions applicable to individuals employed by employers of 10 or fewer employees and self-employed individuals*. (i) A plan contains the provisions described in this paragraph (b)(2) if it requires evidence of good health of both—

(A) Any employee of an employer of 10 or fewer employees (determined without regard to section 414(e)(3)(C), under which a church or convention or association of churches is treated as the employer); and

(B) Any self-employed individual.

(ii) A plan does not contain the provisions described in this paragraph (b)(2) if the plan contains only one of the provisions described in this paragraph (b)(2). Thus, for example, a plan that requires evidence of good health of any self-employed individual, but not of any employee of an employer with 10 or fewer employees, does not contain the provisions described in this paragraph (b)(2). Moreover, a plan does not contain the provision described in paragraph (b)(2)(i)(A) of this section if the plan requires evidence of good health of any employee of an employer of fewer than 10 (or greater than 10) employees. Thus, for example, a plan does not contain the provision described in paragraph (b)(2)(i)(A) of this section if the plan requires evidence of good health of any employee of an employer with five or fewer employees.

(3) *Plan provisions applicable to individuals who enroll after the first 90 days of initial eligibility*. (i) A plan contains the provisions described in this paragraph (b)(3) if it requires evidence of good health of any individual who enrolls after the first 90 days of initial eligibility under the plan.

(ii) A plan does not contain the provisions described in this paragraph (b)(3) if it provides for a longer (or shorter) period than 90 days. Thus, for example, a plan requiring evidence of good health of any individual who enrolls after the first 120 days of initial eligibility under the plan does not contain the provisions described in this paragraph (b)(3).

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

Example 1. (i) *Facts*. A church organization maintains two church plans for entities affiliated with the church. One plan is a group health plan that provides health coverage to all employees (including ministers and lay workers) of any affiliated church entity that has more than 10 employees. The other plan is Plan *O*, which is a group health plan that is not funded through insurance coverage and that provides health coverage to any employee (including ministers and lay workers) of any affiliated church entity that has 10 or

fewer employees and any self-employed individual affiliated with the church (including a self-employed minister of the church). Plan *O* requires evidence of good health in order for any individual of a church entity that has 10 or fewer employees to be covered and in order for any self-employed individual to be covered. On July 15, 1997 and at all times thereafter before the beginning of the plan year, Plan *O* has contained all the preceding provisions.

(ii) *Conclusion*. In this *Example 1,* because Plan *O* contains the plan provisions described in paragraph (b)(2) of this section and because those provisions were in the plan on July 15, 1997 and at all times thereafter before the beginning of the plan year, Plan *O* will not be treated as failing to meet the requirements of section 9802 or § 54.9802–1 for the plan year solely because the plan requires evidence of good health for coverage of the individuals described in those plan provisions.

Example 2. (i) *Facts*. A church organization maintains Plan *P*, which is a church plan that is not funded through insurance coverage and that is a group health plan providing health coverage to individuals employed by entities affiliated with the church and self-employed individuals affiliated with the church (such as ministers). On July 15, 1997 and at all times thereafter before the beginning of the plan year, Plan *P* has required evidence of good health for coverage of any individual who enrolls after the first 90 days of initial eligibility under the plan.

(ii) *Conclusion*. In this *Example 2,* because Plan P contains the plan provisions described in paragraph (b)(3) of this section and because those provisions were in the plan on July 15, 1997 and at all times thereafter before the beginning of the plan year, Plan *P* will not be treated as failing to meet the requirements of section 9802 or § 54.9802–1 for the plan year solely because the plan requires evidence of good health for coverage of individuals enrolling after the first 90 days of initial eligibility under the plan.

(d) *Applicability date*. This section is applicable to plan years beginning on or after July 1, 2007.

[T.D. 9299, 71 FR 75056, Dec. 13, 2006]

§ 54.9802–3T Additional requirements prohibiting discrimination based on genetic information (temporary).

(a) *Definitions*. Unless otherwise provided, the definitions in this paragraph (a) govern in applying the provisions of this section.

(1) *Collect* means, with respect to information, to request, require, or purchase such information.

(2) *Family member* means, with respect to an individual —

(i) A dependent (as defined for purposes of § 54.9801–2) of the individual; or

(ii) Any other person who is a first-degree, second-degree, third-degree, or fourth-degree relative of the individual or of a dependent of the individual. Relatives by affinity (such as by marriage or adoption) are treated the same as relatives by consanguinity (that is, relatives who share a common biological ancestor). In determining the degree of the relationship, relatives by less than full consanguinity (such as half-siblings, who share only one parent) are treated the same as relatives by full consanguinity (such as siblings who share both parents).

(A) First-degree relatives include parents, spouses, siblings, and children.

(B) Second-degree relatives include grandparents, grandchildren, aunts, uncles, nephews, and nieces.

(C) Third-degree relatives include great-grandparents, great-grandchildren, great aunts, great uncles, and first cousins.

(D) Fourth-degree relatives include great-great grandparents, great-great grandchildren, and children of first cousins.

(3) *Genetic information* means—

(i) Subject to paragraphs (a)(3)(ii) and (a)(3)(iii) of this section, with respect to an individual, information about—

(A) The individual's genetic tests (as defined in paragraph (a)(5) of this section);

(B) The genetic tests of family members of the individual;

(C) The manifestation (as defined in paragraph (a)(6) of this section) of a disease or disorder in family members of the individual; or

(D) Any request for, or receipt of, genetic services (as defined in paragraph (a)(4) of this section), or participation in clinical research which includes genetic services, by the individual or any family member of the individual.

(ii) The term *genetic information* does not include information about the sex or age of any individual.

(iii) The term *genetic information* includes—

(A) With respect to a pregnant woman (or a family member of the

pregnant woman), genetic information of any fetus carried by the pregnant woman; and

(B) With respect to an individual (or a family member of the individual) who is utilizing an assisted reproductive technology, genetic information of any embryo legally held by the individual or family member.

(4) *Genetic services* means—

(i) A genetic test, as defined in paragraph (a)(5) of this section;

(ii) Genetic counseling (including obtaining, interpreting, or assessing genetic information); or

(iii) Genetic education.

(5)(i) *Genetic test* means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, if the analysis detects genotypes, mutations, or chromosomal changes. However, a genetic test does not include an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition. Accordingly, a test to determine whether an individual has a BRCA1 or BRCA2 variant is a genetic test. Similarly, a test to determine whether an individual has a genetic variant associated with hereditary nonpolyposis colorectal cancer is a genetic test. However, an HIV test, complete blood count, cholesterol test, liver function test, or test for the presence of alcohol or drugs is not a genetic test.

(ii) The rules of this paragraph (a)(5) are illustrated by the following example:

Example. (i) *Facts*. Individual A is a newborn covered under a group health plan. A undergoes a phenylketonuria (PKU) screening, which measures the concentration of a metabolite, phenylalanine, in A's blood. In PKU, a mutation occurs in the phenylalanine hydroxylase (PAH) gene which contains instructions for making the enzyme needed to break down the amino acid phenylalanine. Individuals with the mutation, who have a deficiency in the enzyme to break down phenylalanine, have high concentrations of phenylalanine.

(ii) *Conclusion*. In this *Example*, the PKU screening is a genetic test with respect to A because the screening is an analysis of metabolites that detects a genetic mutation.

(6)(i) *Manifestation* or *manifested* means, with respect to a disease, disorder, or pathological condition, that an individual has been or could reasonably be diagnosed with the disease, disorder, or pathological condition by a health care professional with appropriate training and expertise in the field of medicine involved. For purposes of this section, a disease, disorder, or pathological condition is not manifested if a diagnosis is based principally on genetic information.

(ii) The rules of this paragraph (a)(6) are illustrated by the following examples:

Example 1. (i) *Facts*. Individual A has a family medical history of diabetes. A begins to experience excessive sweating, thirst, and fatigue. A's physician examines A and orders blood glucose testing (which is not a genetic test). Based on the physician's examination, A's symptoms, and test results that show elevated levels of blood glucose, A's physician diagnoses A as having adult onset diabetes mellitus (Type 2 diabetes).

(ii) *Conclusion*. In this *Example 1*, A has been diagnosed by a health care professional with appropriate training and expertise in the field of medicine involved. The diagnosis is not based principally on genetic information. Thus, Type 2 diabetes is manifested with respect to A.

Example 2. (i) *Facts*. Individual B has several family members with colon cancer. One of them underwent genetic testing which detected a mutation in the MSH2 gene associated with hereditary nonpolyposis colorectal cancer (HNPCC). B's physician, a health care professional with appropriate training and expertise in the field of medicine involved, recommends that B undergo a targeted genetic test to look for the specific mutation found in B's relative to determine if B has an elevated risk for cancer. The genetic test with respect to B showed that B also carries the mutation and is at increased risk to develop colorectal and other cancers associated with HNPCC. B has a colonoscopy which indicates no signs of disease, and B has no symptoms.

(ii) *Conclusion*. In this *Example 2*, because B has no signs or symptoms of colorectal cancer, B has not been and could not reasonably be diagnosed with HNPCC. Thus, HNPCC is not manifested with respect to B.

Example 3. (i) *Facts*. Same facts as *Example 2*, except that B's colonoscopy and subsequent tests indicate the presence of HNPCC. Based on the colonoscopy and subsequent test results, B's physician makes a diagnosis of HNPCC.

(ii) *Conclusion*. In this *Example 3*, HNPCC is manifested with respect to B because a health care professional with appropriate training and expertise in the field of medicine involved has made a diagnosis that is not based principally on genetic information.

Example 4. (i) *Facts.* Individual C has a family member that has been diagnosed with Huntington's Disease. A genetic test indicates that C has the Huntington's Disease gene variant. At age 42, C begins suffering from occasional moodiness and disorientation, symptoms which are associated with Huntington's Disease. C is examined by a neurologist (a physician with appropriate training and expertise for diagnosing Huntington's Disease). The examination includes a clinical neurological exam. The results of the examination do not support a diagnosis of Huntington's Disease.

(ii) *Conclusion.* In this *Example 4,* C is not and could not reasonably be diagnosed with Huntington's Disease by a health care professional with appropriate training and expertise. Therefore, Huntington's Disease is not manifested with respect to C.

Example 5. (i) *Facts.* Same facts as *Example 4,* except that C exhibits additional neurological and behavioral symptoms, and the results of the examination support a diagnosis of Huntington's Disease with respect to C.

(ii) *Conclusion.* In this *Example 5,* C could reasonably be diagnosed with Huntington's Disease by a health care professional with appropriate training and expertise. Therefore, Huntington's Disease is manifested with respect to C.

(7) *Underwriting purposes* has the meaning given in paragraph (d)(1) of this section.

(b) *No group-based discrimination based on genetic information*—(1) *In general.* For purposes of this section, a group health plan must not adjust premium or contribution amounts for any employer, or any group of similarly situated individuals under the plan, on the basis of genetic information. For this purpose, ''similarly situated individuals'' are those described in § 54.9802–1(d).

(2) *Rule of construction.* Nothing in paragraph (b)(1) of this section (or in paragraph (d)(1) or (d)(2) of this section) limits the ability of a group health plan to increase the premium for an employer or for a group of similarly situated individuals under the plan based on the manifestation of a disease or disorder of an individual who is enrolled in the plan. In such a case, however, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members to further increase the premium for an employer or a group of similarly situated individuals under the plan.

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

Example 1. (i) *Facts.* An employer sponsors a group health plan that provides coverage through a health insurance issuer. In order to determine the premium rate for the upcoming plan year, the issuer reviews the claims experience of individuals covered under the plan and other health status information of the individuals, including genetic information. The issuer finds that three individuals covered under the plan had unusually high claims experience. In addition, the issuer finds that the genetic information of two other individuals indicates the individuals have a higher probability of developing certain illnesses although the illnesses are not manifested at this time. The issuer quotes the plan a higher per-participant rate because of both the genetic information and the higher claims experience.

(ii) *Conclusion.* See *Example 1* in 29 CFR 2590.702–1(b)(3) or 45 CFR 146.122(b)(3) for a conclusion that the issuer violates the provisions of 29 CFR 2590.702–1(b) or 45 CFR 146.122(b) similar to the requirements of this paragraph (b) because the issuer adjusts the premium based on genetic information. However, if the adjustment related solely to claims experience, the adjustment would not violate the requirements of 29 CFR 2590.702–1 or 45 CFR 146.122 similar to the requirements of this section (nor would it violate the requirements of paragraph (c) of 29 CFR 2590.702 or 45 CFR 146.121 similar to the requirements of paragraph (c) of § 54.9802–1, which prohibits discrimination in individual premiums or contributions based on a health factor but permits increases in the group rate based on a health factor).

Example 2. (i) *Facts.* An employer sponsors a group health plan that provides coverage through a health insurance issuer. In order to determine the premium rate for the upcoming plan year, the issuer reviews the claims experience of individuals covered under the plan and other health status information of the individuals, including genetic information. The issuer finds that Employee A has made claims for treatment of polycystic kidney disease. A also has two dependent children covered under the plan. The issuer quotes the plan a higher per-participant rate because of both A's claims experience and the family medical history of A's children (that is, the fact that A has the disease).

(ii) *Conclusion.* See *Example 2* in 29 CFR 2590.702–1(b)(3) or 45 CFR 146.122(b)(3) for a conclusion that the issuer violates the provisions of 29 CFR 2590.702–1(b) or 45 CFR 146.122(b) similar to the requirements of this

paragraph (b) because, by taking the likelihood that A's children may develop polycystic kidney disease into account in computing the rate for the plan, the issuer adjusts the premium based on genetic information relating to a condition that has not been manifested in A's children. However, the issuer does not violate the requirements of 29 CFR 2590.702–1(b) or 45 CFR 146.122(b) similar to the requirements of this paragraph (b) by increasing the premium based on A's claims experience.

(c) *Limitation on requesting or requiring genetic testing*—(1) *General rule*. Except as otherwise provided in this paragraph (c), a group health plan must not request or require an individual or a family member of the individual to undergo a genetic test.

(2) *Health care professional may recommend a genetic test*. Nothing in paragraph (c)(1) of this section limits the authority of a health care professional who is providing health care services to an individual to request that the individual undergo a genetic test.

(3) *Examples*. The rules of paragraphs (c)(1) and (c)(2) of this section are illustrated by the following examples:

Example 1. (i) *Facts*. Individual A goes to a physician for a routine physical examination. The physician reviews A's family medical history and A informs the physician that A's mother has been diagnosed with Huntington's Disease. The physician advises A that Huntington's Disease is hereditary and recommends that A undergo a genetic test.

(ii) *Conclusion*. In this *Example 1*, the physician is a health care professional who is providing health care services to A. Therefore, the physician's recommendation that A undergo the genetic test does not violate this paragraph (c).

Example 2. (i) *Facts*. Individual B is covered by a health maintenance organization (HMO). *B* is a child being treated for leukemia. B's physician, who is employed by the HMO, is considering a treatment plan that includes six-mercaptopurine, a drug for treating leukemia in most children. However, the drug could be fatal if taken by a small percentage of children with a particular gene variant. B's physician recommends that B undergo a genetic test to detect this variant before proceeding with this course of treatment.

(ii) *Conclusion*. In this *Example 2*, even though the physician is employed by the HMO, the physician is nonetheless a health care professional who is providing health care services to B. Therefore, the physician's recommendation that B undergo the genetic test does not violate this paragraph (c).

(4) *Determination regarding payment*—(i) *In general*. As provided in this paragraph (c)(4), nothing in paragraph (c)(1) of this section precludes a plan from obtaining and using the results of a genetic test in making a determination regarding payment. For this purpose, ''payment'' has the meaning given such term in 45 CFR 164.501 of the privacy regulations issued under the Health Insurance Portability and Accountability Act. Thus, if a plan conditions payment for an item or service based on its medical appropriateness and the medical appropriateness of the item or service depends on the genetic makeup of a patient, then the plan is permitted to condition payment for the item or service on the outcome of a genetic test. The plan may also refuse payment if the patient does not undergo the genetic test.

(ii) *Limitation*. A plan is permitted to request only the minimum amount of information necessary to make a determination regarding payment. The minimum amount of information necessary is determined in accordance with the minimum necessary standard in 45 CFR 164.502(b) of the privacy regulations issued under the Health Insurance Portability and Accountability Act.

(iii) *Examples*. *See* paragraph (e) of this section for examples illustrating the rules of this paragraph (c)(4), as well as other provisions of this section.

(5) *Research exception*. Notwithstanding paragraph (c)(1) of this section, a plan may request, but not require, that a participant or beneficiary undergo a genetic test if all of the conditions of this paragraph (c)(5) are met:

(i) *Research in accordance with Federal regulations and applicable State or local law or regulations*. The plan makes the request pursuant to research, as defined in 45 CFR 46.102(d), that complies with 45 CFR Part 46 or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research.

(ii) *Written request for participation in research*. The plan makes the request in writing, and the request clearly indicates to each participant or beneficiary (or, in the case of a minor child, to the legal guardian of the beneficiary) that—

(A) Compliance with the request is voluntary; and

(B) Noncompliance will have no effect on eligibility for benefits (as described in § 54.9802–1(b)(1)) or premium or contribution amounts.

(iii) *Prohibition on underwriting.* No genetic information collected or acquired under this paragraph (c)(5) can be used for underwriting purposes (as described in paragraph (d)(1) of this section).

(iv) *Notice to Federal agencies.* The plan completes a copy of the ''Notice of Research Exception under the Genetic Information Nondiscrimination Act'' authorized by the Secretary and provides the notice to the address specified in the instructions thereto.

(d) *Prohibitions on collection of genetic information*—(1) *For underwriting purposes*—(i) *General rule.* A group health plan must not collect (as defined in paragraph (a)(1) of this section) genetic information for underwriting purposes. *See* paragraph (e) of this section for examples illustrating the rules of this paragraph (d)(1), as well as other provisions of this section.

(ii) *Underwriting purposes defined.* Subject to paragraph (d)(1)(iii) of this section, *underwriting purposes* means, with respect to any group health plan, or health insurance coverage offered in connection with a group health plan—

(A) Rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the plan or coverage as described in § 54.9802–1(b)(1)(ii) (including changes in deductibles or other cost-sharing mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program);

(B) The computation of premium or contribution amounts under the plan or coverage (including discounts, rebates, payments in kind, or other premium differential mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program);

(C) The application of any preexisting condition exclusion under the plan or coverage; and

(D) Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

(iii) *Medical appropriateness.* If an individual seeks a benefit under a group health plan, the plan may limit or exclude the benefit based on whether the benefit is medically appropriate, and the determination of whether the benefit is medically appropriate is not within the meaning of underwriting purposes. Accordingly, if an individual seeks a benefit under the plan and the plan conditions the benefit based on its medical appropriateness and the medical appropriateness of the benefit depends on genetic information of the individual, then the plan is permitted to condition the benefit on the genetic information. A plan is permitted to request only the minimum amount of genetic information necessary to determine medical appropriateness. The plan may deny the benefit if the patient does not provide the genetic information required to determine medical appropriateness. If an individual is not seeking a benefit, the medical appropriateness exception of this paragraph (d)(1)(iii) to the definition of underwriting purposes does not apply. *See* paragraph (e) of this section for examples illustrating the medical appropriateness provisions of this paragraph (d)(1)(iii), as well as other provisions of this section.

(2) *Prior to or in connection with enrollment*—(i) *In general.* A group health plan must not collect genetic information with respect to any individual prior to that individual's effective date of coverage under that plan, nor in connection with the rules for eligibility (as defined in § 54.9802–1(b)(1)(ii)) that apply to that individual. Whether or not an individual's information is collected prior to that individual's effective date of coverage is determined at the time of collection.

(ii) *Incidental collection exception*—(A) *In general.* If a group health plan obtains genetic information incidental to the collection of other information concerning any individual, the collection is not a violation of this paragraph (d)(2), as long as the collection is not for underwriting purposes in violation of paragraph (d)(1) of this section.

(B) *Limitation.* The incidental collection exception of this paragraph

(d)(2)(ii) does not apply in connection with any collection where it is reasonable to anticipate that health information will be received, unless the collection explicitly states that genetic information should not be provided.

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

Example 1. (i) *Facts*. A group health plan provides a premium reduction to enrollees who complete a health risk assessment. The health risk assessment is requested to be completed after enrollment. Whether or not it is completed or what responses are given on it has no effect on an individual's enrollment status, or on the enrollment status of members of the individual's family. The health risk assessment includes questions about the individual's family medical history.

(ii) *Conclusion*. In this *Example 1*, the health risk assessment includes a request for genetic information (that is, the individual's family medical history). Because completing the health risk assessment results in a premium reduction, the request for genetic information is for underwriting purposes. Consequently, the request violates the prohibition on the collection of genetic information in paragraph (d)(1) of this section.

Example 2. (i) *Facts*. The same facts as *Example 1*, except there is no premium reduction or any other reward for completing the health risk assessment.

(ii) *Conclusion*. In this *Example 2*, the request is not for underwriting purposes, nor is it prior to or in connection with enrollment. Therefore, it does not violate the prohibition on the collection of genetic information in this paragraph (d).

Example 3. (i) *Facts*. A group health plan requests that enrollees complete a health risk assessment prior to enrollment, and includes questions about the individual's family medical history. There is no reward or penalty for completing the health risk assessment.

(ii) *Conclusion*. In this *Example 3*, because the health risk assessment includes a request for genetic information (that is, the individual's family medical history), and requests the information prior to enrollment, the request violates the prohibition on the collection of genetic information in paragraph (d)(2) of this section. Moreover, because it is a request for genetic information, it is not an incidental collection under paragraph (d)(2)(ii) of this section.

Example 4. (i) *Facts*. The facts are the same as in *Example 1*, except there is no premium reduction or any other reward given for completion of the health risk assessment. However, certain people completing the health risk assessment may become eligible for additional benefits under the plan by being enrolled in a disease management program based on their answers to questions about family medical history. Other people may become eligible for the disease management program based solely on their answers to questions about their individual medical history.

(ii) *Conclusion*. In this *Example 4*, the request for information about an individual's family medical history could result in the individual being eligible for benefits for which the individual would not otherwise be eligible. Therefore, the questions about family medical history on the health risk assessment are a request for genetic information for underwriting purposes and are prohibited under this paragraph (d). Although the plan conditions eligibility for the disease management program based on determinations of medical appropriateness, the exception for determinations of medical appropriateness does not apply because the individual is not seeking benefits.

Example 5. (i) *Facts*. A group health plan requests enrollees to complete two distinct health risk assessments (HRAs) after and unrelated to enrollment. The first HRA instructs the individual to answer only for the individual and not for the individual's family. The first HRA does not ask about any genetic tests the individual has undergone or any genetic services the individual has received. The plan offers a reward for completing the first HRA. The second HRA asks about family medical history and the results of genetic tests the individual has undergone. The plan offers no reward for completing the second HRA and the instructions make clear that completion of the second HRA is wholly voluntary and will not affect the reward given for completion of the first HRA.

(ii) *Conclusion*. In this *Example 5*, no genetic information is collected in connection with the first HRA, which offers a reward, and no benefits or other rewards are conditioned on the request for genetic information in the second HRA. Consequently, the request for genetic information in the second HRA is not for underwriting purposes, and the two HRAs do not violate the prohibition on the collection of genetic information in this paragraph (d).

Example 6. (i) *Facts*. A group health plan waives its annual deductible for enrollees who complete an HRA. The HRA is requested to be completed after enrollment. Whether or not the HRA is completed or what responses are given on it has no effect on an individual's enrollment status, or on the enrollment status of members of the individual's family. The HRA does not include any direct questions about the individual's genetic information (including family medical history). However, the last question reads, ''Is there anything else relevant to your

health that you would like us to know or discuss with you?''

(ii) *Conclusion*. In this *Example 6*, the plan's request for medical information does not explicitly state that genetic information should not be provided. Therefore, any genetic information collected in response to the question is not within the incidental collection exception and is prohibited under this paragraph (d).

Example 7. (i) *Facts*. Same facts as *Example 6*, except that the last question goes on to state, ''In answering this question, you should not include any genetic information. That is, please do not include any family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which you believe you may be at risk.''

(ii) *Conclusion*. In this *Example 7*, the plan's request for medical information explicitly states that genetic information should not be provided. Therefore, any genetic information collected in response to the question is within the incidental collection exception. However, the plan may not use any genetic information it obtains incidentally for underwriting purposes.

Example 8. (i) *Facts*. Issuer M acquires Issuer N. M requests N's records, stating that N should not provide genetic information and should review the records to excise any genetic information. N assembles the data requested by M and, although N reviews it to delete genetic information, the data from a specific region included some individuals' family medical history. Consequently, M receives genetic information about some of N's covered individuals.

(ii) *Conclusion*. In this *Example 8*, M's request for health information explicitly stated that genetic information should not be provided. *See Example 8* in 29 CFR 2590.702–1(d)(3) or 45 CFR 146.122(d)(3) for a conclusion that the collection of genetic information was within the incidental collection exception of 29 CFR 2590.702–1(d)(2)(ii) or 45 CFR 146.122(d)(ii) similar to the incidental exception of paragraph (d)(2)(ii) of this section. *See Example 8* in 29 CFR 2590.702–1(d)(3) or 45 CFR 146.122(d)(3) also for a caveat that M may not use the genetic information it obtained incidentally for underwriting purposes.

(e) *Examples regarding determinations of medical appropriateness*. The application of the rules of paragraphs (c) and (d) of this section to plan determinations of medical appropriateness is illustrated by the following examples:

Example 1. (i) *Facts*. Individual A's group health plan covers genetic testing for celiac disease for individuals who have family members with this condition. After A's son is diagnosed with celiac disease, A undergoes a genetic test and promptly submits a claim for the test to A's issuer for reimbursement. The issuer asks A to provide the results of the genetic test before the claim is paid.

(ii) *Conclusion*. See *Example 1* in 29 CFR 2590.702–1(e) or 45 CFR 146.122(e) for a conclusion under the rules of paragraph (c)(4) of 29 CFR 2590.702–1 or 45 CFR 146.122 similar to the rules of paragraph (c)(4) of this section that the issuer is permitted to request only the minimum amount of information necessary to make a decision regarding payment. Because the results of the test are not necessary for the issuer to make a decision regarding the payment of A's claim, the conclusion in *Example 1* in 29 CFR 2590.702–1(e) or 45 CFR 146.122(e) concludes that the issuer's request for the results of the genetic test violates paragraph (c) of 29 CFR 2590.702–1 or 45 CFR 146.122 similar to paragraph (c) of this section.

Example 2. (i) *Facts*. Individual B's group health plan covers a yearly mammogram for participants and beneficiaries starting at age 40, or at age 30 for those with increased risk for breast cancer, including individuals with BRCA1 or BRCA2 gene mutations. B is 33 years old and has the BRCA2 mutation. B undergoes a mammogram and promptly submits a claim to B's plan for reimbursement. Following an established policy, the plan asks B for evidence of increased risk of breast cancer, such as the results of a genetic test or a family history of breast cancer, before the claim for the mammogram is paid. This policy is applied uniformly to all similarly situated individuals and is not directed at individuals based on any genetic information.

(ii) *Conclusion*. In this *Example 2*, the plan does not violate paragraphs (c) or (d) of this section. Under paragraph (c), the plan is permitted to request and use the results of a genetic test to make a determination regarding payment, provided the plan requests only the minimum amount of information necessary. Because the medical appropriateness of the mammogram depends on the genetic makeup of the patient, the minimum amount of information necessary includes the results of the genetic test. Similarly, the plan does not violate paragraph (d) of this section because the plan is permitted to request genetic information in making a determination regarding the medical appropriateness of a claim if the genetic information is necessary to make the determination (and if the genetic information is not used for underwriting purposes).

Example 3. (i) *Facts*. Individual C was previously diagnosed with and treated for breast cancer, which is currently in remission. In accordance with the recommendation of C's physician, C has been taking a regular dose of tamoxifen to help prevent a recurrence. C's group health plan adopts a new policy requiring patients taking tamoxifen to undergo a genetic test to ensure that tamoxifen is

medically appropriate for their genetic makeup. In accordance with, at the time, the latest scientific research, tamoxifen is not helpful in up to 7 percent of breast cancer patients, those with certain variations of the gene for making the CYP_2D6 enzyme. If a patient has a gene variant making tamoxifen not medically appropriate, the plan does not pay for the tamoxifen prescription.

(ii) *Conclusion*. In this *Example 3*, the plan does not violate paragraph (c) of this section if it conditions future payments for the tamoxifen prescription on C's undergoing a genetic test to determine what genetic markers C has for making the CYP_2D6 enzyme. Nor does the plan violate paragraph (c) of this section if the plan refuses future payment if the results of the genetic test indicate that tamoxifen is not medically appropriate for C.

Example 4. (i) *Facts*. A group health plan offers a diabetes disease management program to all similarly situated individuals for whom it is medically appropriate based on whether the individuals have or are at risk for diabetes. The program provides enhanced benefits related only to diabetes for individuals who qualify for the program. The plan sends out a notice to all participants that describes the diabetes disease management program and explains the terms for eligibility. Individuals interested in enrolling in the program are advised to contact the plan to demonstrate that they have diabetes or that they are at risk for diabetes. For individuals who do not currently have diabetes, genetic information may be used to demonstrate that an individual is at risk.

(ii) *Conclusion*. In this *Example 4*, the plan may condition benefits under the disease management program upon a showing by an individual that the individual is at risk for diabetes, even if such showing may involve genetic information, provided that the plan requests genetic information only when necessary to make a determination regarding whether the disease management program is medically appropriate for the individual and only requests the minimum amount of information necessary to make that determination.

Example 5. (i) *Facts*. Same facts as *Example 4*, except that the plan includes a questionnaire that asks about the occurrence of diabetes in members of the individual's family as part of the notice describing the disease management program.

(ii) *Conclusion*. In this *Example 5*, the plan violates the requirements of paragraph (d)(1) of this section because the requests for genetic information are not limited to those situations in which it is necessary to make a determination regarding whether the disease management program is medically appropriate for the individuals.

Example 6. (i) *Facts*. Same facts as *Example 4*, except the disease management program provides an enhanced benefit in the form of a lower annual deductible to individuals under the program; the lower deductible applies with respect to all medical expenses incurred by the individual. Thus, whether or not a claim relates to diabetes, the individual is provided with a lower deductible based on the individual providing the plan with genetic information.

(ii) *Conclusion*. In this *Example 6*, because the enhanced benefits include benefits not related to the determination of medical appropriateness, making available the enhanced benefits is within the meaning of underwriting purposes. Accordingly, the plan may not request or require genetic information (including family history information) in determining eligibility for enhanced benefits under the program because such a request would be for underwriting purposes and would violate paragraph (d)(1) of this section.

(f) *Effective/applicability date*. This section applies for plan years beginning on or after December 7, 2009.

(g) *Expiration date*. This section expires on or before October 1, 2012.

[T.D. 9464, 74 FR 51678, Oct. 7, 2009]

§ 54.9802–4 Special Rule Allowing Integration of Health Reimbursement Arrangements (HRAs) and Other Account-Based Group Health Plans with Individual Health Insurance Coverage and Medicare and Prohibiting Discrimination In HRAs and Other Account-Based Group Health Plans.

(a) *Scope*. This section applies to health reimbursement arrangements (HRAs) and other account-based group health plans, as defined in § 54.9815–2711(d)(6)(i) of this chapter. For ease of reference, the term ''HRA'' is used in this section to include other account-based group health plans. For related regulations, see 26 CFR 1.36B–2(c)(3)(i) and (c)(5), 29 CFR 2510.3–1(l), and 45 CFR 155.420.

(b) *Purpose*. This section provides the conditions that an HRA must satisfy in order to be integrated with individual health insurance coverage for purposes of Public Health Service Act (PHS Act) sections 2711 and 2713 and § 54.9815–2711(d)(4) of this chapter (referred to as an individual coverage HRA). This section also allows an individual coverage HRA to be integrated with Medicare for purposes of PHS Act sections 2711 and 2713 and § 54.9815–2711(d)(4), subject

to the conditions provided in this section (see paragraph (e) of this section). Some of the conditions set forth in this section specifically relate to compliance with PHS Act sections 2711 and 2713 and some relate to the effect of having or being offered an individual coverage HRA on eligibility for the premium tax credit under section 36B. In addition, this section provides conditions that an individual coverage HRA must satisfy in order to comply with the nondiscrimination provisions in section 9802 and PHS Act section 2705 (which is incorporated in section 9815) and that are consistent with the provisions of the Patient Protection and Affordable Care Act, Public Law 111–148 (124 Stat. 119 (2010)), and the Health Care and Education Reconciliation Act of 2010, Public Law 111–152 (124 Stat. 1029 (2010)), each as amended, that are designed to create a competitive individual market. These conditions are intended to prevent an HRA plan sponsor from intentionally or unintentionally, directly or indirectly, steering any participants or dependents with adverse health factors away from its traditional group health plan, if any, and toward individual health insurance coverage.

(c) *General rule.* An HRA will be considered to be integrated with individual health insurance coverage for purposes of PHS Act sections 2711 and 2713 and § 54.9815–2711(d)(4) of this chapter and will not be considered to discriminate in violation of section 9802 and PHS Act section 2705 solely because it is integrated with individual health insurance coverage, provided that the conditions of this paragraph (c) are satisfied. See paragraph (e) of this section for how these conditions apply to an individual coverage HRA integrated with Medicare. For purposes of this section, medical care expenses means medical care expenses as defined in § 54.9815–2711(d)(6)(ii) of this chapter and Exchange means Exchange as defined in 45 CFR 155.20.

(1) *Enrollment in individual health insurance coverage*—(i) *In general.* The HRA must require that the participant and any dependent(s) are enrolled in individual health insurance coverage that is subject to and complies with the requirements in PHS Act section 2711 (and § 54.9815–2711(a)(2) of this chapter) and PHS Act section 2713 (and § 54.9815–2713(a)(1) of this chapter), for each month that the individual(s) are covered by the HRA. For purposes of this paragraph (c), all individual health insurance coverage, except for individual health insurance coverage that consists solely of excepted benefits, is treated as being subject to and complying with PHS Act sections 2711 and 2713. References to individual health insurance coverage in this paragraph (c) do not include individual health insurance coverage that consists solely of excepted benefits.

(ii) *Forfeiture.* The HRA must provide that if any individual covered by the HRA ceases to be covered by individual health insurance coverage, the HRA will not reimburse medical care expenses that are incurred by that individual after the individual health insurance coverage ceases. In addition, if the participant and all dependents covered by the participant's HRA cease to be covered by individual health insurance coverage, the participant must forfeit the HRA. In either case, the HRA must reimburse medical care expenses incurred by the individual prior to the cessation of individual health insurance coverage to the extent the medical care expenses are otherwise covered by the HRA, but the HRA may limit the period to submit medical care expenses for reimbursement to a reasonable specified time period. If a participant or dependent loses coverage under the HRA for a reason other than cessation of individual health insurance coverage, COBRA and other continuation coverage requirements may apply.

(iii) *Grace periods and retroactive termination of individual health insurance coverage.* In the event an individual is initially enrolled in individual health insurance coverage and subsequently timely fails to pay premiums for the coverage, with the result that the individual is in a grace period, the individual is considered to be enrolled in individual health insurance coverage for purposes of this paragraph (c)(1) and the individual coverage HRA must reimburse medical care expenses incurred by the individual during that time period to the extent the medical

care expenses are otherwise covered by the HRA. If the individual fails to pay the applicable premium(s) by the end of the grace period and the coverage is cancelled or terminated, including retroactively, or if the individual health insurance coverage is cancelled or terminated retroactively for some other reason (for example, a rescission), an individual coverage HRA must require that a participant notify the HRA that coverage has been cancelled or terminated and the date on which the cancellation or termination is effective. After the individual coverage HRA has received the notice of cancellation or termination, the HRA may not reimburse medical care expenses incurred on and after the date the individual health insurance coverage was cancelled or terminated, which is considered to be the date of termination of coverage under the HRA.

(2) *No traditional group health plan may be offered to same participants.* To the extent a plan sponsor offers any class of employees (as defined in paragraph (d) of this section) an individual coverage HRA, the plan sponsor may not also offer a traditional group health plan to the same class of employees, except as provided in paragraph (d)(5) of this section. For purposes of this section, a traditional group health plan is any group health plan other than either an account-based group health plan or a group health plan that consists solely of excepted benefits. Therefore, a plan sponsor may not offer a choice between an individual coverage HRA or a traditional group health plan to any participant or dependent.

(3) *Same terms requirement*—(i) *In general.* If a plan sponsor offers an individual coverage HRA to a class of employees described in paragraph (d) of this section, the HRA must be offered on the same terms to all participants within the class, except as provided in paragraphs (c)(3)(ii) through (vi) and (d)(5) of this section.

(ii) *Carryover amounts, salary reduction arrangements, and transfer amounts.* Amounts that are not used to reimburse medical care expenses for any plan year that are made available to participants in later plan years are disregarded for purposes of determining whether an HRA is offered on the same terms, provided that the method for determining whether participants have access to unused amounts in future years, and the methodology and formula for determining the amounts of unused funds which they may access in future years, is the same for all participants in a class of employees. In addition, the ability to pay the portion of the premium for individual health insurance coverage that is not covered by the HRA, if any, by using a salary reduction arrangement under section 125 is considered to be a term of the HRA for purposes of this paragraph (c)(3). Therefore, an HRA is not provided on the same terms unless the salary reduction arrangement, if made available to any participant in a class of employees, is made available on the same terms to all participants (other than former employees, as defined in paragraph (c)(3)(iv) of this section) in the class of employees. Further, to the extent that a participant in an individual coverage HRA was previously covered by another HRA and the current individual coverage HRA makes available amounts that were not used to reimburse medical care expenses under the prior HRA (transferred amounts), the transferred amounts are disregarded for purposes of determining whether the HRA is offered on the same terms, provided that if the HRA makes available transferred amounts, it does so on the same terms for all participants in the class of employees.

(iii) *Permitted variation.* An HRA does not fail to be provided on the same terms solely because the maximum dollar amount made available to participants in a class of employees to reimburse medical care expenses for any plan year increases in accordance with paragraph (c)(3)(iii)(A) or (B) of this section.

(A) *Variation due to number of dependents.* An HRA does not fail to be provided on the same terms to participants in a class of employees solely because the maximum dollar amount made available to those participants to reimburse medical care expenses for any plan year increases as the number of the participant's dependents who are covered under the HRA increases, so

long as the same maximum dollar amount attributable to the increase in family size is made available to all participants in that class of employees with the same number of dependents covered by the HRA.

(B) *Variation due to age.* An HRA does not fail to be provided on the same terms to participants in a class of employees solely because the maximum dollar amount made available under the terms of the HRA to those participants to reimburse medical care expenses for any plan year increases as the age of the participant increases, so long as the requirements in paragraphs (c)(3)(iii)(B)(*1*) and (*2*) of this section are satisfied. For the purpose of this paragraph (c)(3)(iii)(B), the plan sponsor may determine the age of the participant using any reasonable method for a plan year, so long as the plan sponsor determines each participant's age for the purpose of this paragraph (c)(3)(iii)(B) using the same method for all participants in the class of employees for the plan year and the method is determined prior to the plan year.

(*1*) The same maximum dollar amount attributable to the increase in age is made available to all participants who are the same age.

(*2*) The maximum dollar amount made available to the oldest participant(s) is not more than three times the maximum dollar amount made available to the youngest participant(s).

(iv) *Former employees.* An HRA does not fail to be treated as provided on the same terms if the plan sponsor offers the HRA to some, but not all, former employees within a class of employees. However, if a plan sponsor offers the HRA to one or more former employees within a class of employees, the HRA must be offered to the former employee(s) on the same terms as to all other employees within the class, except as provided in paragraph (c)(3)(ii) of this section. For purposes of this section, a former employee is an employee who is no longer performing services for the employer.

(v) *New employees or new dependents.* For a participant whose coverage under the HRA becomes effective later than the first day of the plan year, the HRA does not fail to be treated as being provided on the same terms to the participant if the maximum dollar amount made available to the participant either is the same as the maximum dollar amount made available to participants in the participant's class of employees whose coverage became effective as of the first day of the plan year, or is pro-rated consistent with the portion of the plan year in which the participant is covered by the HRA. Similarly, if the HRA provides for variation in the maximum amount made available to participants in a class of employees based on the number of a participant's dependents covered by the HRA, and the number of a participant's dependents covered by the HRA changes during a plan year (either increasing or decreasing), the HRA does not fail to be treated as being provided on the same terms to the participant if the maximum dollar amount made available to the participant either is the same as the maximum dollar amount made available to participants in the participant's class of employees who had the same number of dependents covered by the HRA on the first day of the plan year or is pro-rated for the remainder of the plan year after the change in the number of the participant's dependents covered by the HRA consistent with the portion of the plan year in which that number of dependents are covered by the HRA. The method the HRA uses to determine amounts made available for participants whose coverage under the HRA is effective later than the first day of the plan year or who have changes in the number of dependents covered by the HRA during a plan year must be the same for all participants in the class of employees and the method must be determined prior to the beginning of the plan year.

(vi) *HSA-compatible HRAs.* An HRA does not fail to be treated as provided on the same terms if the plan sponsor offers participants in a class of employees a choice between an HSA-compatible individual coverage HRA and an individual coverage HRA that is not HSA compatible, provided both types of HRAs are offered to all participants in the class of employees on the same

terms. For the purpose of this paragraph (c)(3)(vi), an HSA-compatible individual coverage HRA is an individual coverage HRA that is limited in accordance with applicable guidance under section 223 such that an individual covered by such an HRA is not disqualified from being an eligible individual under section 223.

(vii) *Examples*. The following examples illustrate the provisions of this paragraph (c)(3), without taking into account the provisions of paragraph (d) of this section. In each example, the HRA is an individual coverage HRA that has a calendar year plan year and may reimburse any medical care expenses, including premiums for individual health insurance coverage (except as provided in paragraph (c)(3)(vii)(E) of this section (*Example 5*)). Further, in each example, assume the HRA is offered on the same terms, except as otherwise specified in the example and that no participants or dependents are Medicare beneficiaries.

(A) *Example 1: Carryover amounts permitted—(1) Facts*. For 2020 and again for 2021, Plan Sponsor A offers all employees $7,000 each in an HRA, and the HRA provides that amounts that are unused at the end of a plan year may be carried over to the next plan year, with no restrictions on the use of the carryover amounts compared to the use of newly available amounts. At the end of 2020, some employees have used all of the funds in their HRAs, while other employees have balances remaining that range from $500 to $1,750 that are carried over to 2021 for those employees.

(*2*) *Conclusion*. The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(A) (*Example 1*) for 2020 because Plan Sponsor A offers all employees the same amount, $7,000, in an HRA for that year. The same terms requirement is also satisfied for 2021 because Plan Sponsor A again offers all employees the same amount for that year, and the carryover amounts that some employees have are disregarded in applying the same terms requirement because the amount of the carryover for each employee (that employee's balance) and each employee's access to the carryover amounts is based on the same terms.

(B) *Example 2: Employees hired after the first day of the plan year—(1) Facts*. For 2020, Plan Sponsor B offers all employees employed on January 1, 2020, $7,000 each in an HRA for the plan year. Employees hired after January 1, 2020, are eligible to enroll in the HRA with an effective date of the first day of the month following their date of hire, as long as they have enrolled in individual health insurance coverage effective on or before that date, and the amount offered to these employees is pro-rated based on the number of months remaining in the plan year, including the month which includes their coverage effective date.

(*2*) *Conclusion*. The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(B) (*Example 2*) for 2020 because Plan Sponsor B offers all employees employed on the first day of the plan year the same amount, $7,000, in an HRA for that plan year and all employees hired after January 1, 2020, a pro-rata amount based on the portion of the plan year during which they are enrolled in the HRA.

(C) *Example 3: HRA amounts offered vary based on number of dependents—(1) Facts*. For 2020, Plan Sponsor C offers its employees the following amounts in an HRA: $1,500, if the employee is the only individual covered by the HRA; $3,500, if the employee and one dependent are covered by the HRA; and $5,000, if the employee and more than one dependent are covered by the HRA.

(*2*) *Conclusion*. The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(C) (*Example 3*) because paragraph (c)(3)(iii)(A) of this section allows the maximum dollar amount made available in an HRA to increase as the number of the participant's dependents covered by the HRA increases and Plan Sponsor C makes the same amount available to each employee with the same number of dependents covered by the HRA.

(D) *Example 4: HRA amounts offered vary based on increases in employees' ages—(1) Facts*. For 2020, Plan Sponsor D offers its employees the following

amounts in an HRA: $1,000 each for employees age 25 to 35; $2,000 each for employees age 36 to 45; $2,500 each for employees age 46 to 55; and $4,000 each for employees over age 55.

(*2*) *Conclusion*. The same terms requirement of this paragraph (c)(3) is not satisfied in this paragraph (c)(3)(vii)(D) (*Example 4*) because the terms of the HRA provide the oldest participants (those over age 55) with more than three times the amount made available to the youngest participants (those ages 25 to 35), in violation of paragraph (c)(3)(iii)(B)(*2*) of this section.

(E) *Example 5: Application of same terms requirement to premium only HRA*—(*1*) *Facts*. For 2020, Plan Sponsor E offers its employees an HRA that reimburses only premiums for individual health insurance coverage, up to $10,000 for the year. Employee A enrolls in individual health insurance coverage with a $5,000 premium for the year and is reimbursed $5,000 from the HRA. Employee B enrolls in individual health insurance coverage with an $8,000 premium for the year and is reimbursed $8,000 from the HRA.

(*2*) *Conclusion*. The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(E) (*Example 5*) because Plan Sponsor E offers the HRA on the same terms to all employees, notwithstanding that some employees receive a greater amount of reimbursement than others based on the cost of the individual health insurance coverage selected by the employee.

(4) *Opt out*. Under the terms of the HRA, a participant who is otherwise eligible for coverage must be permitted to opt out of and waive future reimbursements on behalf of the participant and all dependents eligible for the HRA from the HRA once, and only once, with respect to each plan year. The HRA may establish timeframes for enrollment in (and opting out of) the HRA but, in general, the opportunity to opt out must be provided in advance of the first day of the plan year. For participants who become eligible to participate in the HRA on a date other than the first day of the plan year (or who become eligible fewer than 90 days prior to the plan year or for whom the notice under paragraph (c)(6) of this section is required to be provided as set forth in paragraph (c)(6)(i)(C) of this section), or for a dependent who newly becomes eligible during the plan year, this opportunity must be provided during the applicable HRA enrollment period(s) established by the HRA for these individuals. Further, under the terms of the HRA, upon termination of employment, for a participant who is covered by the HRA, either the remaining amounts in the HRA must be forfeited or the participant must be permitted to permanently opt out of and waive future reimbursements from the HRA on behalf of the participant and all dependents covered by the HRA.

(5) *Reasonable procedures for coverage substantiation*—(i) *Substantiation of individual health insurance coverage for the plan year*. The HRA must implement, and comply with, reasonable procedures to substantiate that participants and each dependent covered by the HRA are, or will be, enrolled in individual health insurance coverage for the plan year (or for the portion of the plan year the individual is covered by the HRA, if applicable). The HRA may establish the date by which this substantiation must be provided, but, in general, the date may be no later than the first day of the plan year. However, for a participant who is not eligible to participate in the HRA on the first day of the plan year (or who becomes eligible fewer than 90 days prior to the plan year or for whom the notice under paragraph (c)(6) of this section is required to be provided as set forth in paragraph (c)(6)(i)(C) of this section), the HRA may establish the date by which this substantiation must be provided, but that date may be no later than the date the HRA coverage begins. Similarly, for a participant who adds a new dependent during the plan year, the HRA may establish the date by which this substantiation must be provided, but the date may be no later than the date the HRA coverage for the new dependent begins; however, to the extent the dependent's coverage under the HRA is effective retroactively, the HRA may establish a reasonable time by which this substantiation is required, but must require it be provided before the HRA will reimburse any

medical care expense for the newly added dependent. The reasonable procedures an HRA may use to implement the substantiation requirement set forth in this paragraph (c)(5)(i) may include a requirement that a participant substantiate enrollment by providing either:

(A) A document from a third party (for example, the issuer or an Exchange) showing that the participant and any dependents covered by the HRA are, or will be, enrolled in individual health insurance coverage (for example, an insurance card or an explanation of benefits document pertaining to the relevant time period or documentation from the Exchange showing that the individual has completed the application and plan selection); or

(B) An attestation by the participant stating that the participant and dependent(s) covered by the HRA are, or will be, enrolled in individual health insurance coverage, the date coverage began or will begin, and the name of the provider of the coverage.

(ii) *Coverage substantiation with each request for reimbursement of medical care expenses.* Following the initial substantiation of coverage, with each new request for reimbursement of an incurred medical care expense for the same plan year, the HRA may not reimburse a participant for any medical care expenses unless, prior to each reimbursement, the participant substantiates that the individual on whose behalf medical care expenses are requested to be reimbursed continues to be enrolled in individual health insurance coverage for the month during which the medical care expenses were incurred. The HRA must implement, and comply with, reasonable procedures to satisfy this requirement. This substantiation may be in the form of a written attestation by the participant, which may be part of the form used to request reimbursement, or a document from a third party (for example, a health insurance issuer) showing that the participant or the dependent, if applicable, are or were enrolled in individual health insurance coverage for the applicable month.

(iii) *Reliance on substantiation.* For purposes of this paragraph (c)(5), an HRA may rely on the participant's documentation or attestation unless the HRA, its plan sponsor, or any other entity acting in an official capacity on behalf of the HRA has actual knowledge that any individual covered by the HRA is not, or will not be, enrolled in individual health insurance coverage for the plan year (or applicable portion of the plan year) or the month, as applicable.

(6) *Notice requirement*—(i) *Timing.* The HRA must provide a written notice to each participant:

(A) At least 90 calendar days before the beginning of each plan year for any participant who is not described in either paragraph (c)(6)(i)(B) or (C) of this section;

(B) No later than the date on which the HRA may first take effect for the participant, for any participant who is not eligible to participate at the beginning of the plan year (or is not eligible to participate at the time the notice is provided at least 90 calendar days before the beginning of the plan year pursuant to paragraph (c)(6)(i)(A) of this section); or

(C) No later than the date on which the HRA may first take effect for the participant, for any participant who is employed by an employer that is first established less than 120 days before the beginning of the first plan year of the HRA; this paragraph (c)(6)(i)(C) applies only with respect to the first plan year of the HRA.

(ii) *Content.* The notice must include all the information described in this paragraph (c)(6)(ii) (and may include any additional information that does not conflict with that information). To the extent that the Departments of the Treasury, Labor and Health and Human Services provide model notice language for certain elements of this required notice, HRAs are permitted, but not required, to use the model language.

(A) A description of the terms of the HRA, including the maximum dollar amount available for each participant (including the self-only HRA amount available for the plan year (or the maximum dollar amount available for the plan year if the HRA provides for reimbursements up to a single dollar amount regardless of whether a participant has self-only or other than self-

only coverage)), any rules regarding the proration of the maximum dollar amount applicable to any participant (or dependent, if applicable) who is not eligible to participate in the HRA for the entire plan year, whether (and which of) the participant's dependents are eligible for the HRA, a statement that there are different kinds of HRAs (including a qualified small employer health reimbursement arrangement) and the HRA being offered is an individual coverage HRA, a statement that the HRA requires the participant and any covered dependents to be enrolled in individual health insurance coverage (or Medicare Part A and B or Medicare Part C, if applicable), a statement that the coverage in which the participant and any covered dependents must be enrolled cannot be short-term, limited-duration insurance or consist solely of excepted benefits, if the HRA is subject to the Employee Retirement Income Security Act (ERISA), a statement that individual health insurance coverage in which the participant and any covered dependents are enrolled is not subject to ERISA, if the conditions under 29 CFR 2510.3–1(l) are satisfied, the date as of which coverage under the HRA may first become effective (both for participants whose coverage will become effective on the first day of the plan year and for participants whose HRA coverage may become effective at a later date), the dates on which the HRA plan year begins and ends, and the dates on which the amounts newly made available under the HRA will be made available.

(B) A statement of the right of the participant to opt out of and waive future reimbursements from the HRA, as set forth under paragraph (c)(4) of this section.

(C) A description of the potential availability of the premium tax credit if the participant opts out of and waives future reimbursements from the HRA and the HRA is not affordable for one or more months under §1.36B–2(c)(5) of this chapter, a statement that even if the participant opts out of and waives future reimbursements from an HRA, the offer will prohibit the participant (and, potentially, the participant's dependents) from receiving a premium tax credit for the participant's coverage (or the dependent's coverage, if applicable) on an Exchange for any month that the HRA is affordable under §1.36B–2(c)(5) of this chapter, a statement describing how the participant may find assistance with determining affordability, a statement that, if the participant is a former employee, the offer of the HRA does not render the participant (or the participant's dependents, if applicable) ineligible for the premium tax credit regardless of whether it is affordable under §1.36B–2(c)(5) of this chapter, and a statement that if the participant or dependent is enrolled in Medicare, he or she is ineligible for the premium tax credit without regard to the offer or acceptance of the HRA;

(D) A statement that if the participant accepts the HRA, the participant may not claim a premium tax credit for the participant's Exchange coverage for any month the HRA may be used to reimburse medical care expenses of the participant, and a premium tax credit may not be claimed for the Exchange coverage of the participant's dependents for any month the HRA may be used to reimburse medical care expenses of the dependents.

(E) A statement that the participant must inform any Exchange to which the participant applies for advance payments of the premium tax credit of the availability of the HRA; the self-only HRA amount available for the HRA plan year (or the maximum dollar amount available for the plan year if the HRA provides for reimbursements up to a single dollar amount regardless of whether a participant has self-only or other than self-only coverage) as set forth in the written notice in accordance with paragraph (c)(6)(ii)(A) of this section; whether the HRA is also available to the participant's dependents and if so, which ones; the date as of which coverage under the HRA may first become effective; the date on which the plan year begins and the date on which it ends; and whether the participant is a current employee or former employee.

(F) A statement that the participant should retain the written notice because it may be needed to determine whether the participant is allowed a

premium tax credit on the participant's individual income tax return.

(G) A statement that the HRA may not reimburse any medical care expense unless the substantiation requirement set forth in paragraph (c)(5)(ii) of this section is satisfied and a statement that the participant must also provide the substantiation required by paragraph (c)(5)(i) of this section.

(H) A statement that if the individual health insurance coverage (or coverage under Medicare Part A and B or Medicare Part C) of a participant or dependent ceases, the HRA will not reimburse any medical care expenses that are incurred by the participant or dependent, as applicable, after the coverage ceases, and a statement that the participant must inform the HRA if the participant's or dependent's individual health insurance coverage (or coverage under Medicare Part A and B or Medicare Part C) is cancelled or terminated retroactively and the date on which the cancellation or termination is effective.

(I) The contact information (including a phone number) for an individual or a group of individuals who participants may contact in order to receive additional information regarding the HRA. The plan sponsor may determine which individual or group of individuals is best suited to be the specified contact.

(J) A statement of availability of a special enrollment period to enroll in or change individual health insurance coverage, through or outside of an Exchange, for the participant and any dependents who newly gain access to the HRA and are not already covered by the HRA.

(d) *Classes of employees*—(1) *In general.* This paragraph (d) sets forth the rules for determining classes of employees. Paragraph (d)(2) of this section sets forth the specific classes of employees; paragraph (d)(3) of this section sets forth a minimum class size requirement that applies in certain circumstances; paragraph (d)(4) of this section sets forth rules regarding the definition of ''full-time employees,'' ''part-time employees,'' and ''seasonal employees''; paragraph (d)(5) of this section sets forth a special rule for new hires; and paragraph (d)(6) of this section addresses student premium reduction arrangements. For purposes of this section, including determining classes under this paragraph (d), the employer is the common law employer and is determined without regard to the rules under sections 414(b), (c), (m), and (o) that would treat the common law employer as a single employer with certain other entities.

(2) *List of classes.* Participants may be treated as belonging to a class of employees based on whether they are, or are not, included in the classes described in this paragraph (d)(2). If the individual coverage HRA is offered to former employees, former employees are considered to be in the same class in which they were included immediately before separation from service. Before each plan year, a plan sponsor must determine for the plan year which classes of employees it intends to treat separately and the definition of the relevant class(es) it will apply, to the extent these regulations permit a choice. After the classes and the definitions of the classes are established for a plan year, a plan sponsor may not make changes to the classes of employees or the definitions of those relevant classes with respect to that plan year.

(i) Full-time employees, defined at the election of the plan sponsor to mean either full-time employees under section 4980H (and § 54.4980H–1(a)(21) of this chapter) or employees who are not part-time employees (as described in § 1.105–11(c)(2)(iii)(C) of this chapter);

(ii) Part-time employees, defined at the election of the plan sponsor to mean either employees who are not full-time employees under section 4980H (and under § 54.4980H–1(a)(21) of this chapter (which defines full-time employee)) or employees who are part-time employees as described in § 1.105–11(c)(2)(iii)(C) of this chapter;

(iii) Employees who are paid on a salary basis;

(iv) Non-salaried employees (such as, for example, hourly employees);

(v) Employees whose primary site of employment is in the same rating area as defined in 45 CFR 147.102(b);

(vi) Seasonal employees, defined at the election of the plan sponsor to mean seasonal employees as described

in either § 54.4980H–1(a)(38) or § 1.105–11(c)(2)(iii)(C) of this chapter;

(vii) Employees included in a unit of employees covered by a particular collective bargaining agreement (or an appropriate related participation agreement) in which the plan sponsor participates (as described in § 1.105–11(c)(2)(iii)(D) of this chapter);

(viii) Employees who have not satisfied a waiting period for coverage (if the waiting period complies with § 54.9815–2708 of this chapter);

(ix) Non-resident aliens with no U.S.-based income (as described in § 1.105–11(c)(2)(iii)(E) of this chapter);

(x) Employees who, under all the facts and circumstances, are employees of an entity that hired the employees for temporary placement at an entity that is not the common law employer of the employees and that is not treated as a single employer with the entity that hired the employees for temporary placement under section 414(b), (c), (m), or (o); or

(xi) A group of participants described as a combination of two or more of the classes of employees set forth in paragraphs (d)(2)(i) through (x) of this section.

(3) *Minimum class size requirement*—(i) *In general.* If a class of employees is subject to the minimum class size requirement as set forth in this paragraph (d)(3), the class must consist of at least a minimum number of employees (as described in paragraphs (d)(3)(iii) and (iv) of this section), otherwise, the plan sponsor may not treat that class as a separate class of employees. Paragraph (d)(3)(ii) of this section sets forth the circumstances in which the minimum class size requirement applies to a class of employees, paragraph (d)(3)(iii) of this section sets forth the rules for determining the applicable class size minimum, and paragraph (d)(3)(iv) of this section sets forth the rules for a plan sponsor to determine if it satisfies the minimum class size requirement with respect to a class of employees.

(ii) *Circumstances in which minimum class size requirement applies*—(A) The minimum class size requirement applies only if a plan sponsor offers a traditional group health plan to one or more classes of employees and offers an individual coverage HRA to one or more other classes of employees.

(B) The minimum class size requirement does not apply to a class of employees offered a traditional group health plan or a class of employees offered no coverage.

(C) The minimum class size requirement applies to a class of employees offered an individual coverage HRA if the class is full-time employees, part-time employees, salaried employees, non-salaried employees, or employees whose primary site of employment is in the same rating area (described in paragraph (d)(2)(i), (ii), (iii), (iv), or (v) of this section, respectively, and referred to collectively as the applicable classes or individually as an applicable class), except that:

(*1*) In the case of the class of employees whose primary site of employment is in the same rating area (as described in paragraph (d)(2)(v) of this section), the minimum class size requirement does not apply if the geographic area defining the class is a State or a combination of two or more entire States; and

(*2*) In the case of the classes of employees that are full-time employees and part-time employees (as described in paragraphs (d)(2)(i) and (ii) of this section, respectively), the minimum class size requirement applies only to those classes (and the classes are only applicable classes) if the employees in one such class are offered a traditional group health plan while the employees in the other such class are offered an individual coverage HRA. In such a case, the minimum class size requirement applies only to the class offered an individual coverage HRA.

(D) A class of employees offered an individual coverage HRA is also subject to the minimum class size requirement if the class is a class of employees created by combining at least one of the applicable classes (as defined in paragraph (d)(3)(ii)(C) of this section) with any other class, except that the minimum class size requirement shall not apply to a class that is the result of a combination of one of the applicable classes and a class of employees who have not satisfied a waiting period (as described in paragraph (d)(2)(viii) of this section).

(iii) *Determination of the applicable class size minimum*—(A) *In general.* The minimum number of employees that must be in a class of employees that is subject to the minimum class size requirement (the applicable class size minimum) is determined prior to the beginning of the plan year for each plan year of the individual coverage HRA and is:

(*1*) 10, for an employer with fewer than 100 employees;

(*2*) A number, rounded down to a whole number, equal to 10 percent of the total number of employees, for an employer with 100 to 200 employees; and

(*3*) 20, for an employer with more than 200 employees.

(B) *Determining employer size.* For purposes of this paragraph (d)(3), the number of employees of an employer is determined in advance of the plan year of the HRA based on the number of employees that the employer reasonably expects to employ on the first day of the plan year.

(iv) *Determining if a class satisfies the applicable class size minimum.* For purposes of this paragraph (d)(3), whether a class of employees satisfies the applicable class size minimum for a plan year of the individual coverage HRA is based on the number of employees in the class offered the individual coverage HRA as of the first day of the plan year. Therefore, this determination is not based on the number of employees that actually enroll in the individual coverage HRA, and this determination is not affected by changes in the number of employees in the class during the plan year.

(4) *Consistency requirement.* For any plan year, a plan sponsor may define ''full-time employee,'' ''part-time employee,'' and ''seasonal employee'' in accordance with the relevant provisions of sections 105(h) or 4980H, as set forth in paragraphs (d)(2)(i), (ii), and (vi) of this section, if:

(i) To the extent applicable under the HRA for the plan year, each of the three classes of employees are defined in accordance with section 105(h) or each of the three classes of employees are defined in accordance with section 4980H for the plan year; and

(ii) The HRA plan document sets forth the applicable definitions prior to the beginning of the plan year to which the definitions will apply.

(5) *Special rule for new hires*—(i) *In general.* Notwithstanding paragraphs (c)(2) and (3) of this section, a plan sponsor that offers a traditional group health plan to a class of employees may prospectively offer the employees in that class of employees who are hired on or after a certain future date (the new hire date) an individual coverage HRA (with this group of employees referred to as the new hire subclass), while continuing to offer employees in that class of employees who are hired before the new hire date a traditional group health plan (with the rule set forth in this sentence referred to as the special rule for new hires). For the new hire subclass, the individual coverage HRA must be offered on the same terms to all participants within the subclass, in accordance with paragraph (c)(3) of this section. In accordance with paragraph (c)(2) of this section, a plan sponsor may not offer a choice between an individual coverage HRA or a traditional group health plan to any employee in the new hire subclass or to any employee in the class who is not a member of the new hire subclass.

(ii) *New hire date.* A plan sponsor may set the new hire date for a class of employees prospectively as any date on or after January 1, 2020. A plan sponsor may set different new hire dates prospectively for separate classes of employees.

(iii) *Discontinuation of use of special rule for new hires and multiple applications of the special rule for new hires.* A plan sponsor may discontinue use of the special rule for new hires at any time for any class of employees. In that case, the new hire subclass is no longer treated as a separate subclass of employees. In the event a plan sponsor applies the special rule for new hires to a class of employees and later discontinues use of the rule to the class of employees, the plan sponsor may later apply the rule if the application of the rule would be permitted under the

rules for initial application of the special rule for new hires. If a plan sponsor, in accordance with the requirements for the special rule for new hires, applies the rule to a class of employees subsequent to any prior application and discontinuance of the rule to that class, the new hire date must be prospective.

(iv) *Application of the minimum class size requirement under the special rule for new hires.* The minimum class size requirement set forth in paragraph (d)(3) of this section does not apply to the new hire subclass. However, if a plan sponsor subdivides the new hire subclass subsequent to creating the new hire subclass, the minimum class size requirement set forth in paragraph (d)(3) of this section applies to any class of employees created by subdividing the new hire subclass, if the minimum class size requirement otherwise applies.

(6) *Student employees offered student premium reduction arrangements.* For purposes of this section, if an institution of higher education (as defined in the Higher Education Act of 1965) offers a student employee a student premium reduction arrangement, the employee is not considered to be part of the class of employees to which the employee would otherwise belong. For the purpose of this paragraph (d)(6) and paragraph (f)(1) of this section, a student premium reduction arrangement is defined as any program offered by an institution of higher education under which the cost of insured or self-insured student health coverage is reduced for certain students through a credit, offset, reimbursement, stipend or similar arrangement. A student employee offered a student premium reduction arrangement is also not counted for purposes of determining the applicable class size minimum under paragraph (d)(3)(iii) of this section. If a student employee is not offered a student premium reduction arrangement (including if the student employee is offered an individual coverage HRA instead), the student employee is considered to be part of the class of employees to which the employee otherwise belongs and is counted for purposes of determining the applicable class size minimum under paragraph (d)(3)(iii) of this section.

(e) *Integration of Individual Coverage HRAs with Medicare*—(1) *General rule.* An individual coverage HRA will be considered to be integrated with Medicare (and deemed to comply with PHS Act sections 2711 and 2713 and § 54.9815–2711(d)(4) of this chapter), provided that the conditions of paragraph (c) of this section are satisfied, subject to paragraph (e)(2) of this section. Nothing in this section requires that a participant and his or her dependents all have the same type of coverage; therefore, an individual coverage HRA may be integrated with Medicare for some individuals and with individual health insurance coverage for others, including, for example, a participant enrolled in Medicare Part A and B or Part C and his or her dependents enrolled in individual health insurance coverage.

(2) *Application of conditions in paragraph (c) of this section*—(i) *In general.* Except as provided in paragraph (e)(2)(ii) of this section, in applying the conditions of paragraph (c) of this section with respect to integration with Medicare, a reference to ''individual health insurance coverage'' is deemed to refer to coverage under Medicare Part A and B or Part C. References in this section to integration of an HRA with Medicare refer to integration of an individual coverage HRA with Medicare Part A and B or Part C.

(ii) *Exceptions.* For purposes of the statement regarding ERISA under the notice content element under paragraph (c)(6)(ii)(A) of this section and the statement regarding the availability of a special enrollment period under the notice content element under paragraph (c)(6)(ii)(J) of this section, the term individual health insurance coverage means only individual health insurance coverage and does not also mean coverage under Medicare Part A and B or Part C.

(f) *Examples*—(1) *Examples regarding classes and the minimum class size requirement.* The following examples illustrate the provisions of paragraph (c)(3) of this section, taking into account the provisions of paragraphs (d)(1) through (4) and (d)(6) of this section. In each example, the HRA is an

individual coverage HRA that may reimburse any medical care expenses, including premiums for individual health insurance coverage and it is assumed that no participants or dependents are Medicare beneficiaries.

(i) *Example 1: Collectively bargained employees offered traditional group health plan; non-collectively bargained employees offered HRA*—(A) *Facts*. For 2020, Plan Sponsor A offers its employees covered by a collective bargaining agreement a traditional group health plan (as required by the collective bargaining agreement) and all other employees (non-collectively bargained employees) each an HRA on the same terms.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(i) (*Example 1*) because collectively bargained and non-collectively bargained employees may be treated as different classes of employees, one of which may be offered a traditional group health plan and the other of which may be offered an individual coverage HRA, and Plan Sponsor A offers the HRA on the same terms to all participants who are non-collectively bargained employees. The minimum class size requirement does not apply to this paragraph (f)(1)(i) (*Example 1*) even though Plan Sponsor A offers one class a traditional group health plan and one class the HRA because collectively bargained and non-collectively bargained employees are not applicable classes that are subject to the minimum class size requirement.

(ii) *Example 2: Collectively bargained employees in one unit offered traditional group health plan and in another unit offered HRA*—(A) *Facts*. For 2020, Plan Sponsor B offers its employees covered by a collective bargaining agreement with Local 100 a traditional group health plan (as required by the collective bargaining agreement), and its employees covered by a collective bargaining agreement with Local 200 each an HRA on the same terms (as required by the collective bargaining agreement).

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(ii) (*Example 2*) because the employees covered by the collective bargaining agreements with the two separate bargaining units (Local 100 and Local 200) may be treated as two different classes of employees and Plan Sponsor B offers an HRA on the same terms to the participants covered by the agreement with Local 200. The minimum class size requirement does not apply to this paragraph (f)(1)(ii) (*Example 2*) even though Plan Sponsor B offers the Local 100 employees a traditional group health plan and the Local 200 employees an HRA because collectively bargained employees are not applicable classes that are subject to the minimum class size requirement.

(iii) *Example 3: Employees in a waiting period offered no coverage; other employees offered an HRA*—(A) *Facts*. For 2020, Plan Sponsor C offers its employees who have completed a waiting period that complies with the requirements for waiting periods in § 54.9815–2708 of this chapter each an HRA on the same terms and does not offer coverage to its employees who have not completed the waiting period.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(iii) (*Example 3*) because employees who have completed a waiting period and employees who have not completed a waiting period may be treated as different classes and Plan Sponsor C offers the HRA on the same terms to all participants who have completed the waiting period. The minimum class size requirement does not apply to this paragraph (f)(1)(iii) (*Example 3*) because Plan Sponsor C does not offer at least one class of employees a traditional group health plan and because the class of employees who have not completed a waiting period and the class of employees who have completed a waiting period are not applicable classes that are subject to the minimum class size requirement.

(iv) *Example 4: Employees in a waiting period offered an HRA; other employees offered a traditional group health plan*—(A) *Facts*. For 2020, Plan Sponsor D offers its employees who have completed a waiting period that complies with the requirements for waiting periods in

§ 54.9815–2708 of this chapter a traditional group health plan and offers its employees who have not completed the waiting period each an HRA on the same terms.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(iv) (*Example 4*) because employees who have completed a waiting period and employees who have not completed a waiting period may be treated as different classes and Plan Sponsor D offers an HRA on the same terms to all participants who have not completed the waiting period. The minimum class size requirement does not apply to this paragraph (f)(1)(iv) (*Example 4*) even though Plan Sponsor D offers employees who have completed a waiting period a traditional group health plan and employees who have not completed a waiting period an HRA because the class of employees who have not completed a waiting period is not an applicable class that is subject to the minimum class size requirement (nor is the class made up of employees who have completed the waiting period).

(v) *Example 5: Staffing firm employees temporarily placed with customers offered an HRA; other employees offered a traditional group health plan*—(A) *Facts*. Plan Sponsor E is a staffing firm that places certain of its employees on temporary assignments with customers that are not the common law employers of Plan Sponsor E's employees or treated as a single employer with Plan Sponsor E under section 414(b), (c), (m), or (o) (unrelated entities); other employees work in Plan Sponsor E's office managing the staffing business (non-temporary employees). For 2020, Plan Sponsor E offers its employees who are on temporary assignments with customers each an HRA on the same terms. All other employees are offered a traditional group health plan.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(v) (*Example 5*) because the employees who are hired for temporary placement at an unrelated entity and non-temporary employees of Plan Sponsor E may be treated as different classes of employees and Plan Sponsor E offers an HRA on the same terms to all participants temporarily placed with customers. The minimum class size requirement does not apply to this paragraph (f)(1)(v) (*Example 5*) even though Plan Sponsor E offers one class a traditional group health plan and one class the HRA because the class of employees hired for temporary placement is not an applicable class that is subject to the minimum class size requirement (nor is the class made up of non-temporary employees).

(vi) *Example 6: Staffing firm employees temporarily placed with customers in rating area 1 offered an HRA; other employees offered a traditional group health plan*—(A) *Facts*. The facts are the same as in paragraph (f)(1)(v) of this section (*Example 5*), except that Plan Sponsor E has work sites in rating area 1 and rating area 2, and it offers its 10 employees on temporary assignments with a work site in rating area 1 an HRA on the same terms. Plan Sponsor E has 200 other employees in rating areas 1 and 2, including its non-temporary employees in rating areas 1 and 2 and its employees on temporary assignments with a work site in rating area 2, all of whom are offered a traditional group health plan.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(vi) (*Example 6*) because, even though the employees who are temporarily placed with customers generally may be treated as employees of a different class, because Plan Sponsor E is also using a rating area to identify the class offered the HRA (which is an applicable class for the minimum class size requirement) and is offering one class the HRA and another class the traditional group health plan, the minimum class size requirement applies to the class offered the HRA, and the class offered the HRA fails to satisfy the minimum class size requirement. Because Plan Sponsor E employs 210 employees, the applicable class size minimum is 20, and the HRA is offered to only 10 employees.

(vii) *Example 7: Employees in State 1 offered traditional group health plan; employees in State 2 offered HRA*—(A) *Facts*. Plan Sponsor F employs 45 employees whose work site is in State 1 and 7 employees whose primary site of

employment is in State 2. For 2020, Plan Sponsor F offers its 45 employees in State 1 a traditional group health plan, and each of its 7 employees in State 2 an HRA on the same terms.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(vii) (*Example 7*) because Plan Sponsor F offers the HRA on the same terms to all employees with a work site in State 2 and that class is a permissible class under paragraph (d) of this section. This is because employees whose work sites are in different rating areas may be considered different classes and a plan sponsor may create a class of employees by combining classes of employees, including by combining employees whose work site is in one rating area with employees whose work site is in a different rating area, or by combining all employees whose work site is in a state. The minimum class size requirement does not apply to this paragraph (f)(1)(vii) (*Example 7*) because the minimum class size requirement does not apply if the geographic area defining a class of employees is a state or a combination of two or more entire states.

(viii) *Example 8: Full-time seasonal employees offered HRA; all other full-time employees offered traditional group health plan; part-time employees offered no coverage*—(A) *Facts*. Plan Sponsor G employs 6 full-time seasonal employees, 75 full-time employees who are not seasonal employees, and 5 part-time employees. For 2020, Plan Sponsor G offers each of its 6 full-time seasonal employees an HRA on the same terms, its 75 full-time employees who are not seasonal employees a traditional group health plan, and offers no coverage to its 5 part-time employees.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(viii) (*Example 8*) because full-time seasonal employees and full-time employees who are not seasonal employees may be considered different classes and Plan Sponsor G offers the HRA on the same terms to all full-time seasonal employees. The minimum class size requirement does not apply to the class offered the HRA in this paragraph (f)(1)(viii) (*Example 8)* because part-time employees are not offered coverage and full-time employees are not an applicable class subject to the minimum class size requirement if part-time employees are not offered coverage.

(ix) *Example 9: Full-time employees in rating area 1 offered traditional group health plan; full-time employees in rating area 2 offered HRA; part-time employees offered no coverage*—(A) *Facts*. Plan Sponsor H employs 17 full-time employees and 10 part-time employees whose work site is in rating area 1 and 552 full-time employees whose work site is in rating area 2. For 2020, Plan Sponsor H offers its 17 full-time employees in rating area 1 a traditional group health plan and each of its 552 full-time employees in rating area 2 an HRA on the same terms. Plan Sponsor H offers no coverage to its 10 part-time employees in rating area 1. Plan Sponsor H reasonably expects to employ 569 employees on the first day of the HRA plan year.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(ix) (*Example 9*) because employees whose work sites are in different rating areas may be considered different classes and Plan Sponsor H offers the HRA on the same terms to all full-time employees in rating area 2. The minimum class size requirement applies to the class offered the HRA in this paragraph (f)(1)(ix) (*Example 9*) because the minimum class size requirement applies to a class based on a geographic area unless the geographic area is a state or a combination of two or more entire states. However, the minimum class size requirement applies only to the class offered the HRA, and Plan Sponsor H offers the HRA to the 552 full-time employees in rating area 2 on the first day of the plan year, satisfying the minimum class size requirement (because the applicable class size minimum for Plan Sponsor H is 20).

(x) *Example 10: Employees in rating area 1 offered HRA; employees in rating area 2 offered traditional group health plan*—(A) *Facts*. The facts are the same as in paragraph (f)(1)(ix) of this section (*Example 9*) except that Plan Sponsor H offers its 17 full-time employees in rating area 1 the HRA and offers its 552

full-time employees in rating area 2 the traditional group health plan.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(x) (*Example 10*) because, even though employees whose work sites are in different rating areas generally may be considered different classes and Plan Sponsor H offers the HRA on the same terms to all participants in rating area 1, the HRA fails to satisfy the minimum class size requirement. Specifically, the minimum class size requirement applies to this paragraph (f)(1)(x) (*Example 10*) because the minimum class size requirement applies to a class based on a geographic area unless the geographic area is a state or a combination of two or more entire states. Further, the applicable class size minimum for Plan Sponsor H is 20 employees, and the HRA is only offered to the 17 full-time employees in rating area 1 on the first day of the HRA plan year.

(xi) *Example 11: Employees in State 1 and rating area 1 of State 2 offered HRA; employees in all other rating areas of State 2 offered traditional group healthplan*—(A) *Facts*. For 2020, Plan Sponsor I offers an HRA on the same terms to a total of 200 employees it employs with work sites in State 1 and in rating area 1 of State 2. Plan Sponsor I offers a traditional group health plan to its 150 employees with work sites in other rating areas in State 2. Plan Sponsor I reasonably expects to employ 350 employees on the first day of the HRA plan year.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xi) (*Example 11*). Plan Sponsor I may treat all of the employees with a work site in State 1 and rating area 1 of State 2 as a class of employees because employees whose work sites are in different rating areas may be considered different classes and a plan sponsor may create a class of employees by combining classes of employees, including by combining employees whose work site is in one rating area with a class of employees whose work site is in a different rating area. The minimum class size requirement applies to the class of employees offered the HRA (made up of employees in State 1 and in rating area 1 of State 2) because the minimum class size requirement applies to a class based on a geographic area unless the geographic area is a state or a combination of two or more entire states. In this case, the class is made up of a state plus a rating area which is not the entire state. However, this class satisfies the minimum class size requirement because the applicable class size minimum for Plan Sponsor I is 20, and Plan Sponsor I offered the HRA to 200 employees on the first day of the plan year.

(xii) *Example 12: Salaried employees offered a traditional group health plan; hourly employees offered an HRA*—(A) *Facts*. Plan Sponsor J has 163 salaried employees and 14 hourly employees. For 2020, Plan Sponsor J offers its 163 salaried employees a traditional group health plan and each of its 14 hourly employees an HRA on the same terms. Plan Sponsor J reasonably expects to employ 177 employees on the first day of the HRA plan year.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(xii) (*Example 12*) because, even though salaried and hourly employees generally may be considered different classes and Plan Sponsor J offers the HRA on the same terms to all hourly employees, the HRA fails to satisfy the minimum class size requirement. Specifically, the minimum class size requirement applies in this paragraph (f)(1)(xii) (*Example 12*) because employees who are paid on a salaried basis and employees who are not paid on a salaried basis are applicable classes subject to the minimum class size requirement. Because Plan Sponsor J reasonably expects to employ between 100 and 200 employees on the first day of the plan year, the applicable class size minimum is 10 percent, rounded down to a whole number. Ten percent of 177 total employees, rounded down to a whole number is 17, and the HRA is offered to only 14 hourly employees.

(xiii) *Example 13: Part-time employees and full-time employees offered different HRAs; no traditional group health plan offered*—(A) *Facts*. Plan Sponsor K has 50 full-time employees and 7 part-time

employees. For 2020, Plan Sponsor K offers its 50 full-time employees $2,000 each in an HRA otherwise provided on the same terms and each of its 7 part-time employees $500 in an HRA otherwise provided on the same terms. Plan Sponsor K reasonably expects to employ 57 employees on the first day of the HRA plan year.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xiii) (*Example 13*) because full-time employees and part-time employees may be treated as different classes and Plan Sponsor K offers an HRA on the same terms to all the participants in each class. The minimum class size requirement does not apply to either the full-time class or the part-time class because (although in certain circumstances the minimum class size requirement applies to a class of full-time employees and a class of part-time employees) Plan Sponsor K does not offer any class of employees a traditional group health plan, and the minimum class size requirement applies only when, among other things, at least one class of employees is offered a traditional group health plan while another class is offered an HRA.

(xiv) *Example 14: No employees offered an HRA*—(A) *Facts*. The facts are the same facts as in paragraph (f)(1)(xiii) of this section (*Example 13*), except that Plan Sponsor K offers its full-time employees a traditional group health plan and does not offer any group health plan (either a traditional group health plan or an HRA) to its part-time employees.

(B) *Conclusion*. The regulations set forth under this section do not apply to Plan Sponsor K because Plan Sponsor K does not offer an individual coverage HRA to any employee.

(xv) *Example 15: Full-time employees offered traditional group health plan; part-time employees offered HRA*—(A) *Facts*. The facts are the same as in paragraph (f)(1)(xiii) of this section (*Example 13*), except that Plan Sponsor K offers its full-time employees a traditional group health plan and offers each of its part-time employees $500 in an HRA and otherwise on the same terms.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(xv) (*Example 15*) because, even though the full-time employees and the part-time employees generally may be treated as different classes, in this paragraph (f)(1)(xv) (*Example 15*), the minimum class size requirement applies to the part-time employees, and it is not satisfied. Specifically, the minimum class size requirement applies to the part-time employees because that requirement applies to an applicable class offered an HRA when one class is offered a traditional group health plan while another class is offered an HRA, and to the part-time and full-time employee classes when one of those classes is offered a traditional group health plan while the other is offered an HRA. Because Plan Sponsor K reasonably expects to employ fewer than 100 employees on the first day of the HRA plan year, the applicable class size minimum for Plan Sponsor K is 10 employees, but Plan Sponsor K offered the HRA only to its 7 part-time employees.

(xvi) *Example 16: Satisfying minimum class size requirement based on employees offered HRA*—(A) *Facts*. Plan Sponsor L employs 78 full-time employees and 12 part-time employees. For 2020, Plan Sponsor L offers its 78 full-time employees a traditional group health plan and each of its 12 part-times employees an HRA on the same terms. Only 6 part-time employees enroll in the HRA. Plan Sponsor L reasonably expects to employ fewer than 100 employees on the first day of the HRA plan year.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xvi) (*Example 16*) because full-time employees and part-time employees may be treated as different classes, Plan Sponsor L offers an HRA on the same terms to all the participants in the part-time class, and the minimum class size requirement is satisfied. Specifically, whether a class of employees satisfies the applicable class size minimum is determined as of the first day of the plan year based on the number of employees in a class that is offered an HRA, not on the number of employees who enroll in the HRA. The applicable class size minimum for Plan Sponsor L

is 10 employees, and Plan Sponsor L offered the HRA to its 12 part-time employees.

(xvii) *Example 17: Student employees offered student premium reduction arrangements and same terms requirement*—(A) *Facts*. Plan Sponsor M is an institution of higher education that offers each of its part-time employees an HRA on the same terms, except that it offers its part-time employees who are student employees a student premium reduction arrangement, and the student premium reduction arrangement provides different amounts to different part-time student employees.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xvii) (*Example 17*) because Plan Sponsor M offers the HRA on the same terms to its part-time employees who are not students and because the part-time student employees offered a student premium reduction arrangement (and their varying HRAs) are not taken into account as part-time employees for purposes of determining whether a class of employees is offered an HRA on the same terms.

(xiii) *Example 18: Student employees offered student premium reduction arrangements and minimum class size requirement*—(A) *Facts*. Plan Sponsor N is an institution of higher education with 25 hourly employees. Plan Sponsor N offers 15 of its hourly employees, who are student employees, a student premium reduction arrangement and it wants to offer its other 10 hourly employees an HRA for 2022. Plan Sponsor N offers its salaried employees a traditional group health plan. Plan Sponsor N reasonably expects to have 250 employees on the first day of the 2022 HRA plan year, 15 of which will have offers of student premium reduction arrangements.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(xviii) (*Example 18*). The minimum class size requirement will apply to the class of hourly employees to which Plan Sponsor N wants to offer the HRA because Plan Sponsor N offers a class of employees a traditional group health plan and another class the HRA, and the minimum class size requirement generally applies to a class of hourly employees offered an HRA. Plan Sponsor N's applicable class size minimum is 20 because Plan Sponsor N reasonably expects to employ 235 employees on the first day of the plan year (250 employees minus 15 employees receiving a student premium reduction arrangement). Plan Sponsor N may not offer the HRA to its hourly employees because the 10 employees offered the HRA as of the first day of the plan year does not satisfy the applicable class size minimum.

(2) *Examples regarding special rule for new hires*. The following examples illustrate the provisions of paragraph (c)(3) of this section, taking into account the provisions of paragraph (d) of this section, in particular the special rule for new hires under paragraph (d)(5) of this section. In each example, the HRA is an individual coverage HRA that has a calendar year plan year and may reimburse any medical care expenses, including premiums for individual health insurance coverage. The examples also assume that no participants or dependents are Medicare beneficiaries.

(i) *Example 1: Application of special rule for new hires to all employees*—(A) *Facts*. For 2021, Plan Sponsor A offers all employees a traditional group health plan. For 2022, Plan Sponsor A offers all employees hired on or after January 1, 2022, an HRA on the same terms and continues to offer the traditional group health plan to employees hired before that date. On the first day of the 2022 plan year, Plan Sponsor A has 2 new hires who are offered the HRA.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(i) (*Example 1*) because, under the special rule for new hires in paragraph (d)(5) of this section, the employees newly hired on and after January 1, 2022, may be treated as a new hire subclass, Plan Sponsor A offers the HRA on the same terms to all participants in the new hire subclass, and the minimum class size requirement does not apply to the new hire subclass.

(ii) *Example 2: Application of special rule for new hires to full-time employees*—(A) *Facts*. For 2021, Plan Sponsor B offers a traditional group health plan to its full-time employees and does not

offer any coverage to its part-time employees. For 2022, Plan Sponsor B offers full-time employees hired on or after January 1, 2022, an HRA on the same terms, continues to offer its full-time employees hired before that date a traditional group health plan, and continues to offer no coverage to its part-time employees. On the first day of the 2022 plan year, Plan Sponsor B has 2 new hire, full-time employees who are offered the HRA.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(ii) (*Example 2*) because, under the special rule for new hires in paragraph (d)(5) of this section, the full-time employees newly hired on and after January 1, 2022, may be treated as a new hire subclass and Plan Sponsor B offers the HRA on the same terms to all participants in the new hire subclass. The minimum class size requirement does not apply to the new hire subclass.

(iii) *Example 3: Special rule for new hires impermissibly applied retroactively*—(A) *Facts*. For 2025, Plan Sponsor C offers a traditional group health plan to its full-time employees. For 2026, Plan Sponsor C wants to offer an HRA to its full-time employees hired on and after January 1, 2023, while continuing to offer a traditional group health plan to its full-time employees hired before January 1, 2023.

(B) *Conclusion*. The special rule for new hires under paragraph (d)(5) of this section does not apply in this paragraph (f)(2)(iii) (*Example 3*) because the rule must be applied prospectively. That is, Plan Sponsor C may not, in 2026, choose to apply the special rule for new hires retroactive to 2023. If Plan Sponsor C were to offer an HRA in this way, it would fail to satisfy the conditions under paragraphs (c)(2) and (3) of this section because the new hire subclass would not be treated as a subclass for purposes of applying those rules and, therefore, all full-time employees would be treated as one class to which either a traditional group health plan or an HRA could be offered, but not both.

(iv) *Example 4: Permissible second application of the special rule for new hires to the same class of employees*—(A) *Facts*. For 2021, Plan Sponsor D offers all of its full-time employees a traditional group health plan. For 2022, Plan Sponsor D applies the special rule for new hires and offers an HRA on the same terms to all employees hired on and after January 1, 2022, and continues to offer a traditional group health plan to full-time employees hired before that date. For 2025, Plan Sponsor D discontinues use of the special rule for new hires, and again offers all full-time employees a traditional group health plan. In 2030, Plan Sponsor D decides to apply the special rule for new hires to the full-time employee class again, offering an HRA to all full-time employees hired on and after January 1, 2030, on the same terms, while continuing to offer employees hired before that date a traditional group health plan.

(B) *Conclusion*. Plan Sponsor D has permissibly applied the special rule for new hires and is in compliance with the requirements of paragraphs (c)(2) and (3) of this section.

(v) *Example 5: Impermissible second application of the special rule for new hires to the same class of employees*—(A) *Facts*. The facts are the same as in paragraph (f)(2)(iv) of this section (*Example 4*), except that for 2025, Plan Sponsor D discontinues use of the special rule for new hires by offering all full-time employees an HRA on the same terms. Further, for 2030, Plan Sponsor D wants to continue to offer an HRA on the same terms to all full-time employees hired before January 1, 2030, and to offer all full-time employees hired on or after January 1, 2030, an HRA in a different amount.

(B) *Conclusion*. Plan Sponsor D may not apply the special rule for new hires for 2030 to the class of full-time employees being offered an HRA because the special rule for new hires may only be applied to a class that is being offered a traditional group health plan.

(vi) *Example 6: New full-time employees offered different HRAs in different rating areas*—(A) *Facts*. Plan Sponsor E has work sites in rating area 1, rating area 2, and rating area 3. For 2021, Plan Sponsor E offers its full-time employees a traditional group health plan. For 2022, Plan Sponsor E offers its full-time employees hired on or after January 1, 2022, in rating area 1 an HRA of $3,000, its full-time employees hired on or

after January 1, 2022, in rating area 2 an HRA of $5,000, and its full-time employees hired on or after January 1, 2022, in rating area 3 an HRA of $7,000. Within each class offered an HRA, Plan Sponsor E offers the HRA on the same terms. Plan Sponsor E offers its full-time employees hired prior to January 1, 2022, in each of those classes a traditional group health plan. On the first day of the 2022 plan year, there is one new hire, full-time employee in rating area 1, three new hire, full-time employees in rating area 2, and 10 new hire-full-time employees in rating area 3.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(vi) (*Example 6*) because, under the special rule for new hires in paragraph (d)(5) of this section, the full-time employees in each of the three rating areas newly hired on and after January 1, 2022, may be treated as three new hire subclasses and Plan Sponsor E offers the HRA on the same terms to all participants in the new hire subclasses. Further, the minimum class size requirement does not apply to the new hire subclasses.

(vii) *Example 7: New full-time employee class subdivided based on rating area*—(A) *Facts*. Plan Sponsor F offers its full-time employees hired on or after January 1, 2022, an HRA on the same terms and it continues to offer its full-time employees hired before that date a traditional group health plan. Plan Sponsor F offers no coverage to its part-time employees. For the 2025 plan year, Plan Sponsor F wants to subdivide the full-time new hire subclass so that those whose work site is in rating area 1 will be offered the traditional group health plan and those whose work site is in rating area 2 will continue to receive the HRA. Plan Sponsor F reasonably expects to employ 219 employees on January 1, 2025. As of January 1, 2025, Plan Sponsor F has 15 full-time employees whose work site in in rating area 2 and who were hired between January 1, 2022, and January 1, 2025.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(2)(vii) (*Example 7*) because the new hire subclass has been subdivided in a manner that is subject to the minimum class size requirement, and the class offered the HRA fails to satisfy the minimum class size requirement. Specifically, once the new hire subclass is subdivided the general rules for applying the minimum class size requirement apply to the employees offered the HRA in the new hire subclass. In this case, because the subdivision of the new hire full-time subclass is based on rating areas; a class based on rating areas is an applicable class subject to the minimum class size requirement; and the employees in one rating area are to be offered the HRA, while the employees in the other rating area are offered the traditional group health plan, the minimum class size requirement would apply on and after the date of the subdivision. Further, the minimum class size requirement would not be satisfied, because the applicable class size minimum for Plan Sponsor F would be 20, and only 15 employees in rating area 2 would be offered the HRA.

(viii) *Example 8: New full-time employee class subdivided based on state*—(A) *Facts*. The facts are the same as in paragraph (f)(2)(vii) of this section (*Example 7*), except that for the 2025 plan year, Plan Sponsor F intends to subdivide the new hire, full-time class so that those in State 1 will be offered the traditional group health plan and those in State 2 will each be offered an HRA on the same terms.

(B) *Conclusion*. The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(viii) (*Example 8*) because even though the new hire subclass has been subdivided, it has been subdivided in a manner that is not subject to the minimum class size requirement as the subdivision is based on the entire state.

(ix) *Example 9: New full-time employees and part-time employees offered HRA*—(A) *Facts*. In 2021, Plan Sponsor G offers its full-time employees a traditional group health plan and does not offer coverage to its part-time employees. For the 2022 plan year, Plan Sponsor G offers its full-time employees hired on or after January 1, 2022, and all of its part-time employees, including those hired before January 1, 2022, and those hired on and after January 1, 2022, an

HRA on the same terms, and it continues to offer its full-time employees hired before January 1, 2022, a traditional group health plan.

(B) *Conclusion*. The minimum class size requirement applies to the part-time employees offered the HRA in 2022 because the class is being offered an HRA; the special rule for new hires does not apply (because this class was not previously offered a traditional group health plan) and so it is not a new hire subclass exempt from the minimum class size requirement; another class of employees (that is, full-time hired before January 1, 2022) are being offered a traditional group health plan; and the part-time employee class is generally an applicable classes that is subject to the minimum class size requirement. However, because the full-time, new hire subclass is based on the special rule for new hires, the minimum class size requirement does not apply to full-time new hires offered an HRA in 2022.

(g) *Applicability date*. This section applies to plan years beginning on or after January 1, 2020.

[T.D. 9867, 84 FR 28987, June 20, 2019]

§ 54.9811–1 Standards relating to benefits for mothers and newborns.

(a) *Hospital length of stay*—(1) *General rule*. Except as provided in paragraph (a)(5) of this section, a group health plan that provides benefits for a hospital length of stay in connection with childbirth for a mother or her newborn may not restrict benefits for the stay to less than—

(i) 48 hours following a vaginal delivery; or

(ii) 96 hours following a delivery by cesarean section.

(2) *When stay begins*—(i) *Delivery in a hospital*. If delivery occurs in a hospital, the hospital length of stay for the mother or newborn child begins at the time of delivery (or in the case of multiple births, at the time of the last delivery).

(ii) *Delivery outside a hospital*. If delivery occurs outside a hospital, the hospital length of stay begins at the time the mother or newborn is admitted as a hospital inpatient in connection with childbirth. The determination of whether an admission is in connection with childbirth is a medical decision to be made by the attending provider.

(3) *Examples*. The rules of paragraphs (a)(1) and (2) of this section are illustrated by the following examples. In each example, the group health plan provides benefits for hospital lengths of stay in connection with childbirth and is subject to the requirements of this section, as follows:

Example 1. (i) *Facts*. A pregnant woman covered under a group health plan goes into labor and is admitted to the hospital at 10 p.m. on June 11. She gives birth by vaginal delivery at 6 a.m. on June 12.

(ii) *Conclusion*. In this *Example 1*, the 48-hour period described in paragraph (a)(1)(i) of this section ends at 6 a.m. on June 14.

Example 2. (i) *Facts*. A woman covered under a group health plan gives birth at home by vaginal delivery. After the delivery, the woman begins bleeding excessively in connection with the childbirth and is admitted to the hospital for treatment of the excessive bleeding at 7 p.m. on October 1.

(ii) *Conclusion*. In this *Example 2*, the 48-hour period described in paragraph (a)(1)(i) of this section ends at 7 p.m. on October 3.

Example 3. (i) *Facts*. A woman covered under a group health plan gives birth by vaginal delivery at home. The child later develops pneumonia and is admitted to the hospital. The attending provider determines that the admission is not in connection with childbirth.

(ii) *Conclusion*. In this *Example 3*, the hospital length-of-stay requirements of this section do not apply to the child's admission to the hospital because the admission is not in connection with childbirth.

(4) *Authorization not required*—(i) *In general*. A plan may not require that a physician or other health care provider obtain authorization from the plan, or from a health insurance issuer offering health insurance coverage under the plan, for prescribing the hospital length of stay specified in paragraph (a)(1) of this section. (See also paragraphs (b)(2) and (c)(3) of this section for rules and examples regarding other authorization and certain notice requirements.)

(ii) *Example*. The rule of this paragraph (a)(4) is illustrated by the following example:

Example. (i) *Facts*. In the case of a delivery by cesarean section, a group health plan subject to the requirements of this section automatically provides benefits for any hospital length of stay of up to 72 hours. For any longer stay, the plan requires an attending

provider to complete a certificate of medical necessity. The plan then makes a determination, based on the certificate of medical necessity, whether a longer stay is medically necessary.

(ii) *Conclusion.* In this *Example,* the requirement that an attending provider complete a certificate of medical necessity to obtain authorization for the period between 72 hours and 96 hours following a delivery by cesarean section is prohibited by this paragraph (a)(4).

(5) *Exceptions*—(i) *Discharge of mother.* If a decision to discharge a mother earlier than the period specified in paragraph (a)(1) of this section is made by an attending provider, in consultation with the mother, the requirements of paragraph (a)(1) of this section do not apply for any period after the discharge.

(ii) *Discharge of newborn.* If a decision to discharge a newborn child earlier than the period specified in paragraph (a)(1) of this section is made by an attending provider, in consultation with the mother (or the newborn's authorized representative), the requirements of paragraph (a)(1) of this section do not apply for any period after the discharge.

(iii) *Attending provider defined.* For purposes of this section, attending provider means an individual who is licensed under applicable state law to provide maternity or pediatric care and who is directly responsible for providing maternity or pediatric care to a mother or newborn child. Therefore, a plan, hospital, managed care organization, or other issuer is not an attending provider.

(iv) *Example.* The rules of this paragraph (a)(5) are illustrated by the following example:

Example. (i) *Facts.* A pregnant woman covered under a group health plan subject to the requirements of this section goes into labor and is admitted to a hospital. She gives birth by cesarean section. On the third day after the delivery, the attending provider for the mother consults with the mother, and the attending provider for the newborn consults with the mother regarding the newborn. The attending providers authorize the early discharge of both the mother and the newborn. Both are discharged approximately 72 hours after the delivery. The plan pays for the 72-hour hospital stays.

(ii) *Conclusion.* In this *Example,* the requirements of this paragraph (a) have been satisfied with respect to the mother and the newborn. If either is readmitted, the hospital stay for the readmission is not subject to this section.

(b) *Prohibitions*—(1) *With respect to mothers*—(i) *In general.* A group health plan may not—

(A) Deny a mother or her newborn child eligibility or continued eligibility to enroll or renew coverage under the terms of the plan solely to avoid the requirements of this section; or

(B) Provide payments (including payments-in-kind) or rebates to a mother to encourage her to accept less than the minimum protections available under this section.

(ii) *Examples.* The rules of this paragraph (b)(1) are illustrated by the following examples. In each example, the group health plan is subject to the requirements of this section, as follows:

Example 1. (i) *Facts.* A group health plan provides benefits for at least a 48-hour hospital length of stay following a vaginal delivery. If a mother and newborn covered under the plan are discharged within 24 hours after the delivery, the plan will waive the copayment and deductible.

(ii) *Conclusion.* In this *Example 1,* because waiver of the copayment and deductible is in the nature of a rebate that the mother would not receive if she and her newborn remained in the hospital, it is prohibited by this paragraph (b)(1). (In addition, the plan violates paragraph (b)(2) of this section because, in effect, no copayment or deductible is required for the first portion of the stay and a double copayment and a deductible are required for the second portion of the stay.)

Example 2. (i) *Facts.* A group health plan provides benefits for at least a 48-hour hospital length of stay following a vaginal delivery. In the event that a mother and her newborn are discharged earlier than 48 hours and the discharges occur after consultation with the mother in accordance with the requirements of paragraph (a)(5) of this section, the plan provides for a follow-up visit by a nurse within 48 hours after the discharges to provide certain services that the mother and her newborn would otherwise receive in the hospital.

(ii) *Conclusion.* In this *Example 2,* because the follow-up visit does not provide any services beyond what the mother and her newborn would receive in the hospital, coverage for the follow-up visit is not prohibited by this paragraph (b)(1).

(2) *With respect to benefit restrictions*—(i) *In general.* Subject to paragraph (c)(3) of this section, a group health plan may not restrict the benefits for

any portion of a hospital length of stay specified in paragraph (a) of this section in a manner that is less favorable than the benefits provided for any preceding portion of the stay.

(ii) *Example*. The rules of this paragraph (b)(2) are illustrated by the following example:

Example. (i) *Facts*. A group health plan subject to the requirements of this section provides benefits for hospital lengths of stay in connection with childbirth. In the case of a delivery by cesarean section, the plan automatically pays for the first 48 hours. With respect to each succeeding 24-hour period, the participant or beneficiary must call the plan to obtain precertification from a utilization reviewer, who determines if an additional 24-hour period is medically necessary. If this approval is not obtained, the plan will not provide benefits for any succeeding 24-hour period.

(ii) *Conclusion*. In this *Example*, the requirement to obtain precertification for the two 24-hour periods immediately following the initial 48-hour stay is prohibited by this paragraph (b)(2) because benefits for the latter part of the stay are restricted in a manner that is less favorable than benefits for a preceding portion of the stay. (However, this section does not prohibit a plan from requiring precertification for any period after the first 96 hours.) In addition, the requirement to obtain precertification from the plan based on medical necessity for a hospital length of stay within the 96-hour period would also violate paragraph (a) of this section.

(3) *With respect to attending providers*. A group health plan may not directly or indirectly—

(i) Penalize (for example, take disciplinary action against or retaliate against), or otherwise reduce or limit the compensation of, an attending provider because the provider furnished care to a participant or beneficiary in accordance with this section; or

(ii) Provide monetary or other incentives to an attending provider to induce the provider to furnish care to a participant or beneficiary in a manner inconsistent with this section, including providing any incentive that could induce an attending provider to discharge a mother or newborn earlier than 48 hours (or 96 hours) after delivery.

(c) *Construction*. With respect to this section, the following rules of construction apply:

(1) *Hospital stays not mandatory*. This section does not require a mother to—

(i) Give birth in a hospital; or

(ii) Stay in the hospital for a fixed period of time following the birth of her child.

(2) *Hospital stay benefits not mandated*. This section does not apply to any group health plan that does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn child.

(3) *Cost-sharing rules*—(i) *In general*. This section does not prevent a group health plan from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or a newborn under the plan or coverage, except that the coinsurance or other cost-sharing for any portion of the hospital length of stay specified in paragraph (a) of this section may not be greater than that for any preceding portion of the stay.

(ii) *Examples*. The rules of this paragraph (c)(3) are illustrated by the following examples. In each example, the group health plan is subject to the requirements of this section, as follows:

Example 1. (i) *Facts*. A group health plan provides benefits for at least a 48-hour hospital length of stay in connection with vaginal deliveries. The plan covers 80 percent of the cost of the stay for the first 24-hour period and 50 percent of the cost of the stay for the second 24-hour period. Thus, the coinsurance paid by the patient increases from 20 percent to 50 percent after 24 hours.

(ii) *Conclusion*. In this *Example 1*, the plan violates the rules of this paragraph (c)(3) because coinsurance for the second 24-hour period of the 48-hour stay is greater than that for the preceding portion of the stay. (In addition, the plan also violates the similar rule in paragraph (b)(2) of this section.)

Example 2. (i) *Facts*. A group health plan generally covers 70 percent of the cost of a hospital length of stay in connection with childbirth. However, the plan will cover 80 percent of the cost of the stay if the participant or beneficiary notifies the plan of the pregnancy in advance of admission and uses whatever hospital the plan may designate.

(ii) *Conclusion*. In this *Example 2*, the plan does not violate the rules of this paragraph (c)(3) because the level of benefits provided (70 percent or 80 percent) is consistent throughout the 48-hour (or 96-hour) hospital length of stay required under paragraph (a) of this section. (In addition, the plan does

not violate the rules in paragraph (a)(4) or (b)(2) of this section.)

(4) *Compensation of attending provider.* This section does not prevent a group health plan from negotiating with an attending provider the level and type of compensation for care furnished in accordance with this section (including paragraph (b) of this section).

(d) *Notice requirement.* See 29 CFR 2520.102–3(u) for rules relating to a disclosure requirement imposed under section 711(d) of ERISA (29 U.S.C. 1181) on certain group health plans that provide benefits for hospital lengths of stay in connection with childbirth.

(e) *Applicability in certain states*—(1) *Health insurance coverage.* The requirements of section 9811 and this section do not apply with respect to health insurance coverage offered in connection with a group health plan if there is a state law regulating the coverage that meets any of the following criteria:

(i) The state law requires the coverage to provide for at least a 48-hour hospital length of stay following a vaginal delivery and at least a 96-hour hospital length of stay following a delivery by cesarean section.

(ii) The state law requires the coverage to provide for maternity and pediatric care in accordance with guidelines that relate to care following childbirth established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or any other established professional medical association.

(iii) The state law requires, in connection with the coverage for maternity care, that the hospital length of stay for such care is left to the decision of (or is required to be made by) the attending provider in consultation with the mother. State laws that require the decision to be made by the attending provider with the consent of the mother satisfy the criterion of this paragraph (e)(1)(iii).

(2) *Group health plans*—(i) *Fully-insured plans.* For a group health plan that provides benefits solely through health insurance coverage, if the state law regulating the health insurance coverage meets any of the criteria in paragraph (e)(1) of this section, then the requirements of section 9811 and this section do not apply.

(ii) *Self-insured plans.* For a group health plan that provides all benefits for hospital lengths of stay in connection with childbirth other than through health insurance coverage, the requirements of section 9811 and this section apply.

(iii) *Partially-insured plans.* For a group health plan that provides some benefits through health insurance coverage, if the state law regulating the health insurance coverage meets any of the criteria in paragraph (e)(1) of this section, then the requirements of section 9811 and this section apply only to the extent the plan provides benefits for hospital lengths of stay in connection with childbirth other than through health insurance coverage.

(3) *Preemption provisions under section 731(a) of ERISA.* See 29 CFR 2590.711(e)(3) for a rule providing that the preemption provisions contained in section 731(a)(1) of ERISA and 29 CFR 2590.731(a) do not supersede a state law if the state law is described in paragraph (e)(1) of 29 CFR 2590.711 (which is substantially similar to paragraph (e)(1) of this section).

(4) *Examples.* The rules of this paragraph (e) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan buys group health insurance coverage in a state that requires that the coverage provide for at least a 48-hour hospital length of stay following a vaginal delivery and at least a 96-hour hospital length of stay following a delivery by cesarean section.

(ii) *Conclusion.* In this *Example 1*, the coverage is subject to state law, and the requirements of section 9811 and this section do not apply.

Example 2. (i) *Facts.* A self-insured group health plan covers hospital lengths of stay in connection with childbirth in a state that requires health insurance coverage to provide for maternity and pediatric care in accordance with guidelines that relate to care following childbirth established by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics.

(ii) *Conclusion.* In this *Example 2*, even though the state law satisfies the criterion of paragraph (e)(1)(ii) of this section, because the plan provides benefits for hospital lengths of stay in connection with childbirth other than through health insurance coverage, the plan is subject to the requirements of section 9811 and this section.

(f) *Effective/applicability date.* This section applies to group health plans for plan years beginning on or after January 1, 2009.

[T.D. 9427, 73 FR 62420, Oct. 20, 2008]

§ 54.9812–1 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.

(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 limit calculated for medical/surgical benefits in the following manner. The average

limit is calculated by taking into account the weighted average of the aggregate lifetime or annual dollar limits, as appropriate, that are applicable to the categories of medical/surgical benefits. Limits based on delivery systems, such as inpatient/outpatient treatment or normal treatment of common, low-cost conditions (such as treatment of normal births), do not constitute categories for purposes of this paragraph (b)(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)(ii) of this section.

(ii) *Type of financial requirement or treatment limitation*. When reference is made in this paragraph (c) to a type of financial requirement or treatment limitation, the reference to type means its nature. Different types of financial requirements include deductibles, copayments, coinsurance, and out-of-pocket maximums. Different types of quantitative treatment limitations include annual, episode, and lifetime day and visit limits. See paragraph (c)(4)(ii) of this section for an illustrative list of nonquantitative treatment limitations.

(iii) *Level of a type of financial requirement or treatment limitation*. When reference is made in this paragraph (c) to a level of a type of financial requirement or treatment limitation, level refers to the magnitude of the type of financial requirement or treatment limitation. For example, different levels of coinsurance include 20 percent and 30 percent; different levels of a copayment include $15 and $20; different levels of a deductible include $250 and $500; and different levels of an episode limit include 21 inpatient days per episode and 30 inpatient days per episode.

(iv) *Coverage unit*. When reference is made in this paragraph (c) to a coverage unit, coverage unit refers to the way in which a plan (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 nonquantitative treatment limitations is addressed in paragraph (c)(4) of this section.

(ii) *Classifications of benefits used for applying rules*—(A) *In general*. If a plan (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.

(*5*) *Emergency care*. Benefits for emergency care.

(*6*) *Prescription drugs*. Benefits for prescription drugs. See special rules for multi-tiered prescription drug benefits in paragraph (c)(3)(iii) of this section.

(B) *Application to out-of-network providers*. See paragraph (c)(2)(ii)(A) of this section, under which a plan (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*—(*1*) If a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical/surgical benefits in a classification as determined under paragraph (c)(3)(i)(A) of this section, the level of the financial requirement or quantitative treatment limitation that is considered the predominant level of that type in a classification of benefits is the level that applies to more than one-half of medical/surgical benefits in that classification subject to the financial requirement or quantitative treatment limitation.

(*2*) If, with respect to a type of financial requirement or quantitative treatment limitation that applies to at least two-thirds of all medical/surgical benefits in a classification, there is no single level that applies to more than one-half of medical/surgical benefits in the classification subject to the financial requirement or quantitative treatment limitation, the plan (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 all plan payments for medical/surgical benefits in the classification expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the financial requirement or quantitative treatment limitation).

(D) *Clarifications for certain threshold requirements.* For any deductible, the dollar amount of plan payments includes all plan payments with respect to claims that would be subject to the

deductible if it had not been satisfied. For any out-of-pocket maximum, the dollar amount of plan payments includes all plan payments associated with out-of-pocket payments that are taken into account towards the out-of-pocket maximum as well as all plan payments associated with out-of-pocket payments that would have been made towards the out-of-pocket maximum if it had not been satisfied. Similar rules apply for any other thresholds at which the rate of plan payment changes. (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).

(ii) *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.

(iii) *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 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.

(C) *Sub-classifications permitted for office visits, separate from other outpatient services.* For purposes of applying the financial requirement and treatment limitation rules of this paragraph (c), a plan or issuer may divide its benefits furnished on an outpatient basis into the two sub-classifications described in this paragraph (c)(3)(iii)(C). After the sub-classifications are established, the plan or issuer may not impose any financial requirement or quantitative treatment limitation on mental health or substance use disorder benefits in any sub-classification that is more restrictive than the predominant financial requirement or quantitative 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:

(*1*) 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:

Coinsurance rate	0%	10%	15%	20%	30%	Total.
Projected payments ..	$200x	$100x	$450x	$100x	$150x	$1,000x.
Percent of total plan costs.	20%	10%	45%	10%	15%	
Percent subject to coinsurance level.	N/A	12.5% (100x/800x)	56.25% (450x/800x)	12.5% (100x/800x)	18.75% (150x/800x)	

The plan projects plan costs of $800x to be subject to coinsurance ($100x + $450x + $100x + $150x = $800x). Thus, 80 percent ($800x/$1,000x) of the benefits are projected to be subject to coinsurance, and 56.25 percent of the benefits subject to coinsurance are projected to be subject to the 15 percent coinsurance level.

(ii) *Conclusion*. In this *Example 1*, the two-thirds threshold of the substantially all standard is met for coinsurance because 80 percent of all inpatient, out-of-network medical/surgical benefits are subject to coinsurance. Moreover, the 15 percent coinsurance is the predominant level because it is applicable to more than one-half of inpatient, out-of-network medical/surgical benefits subject to the coinsurance requirement. The plan may not impose any level of coinsurance with respect to inpatient, out-of-network mental health or substance use disorder benefits that is more restrictive than the 15 percent level of coinsurance.

Example 2. (i) *Facts*. For outpatient, in-network medical/surgical benefits, a plan imposes five different copayment levels. Using a reasonable method, the plan projects payments for the upcoming year as follows:

Copayment amount ...	$0	$10	$15	$20	$50	Total.
Projected payments ..	$200x	$200x	$200x	$300x	$100x	$1,000x.
Percent of total plan costs.	20%	20%	20%	30%	10%	
Percent subject to copayments.	N/A	25% (200x/800x)	25% (200x/800x)	37.5% (300x/800x)	12.5% (100x/800x)	

The plan projects plan costs of $800x to be subject to copayments ($200x + $200x + $300x + $100x = $800x). Thus, 80 percent ($800x/$1,000x) of the benefits are projected to be subject to a copayment.

(ii) *Conclusion*. In this *Example 2*, the two-thirds threshold of the substantially all standard is met for copayments because 80 percent of all outpatient, in-network medical/surgical benefits are subject to a copayment. Moreover, there is no single level that applies to more than one-half of medical/surgical benefits in the classification subject to a copayment (for the $10 copayment, 25%; 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 copayments ($100x + $300x + $200x = $600x; $600x/$800x = 75%). Thus, the plan may not impose any copayment on outpatient, in-network mental health or substance use disorder benefits that is more restrictive than the least restrictive copayment in the combination, the $15 copayment.

Example 3. (i) *Facts.* A plan imposes a $250 deductible on all medical/surgical benefits for self-only coverage and a $500 deductible on all medical/surgical benefits for family coverage. The plan has no network of providers. For all medical/surgical benefits, the plan imposes a coinsurance requirement. The plan imposes no other financial requirements or treatment limitations.

(ii) *Conclusion.* In this *Example 3,* because the plan has no network of providers, all benefits are provided out-of-network. Because self-only and family coverage are subject to different deductibles, whether the deductible applies to substantially all medical/surgical benefits is determined separately for self-only medical/surgical benefits and family medical/surgical benefits. Because the coinsurance is applied without regard to coverage units, the predominant coinsurance that applies to substantially all medical/surgical benefits is determined without regard to coverage units.

Example 4. (i) *Facts.* A plan applies the following financial requirements for prescription drug benefits. The requirements are applied without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use disorder benefits. Moreover, the process for certifying a particular drug as ''generic'', ''preferred brand name'', ''non-preferred brand name'', or ''specialty'' complies with the rules of paragraph (c)(4)(i) of this section (relating to requirements for nonquantitative treatment limitations).

	Tier 1	Tier 2	Tier 3	Tier 4
Tier description	Generic drugs	Preferred brand name drugs	Non-preferred brand name drugs (which may have Tier 1 or Tier 2 alternatives)	Specialty drugs
Percent paid by plan	90%	80%	60%	50%

(ii) *Conclusion.* In this *Example 4,* the financial requirements that apply to prescription drug benefits are applied without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use disorder benefits; the process for certifying drugs in different tiers complies with paragraph (c)(4) of this section; and the bases for establishing different levels or types of financial requirements are reasonable. The financial requirements applied to prescription drug benefits do not violate the parity requirements of this paragraph (c)(3).

Example 5. (i) *Facts.* A plan has two-tiers of network of providers: a preferred provider tier and a participating provider tier. Providers are placed in either the preferred tier or participating tier based on reasonable factors determined in accordance with the rules in paragraph (c)(4)(i) of this section, such as accreditation, 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:

Classification	Benefits subject to deductible	Total benefits	Percent subject to deductible
Inpatient, in-network	$1,800x	$2,000x	90
Inpatient, out-of-network	1,000x	1,000x	100
Outpatient, in-network	1,400x	2,000x	70
Outpatient, out-of-network	1,880x	2,000x	94
Emergency care	300x	500x	60

(ii) *Conclusion*. In this *Example 4*, the two-thirds threshold of the substantially all standard is met with respect to each classification except emergency care because in each of those other classifications at least two-thirds of medical/surgical benefits are subject to the $500 deductible. Moreover, the $500 deductible is the predominant level in each of those other classifications because it is the only level. However, emergency care mental health and substance use disorder benefits cannot be subject to the $500 deductible because it does not apply to substantially all emergency care medical/surgical benefits.

(4) *Nonquantitative treatment limitations*—(i) *General rule*. A group health plan (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 investigative;

(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 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 0.8). 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 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 a 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 highest 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 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 because the scope of their licensure 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 accordance with this paragraph (d)(2).

(i) *Plans subject to ERISA.* If a plan is subject to ERISA, it must provide the reason for the claim denial in a form and manner consistent with the requirements of 29 CFR 2560.503–1 for group health plans.

(ii) *Plans not subject to ERISA.* If a plan is not subject to ERISA, upon the request of a participant or beneficiary the reason for the claim denial must be provided within a reasonable time and in a reasonable manner. For this purpose, a plan that follows the requirements of 29 CFR 2560.503–1 for group health plans complies with the requirements of this paragraph (d)(2)(ii).

(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 29 CFR 2520.104b–1 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, 29 CFR 2560.503–1 and 29 CFR 2590.715–2719 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) that provides coverage for mental health 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 9831(a) and § 54.9831–1(b), which provide that this section (and certain other sections) does not apply to any group health plan for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees.

(2) *Rules in determining employer size*. For purposes of paragraph (f)(1) of this section—

(i) All persons treated as a single employer under subsections (b), (c), (m), and (o) of section 414 are treated as one employer;

(ii) If an employer was not in existence throughout the preceding calendar year, whether it is a small employer is determined based on the average number of employees the employer reasonably expects to employ on business days during the current calendar year; and

(iii) Any reference to an employer for purposes of the small employer exemption includes a reference to a predecessor of the employer.

(g) *Increased cost exemption*—(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*—(i) 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 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:

$$[(E_1 - E_0)/T_0] - D > k$$

(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 $(E_1 - E_0)/T_0$ 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 is based

(as required under paragraph (g)(6)(i)(D) of this section).

(B) *Use of summary of material reductions in covered services or benefits.* A plan or issuer may satisfy the requirements of paragraph (g)(6)(i)(A) of this section by providing participants and beneficiaries (in accordance with paragraph (g)(6)(i)(C) of this section) with a summary of material reductions in covered services or benefits consistent with 29 CFR 2520.104b–3(d) that also includes the information specified in paragraph (g)(6)(i)(A) of this section. However, in all cases, the exemption is not effective until 30 days after notice has been sent.

(C) *Delivery.* The notice described in this paragraph (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 with respect to church plans.* A church plan (as defined in section 414(e)) claiming the exemption of this paragraph (g) for any benefit package, must provide notice to the Department of the Treasury. This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (g)(6)(ii)(A) of this section identifying the benefit package to which the exemption applies.

(C) *Reporting with respect to ERISA plans.* See 29 CFR 2590.712(g)(6)(ii) for delivery with respect to ERISA plans.

(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.

(h) *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.

(i) *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.

(2) *Special effective date for certain collectively-bargained plans*. For a group health plan maintained pursuant to one or more collective bargaining agreements ratified before October 3, 2008, the requirements of this section do not apply to the plan (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).

[T.D. 9640, 78 FR 68266, Nov. 13, 2013]

§ 54.9815–1251 Preservation of right to maintain existing coverage.

(a) *Definition of grandfathered health plan coverage*—(1) *In general*—(i) *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 or group health insurance coverage has continuously covered someone since March 23, 2010 (not necessarily the same person, but at all times at least one person). In addition, subject to the limitation set forth in paragraph (a)(1)(ii) of this section, a group health plan (and any health insurance coverage offered in connection with the group health plan) does not cease to be a grandfathered health plan merely because the plan (or its sponsor) enters into a new policy, certificate, or contract of insurance after March 23, 2010 (for example, a plan enters into a contract with a new issuer or a new policy is issued with an existing issuer). For purposes of this section, a plan or health insurance coverage that provides grandfathered health plan coverage is referred to as a grandfathered health plan. The rules of this section apply separately to each benefit package made available under a group health plan or health insurance coverage. Accordingly, if any benefit package relinquishes grandfather status, it will not affect the grandfather status of the other benefit packages.

(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 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, in any

summary of benefits provided under the plan.

(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 dollar 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.healthcare.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 dollar 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. Further, the addition of a new contributing employer or new group of employees of an existing contributing employer to a grandfathered multiemployer health plan will not affect the plan's grandfather status.

(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.

(iii) *Illustrative list of bona fide employment-based reasons.* For purposes of paragraph (b)(2)(ii)(C) of this section, bona fide employment-based reasons include—

(A) When a benefit package is being eliminated because the issuer is exiting the market;

(B) When a benefit package is being eliminated because the issuer no longer offers the product to the employer;

(C) When low or declining participation by plan participants in the benefit package makes it impractical for the plan sponsor to continue to offer the benefit package;

(D) When a benefit package is eliminated from a multiemployer plan as agreed upon as part of the collective bargaining process; or

(E) When a benefit package is eliminated for any reason and multiple benefit packages covering a significant portion of other employees remain available to the employees being transferred.

(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.* A group health plan offers two benefit packages on March 23, 2010, Options *H* and *I*. On March 23, 2010, Option *H* provides coverage only for employees in one manufacturing plant. Subsequently, the plant is closed, and some employees in the closed plant are moved to another plant. The employer eliminates Option *H* and the employees that are moved are transferred to Option *I*. If instead of transferring employees from Option *H* to Option *I*, Option *H* was amended to match the terms of Option *I*, then Option *H* would cease to be a grandfathered health plan.

(ii) *Conclusion.* In this *Example 2*, 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 dollar 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 dollar 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 dollar 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 paragraphs (g)(2) and (3) 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. A plan or coverage will cease to be a grandfathered health plan when an amendment to plan terms that results in a change described in this paragraph (g)(1) becomes effective, regardless of when the amendment was adopted. Once grandfather status is lost, it cannot be regained.

(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. Whether or not a plan or coverage has eliminated substantially all benefits to diagnose or treat a particular condition must be determined based on all the facts and circumstances, taking into account the

items and services provided for a particular condition under the plan on March 23, 2010, as compared to the benefits offered at the time the plan or coverage makes the benefit change effective.

(ii) *Increase in percentage cost-sharing requirement.* Any increase, measured from March 23, 2010, in a percentage cost-sharing requirement (such as an individual's coinsurance requirement) causes a group health plan or health insurance coverage to cease to be a grandfathered health plan.

(iii) *Increase in a fixed-amount cost-sharing requirement other than a copayment.* Any increase in a fixed-amount cost-sharing requirement other than a copayment (for example, deductible or out-of-pocket limit), determined as of the effective date of the increase, causes a group health plan or health insurance coverage to cease to be a grandfathered health plan, if the total percentage increase in the cost-sharing requirement measured from March 23, 2010 exceeds the maximum percentage increase (as defined in paragraph (g)(4)(ii) of this section).

(iv) *Increase in a fixed-amount copayment.* Any increase in a fixed-amount copayment, determined as of the effective date of the increase, and determined for each copayment level if a plan has different copayment levels for different categories of services, causes a group health plan or health insurance coverage to cease to be a grandfathered health plan, if the total increase in the copayment measured from March 23, 2010 exceeds the greater of:

(A) An amount equal to $5 increased by medical inflation, as defined in paragraph (g)(4)(i) of this section (that is, $5 times medical inflation, plus $5); or

(B) The maximum percentage increase (as defined in paragraph (g)(4)(ii) of this section), determined by expressing the total increase in the copayment as a percentage.

(v) *Decrease in contribution rate by employers and employee organizations*—(A) *Contribution rate based on cost of coverage.* A group health plan or group health insurance coverage ceases to be a grandfathered health plan if the employer or employee organization decreases its contribution rate based on cost of coverage (as defined in paragraph (g)(4)(iii)(A) of this section) towards the cost of any tier of coverage for any class of similarly situated individuals (as described in §54.9802(d)) by more than 5 percentage points below the contribution rate for the coverage period that includes March 23, 2010.

(B) *Contribution rate based on a formula.* A group health plan or group health insurance coverage ceases to be a grandfathered health plan if the employer or employee organization decreases its contribution rate based on a formula (as defined in paragraph (g)(4)(iii)(B) of this section) towards the cost of any tier of coverage for any class of similarly situated individuals (as described in §54.9802(d)) by more than 5 percent below the contribution rate for the coverage period that includes March 23,

(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. (But see §54.9815–2711, which prohibits all annual dollar limits on essential health benefits for plan years beginning on or after January 1, 2014).

(B) *Decrease in limit for a plan or coverage with only a lifetime limit.* A group health plan, or group health insurance coverage, that, on March 23, 2010, imposed an overall lifetime limit on the dollar value of all benefits but no overall annual limit on the dollar value of all benefits ceases to be a grandfathered health plan if the plan or health insurance coverage adopts an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit on March 23, 2010. (But see §54.9815–2711, which prohibits all annual dollar limits on essential health benefits for plan years beginning on or after January 1, 2014).

(C) *Decrease in limit for a plan or coverage with an annual limit.* A group health plan, or group health insurance coverage, that, on March 23, 2010, imposed an overall annual limit on the dollar value of all benefits ceases to be

a grandfathered health plan if the plan or health insurance coverage decreases the dollar value of the annual limit (regardless of whether the plan or health insurance coverage also imposed an overall lifetime limit on March 23, 2010 on the dollar value of all benefits). (But see § 54.9815–2711, which prohibits all annual dollar limits on essential health benefits for plan years beginning on or after January 1, 2014).

(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) *Special rule for certain grandfathered high deductible health plans.* With respect to a grandfathered group health plan or group health insurance coverage that is a high deductible health plan within the meaning of section 223(c)(2), increases to fixed-amount cost-sharing requirements made effective on or after June 15, 2021 that otherwise would cause a loss of grandfather status will not cause the plan or coverage to relinquish its grandfather status, but only to the extent such increases are necessary to maintain its status as a high deductible health plan under section 223(c)(2)(A).

(4) *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 purposes of this paragraph (g)(4)(i), 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:

(A) With respect to increases for a group health plan and group health insurance coverage made effective on or after March 23, 2010, and before June 15, 2021, medical inflation (as defined in paragraph (g)(4)(i) of this section), expressed as a percentage, plus 15 percentage points; and

(B) With respect to increases for a group health plan and group health insurance coverage made effective on or after June 15, 2021, the greater of:

(*1*) Medical inflation (as defined in paragraph (g)(4)(i) of this section), expressed as a percentage, plus 15 percentage points; or

(*2*) The portion of the premium adjustment percentage, as defined in 45 CFR 156.130(e), that reflects the relative change between 2013 and the calendar year prior to the effective date of the increase (that is, the premium adjustment percentage minus 1), 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 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.

(5) *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 group 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, effective before June 15, 2021. Within the 12-month period before the $40 copayment takes effect, the greatest value of the overall medical care component of the CPI–U (unadjusted) is 475.

(ii) *Conclusion*. In this *Example 3*, the increase in the copayment from $30 to $40, expressed as a percentage, is 33.33% (40 − 30 = 10; 10 ÷ 30 = 0.3333; 0.3333 = 33.33%). Medical inflation (as defined in paragraph (g)(4)(i) of this section) from March 2010 is 0.2269 (475 − 387.142 = 87.858; 87.858 ÷ 387.142 = 0.2269). The maximum percentage increase permitted is 37.69% (0.2269 = 22.69%; 22.69% + 15% = 37.69%). Because 33.33% does not exceed 37.69%, the change in the copayment requirement at that time does not cause the plan to cease to be a grandfathered health plan.

Example 4. (i) *Facts*. Same facts as *Example 3* of this paragraph (g)(5), except the grandfathered group health plan subsequently increases the $40 copayment requirement to $45 for a later plan year, effective before June 15, 2021. Within the 12-month period before the $45 copayment takes effect, the greatest value of the overall medical care component of the CPI–U (unadjusted) is 485.

(ii) *Conclusion*. In this *Example 4*, the increase in the copayment from $30 (the copayment that was in effect on March 23, 2010) to $45, expressed as a percentage, is 50% (45 − 30 = 15; 15 ÷ 30 = 0.5; 0.5 = 50%). Medical inflation (as defined in paragraph (g)(4)(i) of this section) from March 2010 is 0.2527 (485 − 387.142 = 97.858; 97.858 ÷ 387.142 = 0.2527). The increase that would cause a plan to cease to be a grandfathered health plan under paragraph (g)(1)(iv) of this section is the greater of the maximum percentage increase of 40.27% (0.2527 = 25.27%; 25.27% + 15% = 40.27%), or

$6.26 (5 × 0.2527 = $1.26; $1.26 + $5 = $6.26). Because 50% exceeds 40.27% and $15 exceeds $6.26, the change in the copayment requirement at that time causes the plan to cease to be a grandfathered health plan.

Example 5. (i) *Facts.* Same facts as *Example 4* of this paragraph (g)(5), except the grandfathered group health plan increases the copayment requirement to $45, effective *after* June 15, 2021. The greatest value of the overall medical care component of the CPI–U (unadjusted) in the preceding 12-month period is still 485. In the calendar year that includes the effective date of the increase, the applicable portion of the premium adjustment percentage is 36%.

(ii) *Conclusion.* In this *Example 5,* the grandfathered health plan may increase the copayment by the greater of: Medical inflation, expressed as a percentage, plus 15 percentage points; or the applicable portion of the premium adjustment percentage for the calendar year that includes the effective date of the increase, plus 15 percentage points. The latter amount is greater because it results in a 51% maximum percentage increase (36% + 15% = 51%) and, as demonstrated in *Example 4* of this paragraph (g)(5), determining the maximum percentage increase using medical inflation yields a result of 40.27%. The increase in the copayment, expressed as a percentage, is 50% (45 − 30 = 15; 15 ÷ 30 = 0.5; 0.5 = 50%). Because the 50% increase in the copayment is less than the 51% maximum percentage increase, the change in the copayment requirement at that time does not cause the plan to cease to be a grandfathered health plan.

Example 6. (i) *Facts.* On March 23, 2010, a grandfathered group 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, effective before June 15, 2021. Within the 12-month period before the $15 copayment takes effect, the greatest value of the overall medical care component of the CPI–U (unadjusted) is 415.

(ii) *Conclusion.* In this *Example 6,* 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)(4)(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 group plan to cease to be a grandfathered health plan under paragraph (g)(1)(iv) of this section is the greater of the maximum percentage increase of 22.20% (0.0720 = 7.20%; 7.20% + 15% = 22.20%), or $5.36 ($5 × 0.0720 = $0.36; $0.36 + $5 = $5.36). The $5 increase in copayment in this *Example 6* would not cause the plan to cease to be a grandfathered health plan pursuant to paragraph (g)(1)(iv) of this section, which would permit an increase in the copayment of up to $5.36.

Example 7. (i) *Facts.* Same facts as *Example 6* of this paragraph (g)(5), except on March 23, 2010, the grandfathered health plan has no copayment ($0) for office visits for primary care providers. The plan is subsequently, amended to increase the copayment requirement to $5, effective before June 15, 2021.

(ii) *Conclusion.* In this *Example 7,* medical inflation (as defined in paragraph (g)(4)(i) of this section) from March 2010 is 0.0720 (415.0 − 387.142 = 27.858; 27.858 ÷ 387.142 = 0.0720). The increase that would cause a plan to cease to be a grandfathered health plan under paragraph (g)(1)(iv)(A) of this section is $5.36 ($5 × 0.0720 = $0.36; $0.36 + $5 = $5.36). The $5 increase in copayment in this *Example 7* is less than the amount calculated pursuant to paragraph (g)(1)(iv)(A) of this section of $5.36. Thus, the $5 increase in copayment does not cause the plan to cease to be a grandfathered health plan.

Example 8. (i) *Facts.* On March 23, 2010, a self-insured group health plan provides two tiers of coverage—self-only and family. The employer contributes 80% of the total cost of coverage for self-only and 60% of the total cost of coverage for family. Subsequently, the employer reduces the contribution to 50% for family coverage, but keeps the same contribution rate for self-only coverage.

(ii) *Conclusion.* In this *Example 8,* the decrease of 10 percentage points for family coverage in the contribution rate based on cost of coverage causes the plan to cease to be a grandfathered health plan. The fact that the contribution rate for self-only coverage remains the same does not change the result.

Example 9. (i) *Facts.* On March 23, 2010, a self-insured grandfathered health plan has a COBRA premium for the 2010 plan year of $5,000 for self-only coverage and $12,000 for family coverage. The required employee contribution for the coverage is $1,000 for self-only coverage and $4,000 for family coverage. Thus, the contribution rate based on cost of coverage for 2010 is 80% ((5,000 − 1,000)/5,000) for self-only coverage and 67% ((12,000 − 4,000)/12,000) for family coverage. For a subsequent plan year, the COBRA premium is $6,000 for self-only coverage and $15,000 for family coverage. The employee contributions for that plan year are $1,200 for self-only coverage and $5,000 for family coverage. Thus, the contribution rate based on cost of coverage is 80% ((6,000 − 1,200)/6,000) for self-only coverage and 67% ((15,000 − 5,000)/15,000) for family coverage.

(ii) *Conclusion.* In this *Example 9,* because there is no change in the contribution rate based on cost of coverage, the plan retains its status as a grandfathered health plan. The result would be the same if all or part of the employee contribution was made pre-tax through a cafeteria plan under section 125.

Example 10. (i) *Facts.* A group health plan not maintained pursuant to a collective bargaining agreement offers three benefit packages on March 23, 2010. Option *F* is a self-insured option. Options *G* and *H* are insured options. Beginning July 1, 2013, the plan increases coinsurance under Option *H* from 10% to 15%.

(ii) *Conclusion.* In this *Example 10,* the coverage under Option *H* is not grandfathered health plan coverage as of July 1, 2013, consistent with the rule in paragraph (g)(1)(ii) of this section. Whether the coverage under Options *F* and *G* is grandfathered health plan coverage is determined separately under the rules of this paragraph (g).

Example 11. (i) *Facts.* A group health plan that is a grandfathered health plan and also a high deductible health plan within the meaning of section 223(c)(2) had a $2,400 deductible for family coverage on March 23, 2010. The plan is subsequently amended after June 15, 2021 to increase the deductible limit by the amount that is necessary to comply with the requirements for a plan to qualify as a high deductible health plan under section 223(c)(2)(A), but that exceeds the maximum percentage increase.

(ii) *Conclusion.* In this *Example 11,* the increase in the deductible at that time does not cause the plan to cease to be a grandfathered health plan because the increase was necessary for the plan to continue to satisfy the definition of a high deductible health plan under section 223(c)(2)(A).

[T.D. 9744, 80 FR 72238, Nov. 18, 2015, as amended by T.D. 9928, 85 FR 81116, Dec. 15, 2020]

§ 54.9815–2704 Prohibition of preexisting condition exclusions.

(a) *No preexisting condition exclusions.* A group health plan, or a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion (as defined in § 54.9801–2).

(b) *Examples.* The rules of paragraph (a) of this section are illustrated by the following examples (for additional examples illustrating the definition of a preexisting condition exclusion, *see* § 54.9801–3(a)(2)):

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. Therefore, such an exclusion is prohibited.

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. Therefore, such an exclusion is prohibited.

(c) *Applicability date.* The provisions of this section are applicable to group health plans and health insurance issuers for plan years beginning on or after January 1, 2017. Until the applicability date for this regulation, plans and issuers are required to continue to comply with the interim final regulations promulgated by the Department of Labor at 29 CFR part 2590, contained in the 29 CFR, parts 1927 to end, edition revised as of July 1, 2015.

[T.D. 9744, 80 FR 72243, Nov. 18, 2015]

§ 54.9815–2705 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 § 54.9802–1.

(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.

[T.D. 9620, 78 FR 33181, June 3, 2013]

§ 54.9815–2708 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 § 54.9801–2) or special enrollee (as described in § 54.9801–6), 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).

(i) *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 the cumulative hours-of-service requirement does not exceed 1,200 hours.

(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. If there is not a corresponding date in the next calendar month upon adding a calendar month, the last permitted day of the orientation period is the last day of the next calendar month. For example, if the employee's start date is January 30, the last permitted day of the orientation period is February 28 (or February 29 in a leap year). Similarly, if the employee's start date is August 31, the last permitted day of the orientation period is September 30.

(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 §54.9801–2), 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* 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*, except that *B* 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 after a measurement period of 12 months that begins on the employee's start date. Coverage is made 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 February 14, 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.

(h) *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.*, § 54.9802–1, which prohibits discrimination in eligibility for coverage based on a health factor and section 4980H, which generally requires applicable large employers to offer coverage to full-time employees and their dependents or make an assessable payment.

(i) *Applicability date*. The provisions of this section apply for plan years beginning on or after January 1, 2015. *See* section 1251 of the Affordable Care Act, as amended by section 10103 of the Affordable Care Act and section 2301 of the Health Care and Education Reconciliation Act, and its implementing regulations 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.

[T.D. 9656, 79 FR 10306, Feb. 24, 2014, as amended by T.D. 9671, 79 FR 35947, June 25, 2014]

§ 54.9815–2711 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 essential health benefits for any individual, whether provided in-network or out-of-network.

(2) *Annual limits*—(i) *General rule*. Except as provided in paragraphs (a)(2)(ii) and (b) 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 essential health benefits for any individual, whether provided in-network or out-of-network.

(ii) *Exception for health flexible spending arrangements*. A health flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code) offered through a cafeteria plan pursuant to section 125 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. For the purpose of this section, a group health plan or a health insurance issuer that is not required to provide essential health benefits under section 1302(b) must define ''essential health benefits'' in a

manner that is consistent with the following:

(1) For plan years beginning before January 1, 2020, one of the EHB-benchmark plans applicable in a State under 45 CFR 156.110, and including coverage of any additional required benefits that are considered essential health benefits consistent with 45 CFR 155.170(a)(2), or one of the three Federal Employees Health Benefits Program (FEHBP) plan options as defined by 45 CFR 156.100(a)(3), supplemented as necessary, to satisfy the standards in 45 CFR 156.110; or

(2) For plan years beginning on or after January 1, 2020, an EHB-benchmark plan selected by a State in accordance with the available options and requirements for EHB-benchmark plan selection at 45 CFR 156.111, including an EHB-benchmark plan in a State that takes no action to change its EHB-benchmark plan and thus retains the EHB-benchmark plan applicable in that State for the prior year in accordance with 45 CFR 156.111(d)(1), and including coverage of any additional required benefits that are considered essential health benefits consistent with 45 CFR 155.170(a)(2).

(d) *Health reimbursement arrangements (HRAs) and other account-based group health plans*—(1) *In general.* If an HRA or other account-based group health plan is integrated with another group health plan or individual health insurance coverage and the other group health plan or individual health insurance coverage, as applicable, separately is subject to and satisfies the requirements in PHS Act section 2711 and paragraph (a)(2) of this section, the fact that the benefits under the HRA or other account-based group health plan are limited does not cause the HRA or other account-based group health plan to fail to satisfy the requirements of PHS Act section 2711 and paragraph (a)(2) of this section. Similarly, if an HRA or other account-based group health plan is integrated with another group health plan or individual health insurance coverage and the other group health plan or individual health insurance coverage, as applicable, separately is subject to and satisfies the requirements in PHS Act section 2713 and § 54.9815–2713(a)(1) of this chapter, the fact that the benefits under the HRA or other account-based group health plan are limited does not cause the HRA or other account-based group health plan to fail to satisfy the requirements of PHS Act section 2713 and § 54.9815–2713(a)(1) of this chapter. For the purpose of this paragraph (d), all individual health insurance coverage, except for coverage that consists solely of excepted benefits, is treated as being subject to and complying with PHS Act sections 2711 and 2713.

(2) *Requirements for an HRA or other account-based group health plan to be integrated with another group health plan.* An HRA or other account-based group health plan is integrated with another group health plan for purposes of PHS Act section 2711 and paragraph (a)(2) of this section if it satisfies the requirements under one of the integration methods set forth in paragraph (d)(2)(i) or (ii) of this section. For purposes of the integration methods under which an HRA or other account-based group health plan is integrated with another group health plan, integration does not require that the HRA or other account-based group health plan and the other group health plan with which it is integrated share the same plan sponsor, the same plan document or governing instruments, or file a single Form 5500, if applicable. An HRA or other account-based group health plan integrated with another group health plan for purposes of PHS Act section 2711 and paragraph (a)(2) of this section may not be used to purchase individual health insurance coverage unless that coverage consists solely of excepted benefits, as defined in 45 CFR 148.220.

(i) *Method for integration with a group health plan: Minimum value not required.* An HRA or other account-based group health plan is integrated with another group health plan for purposes of this paragraph (d) if:

(A) The plan sponsor offers a group health plan (other than the HRA or other account-based group health plan) to the employee that does not consist solely of excepted benefits;

(B) The employee receiving the HRA or other account-based group health plan is actually enrolled in a group health plan (other than the HRA or other account-based group health plan)

that does not consist solely of excepted benefits, regardless of whether the plan is offered by the same plan sponsor (referred to as non-HRA group coverage);

(C) The HRA or other account-based group health plan is available only to employees who are enrolled in non-HRA group coverage, regardless of whether the non-HRA group coverage is offered by the plan sponsor of the HRA or other account-based group health plan (for example, the HRA may be offered only to employees who do not enroll in an employer's group health plan but are enrolled in other non-HRA group coverage, such as a group health plan maintained by the employer of the employee's spouse);

(D) The benefits under the HRA or other account-based group health plan are limited to reimbursement of one or more of the following—co-payments, co-insurance, deductibles, and premiums under the non-HRA group coverage, as well as medical care expenses that do not constitute essential health benefits as defined in paragraph (c) of this section; and

(E) Under the terms of the HRA or other account-based group health plan, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based group health plan at least annually and, upon termination of employment, either the remaining amounts in the HRA or other account-based group health plan are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based group health plan (see paragraph (d)(3) of this section for additional rules regarding forfeiture and waiver).

(ii) *Method for integration with another group health plan: Minimum value required.* An HRA or other account-based group health plan is integrated with another group health plan for purposes of this paragraph (d) if:

(A) The plan sponsor offers a group health plan (other than the HRA or other account-based group health plan) to the employee that provides minimum value pursuant to section 36B(c)(2)(C)(ii) (and its implementing regulations and applicable guidance);

(B) The employee receiving the HRA or other account-based group health plan is actually enrolled in a group health plan (other than the HRA or other account-based group health plan) that provides minimum value pursuant to section 36B(c)(2)(C)(ii) (and applicable guidance), regardless of whether the plan is offered by the plan sponsor of the HRA or other account-based group health plan (referred to as non-HRA MV group coverage);

(C) The HRA or other account-based group health plan is available only to employees who are actually enrolled in non-HRA MV group coverage, regardless of whether the non-HRA MV group coverage is offered by the plan sponsor of the HRA or other account-based group health plan (for example, the HRA may be offered only to employees who do not enroll in an employer's group health plan but are enrolled in other non-HRA MV group coverage, such as a group health plan maintained by an employer of the employee's spouse); and

(D) Under the terms of the HRA or other account-based group health plan, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based group health plan at least annually, and, upon termination of employment, either the remaining amounts in the HRA or other account-based group health plan are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based group health plan (see paragraph (d)(3) of this section for additional rules regarding forfeiture and waiver).

(3) *Forfeiture.* For purposes of integration under paragraphs (d)(2)(i)(E) and (d)(2)(ii)(D) of this section, forfeiture or waiver occurs even if the forfeited or waived amounts may be reinstated upon a fixed date, a participant's death, or the earlier of the two events (the reinstatement event). For the purpose of this paragraph (d)(3), coverage under an HRA or other account-based group health plan is considered forfeited or waived prior to a reinstatement event only if the participant's election to forfeit or waive is irrevocable, meaning that, beginning on the

effective date of the election and through the date of the reinstatement event, the participant and the participant's beneficiaries have no access to amounts credited to the HRA or other account-based group health plan. This means that upon and after reinstatement, the reinstated amounts under the HRA or other account-based group health plan may not be used to reimburse or pay medical care expenses incurred during the period after forfeiture and prior to reinstatement.

(4) *Requirements for an HRA or other account-based group health plan to be integrated with individual health insurance coverage or Medicare Part A and B or Medicare Part C.* An HRA or other account-based group health plan is integrated with individual health insurance coverage or Medicare Part A and B or Medicare Part C (and treated as complying with PHS Act sections 2711 and 2713) if the HRA or other account-based group health plan satisfies the requirements of § 54.9802–4(c) of this chapter (as modified by § 54.9802–4(e), for HRAs or other account-based group health plans integrated with Medicare Part A and B or Medicare Part C).

(5) *Integration with Medicare Part B and D.* For employers that are not required to offer their non-HRA group health plan coverage to employees who are Medicare beneficiaries, an HRA or other account-based group health plan that may be used to reimburse premiums under Medicare Part B or D may be integrated with Medicare (and deemed to comply with PHS Act sections 2711 and 2713) if the following requirements are satisfied with respect to employees who would be eligible for the employer's non-HRA group health plan but for their eligibility for Medicare (and the integration rules under paragraphs (d)(2)(i) and (ii) of this section continue to apply to employees who are not eligible for Medicare):

(i) The plan sponsor offers a group health plan (other than the HRA or other account-based group health plan and that does not consist solely of excepted benefits) to employees who are not eligible for Medicare;

(ii) The employee receiving the HRA or other account-based group health plan is actually enrolled in Medicare Part B or D;

(iii) The HRA or other account-based group health plan is available only to employees who are enrolled in Medicare Part B or D; and

(iv) The HRA or other account-based group health plan complies with paragraphs (d)(2)(i)(E) and (d)(2)(ii)(D) of this section.

(6) *Definitions.* The following definitions apply for purposes of this section.

(i) *Account-based group health plan.* An account-based group health plan is an employer-provided group health plan that provides reimbursements of medical care expenses with the reimbursement subject to a maximum fixed dollar amount for a period. An HRA is a type of account-based group health plan. An account-based group health plan does not include a qualified small employer health reimbursement arrangement, as defined in section 9831(d)(2).

(ii) *Medical care expenses.* Medical care expenses means expenses for medical care as defined under section 213(d).

(e) *Applicability date.* The provisions of this section are applicable to group health plans and health insurance issuers for plan years beginning on or after January 1, 2020. Until the applicability date for this section, plans and issuers are required to continue to comply with the corresponding sections of 26 CFR part 54, contained in the 26 CFR, subchapter D, revised as of April 1, 2018.

[T.D. 9744, 80 FR 72243, Nov. 18, 2015, as amended by T.D. 9791, 81 FR 75324, Oct. 31, 2016; T.D. 9867, 84 FR 28997, June 20, 2019]

§ 54.9815–2712 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 makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage. A group health plan, or a health insurance issuer offering group health insurance coverage, must provide at least 30 days advance written notice to each participant who would be affected before coverage may be rescinded under this paragraph (a)(1), regardless of whether the coverage is insured or self-insured, or whether the rescission applies to an entire group or only to an individual within the group. (The rules of this paragraph (a)(1) apply regardless of any contestability period that may otherwise apply.)

(2) For purposes of this section, a rescission is a cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats a policy as void from the time of the individual's or group's enrollment is a rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a rescission for this purpose. A cancellation or discontinuance of coverage is not a rescission if—

(i) The cancellation or discontinuance of coverage has only a prospective effect;

(ii) The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions (including COBRA premiums) towards the cost of coverage;

(iii) The cancellation or discontinuance of coverage is initiated by the individual (or by the individual's authorized representative) and the sponsor, employer, plan, or issuer does not, directly or indirectly, take action to influence the individual's decision to cancel or discontinue coverage retroactively or otherwise take any adverse action or retaliate against, interfere with, coerce, intimidate, or threaten the individual; or

(iv) The cancellation or discontinuance of coverage is initiated by the Exchange pursuant to 45 CFR 155.430 (other than under paragraph (b)(2)(iii)).

(3) The rules of this paragraph (a) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *A* seeks enrollment in an insured group health plan. The plan terms permit rescission of coverage with respect to an individual if the individual engages in fraud or makes an intentional misrepresentation of a material fact. The plan requires *A* to complete a questionnaire regarding *A*'s prior medical history, which affects setting the group rate by the health insurance issuer. The questionnaire complies with the other requirements of this part. The questionnaire includes the following question: ''Is there anything else relevant to your health that we should know?'' *A* inadvertently fails to list that *A* visited a psychologist on two occasions, six years previously. *A* is later diagnosed with breast cancer and seeks benefits under the plan. On or around the same time, the issuer receives information about *A*'s visits to the psychologist, which was not disclosed in the questionnaire.

(ii) *Conclusion.* In this *Example 1*, the plan cannot rescind *A*'s coverage because *A*'s failure to disclose the visits to the psychologist was inadvertent. Therefore, it was not fraudulent or an intentional misrepresentation of material fact.

Example 2. (i) *Facts.* An employer sponsors a group health plan that provides coverage for employees who work at least 30 hours per week. Individual *B* has coverage under the plan as a full-time employee. The employer reassigns *B* to a part-time position. Under the terms of the plan, *B* is no longer eligible for coverage. The plan mistakenly continues to provide health coverage, collecting premiums from *B* and paying claims submitted by *B*. After a routine audit, the plan discovers that *B* no longer works at least 30 hours per week. The plan rescinds *B*'s coverage effective as of the date that *B* changed from a full-time employee to a part-time employee.

(ii) *Conclusion.* In this *Example 2*, the plan cannot rescind *B*'s coverage because there was no fraud or an intentional misrepresentation of material fact. The plan may cancel coverage for *B* prospectively, subject to other applicable Federal and State laws.

(b) *Compliance with other requirements.* Other requirements of Federal or State law may apply in connection with a rescission of coverage.

(c) *Applicability date.* The provisions of this section are applicable to group health plans and health insurance issuers for plan years beginning on or after January 1, 2017. Until the applicability date for this regulation, plans and issuers are required to continue to comply with the interim final regulations promulgated by the Department of Labor at 29 CFR part 2590, contained

in the 29 CFR, parts 1927 to end, edition revised as of July 1, 2015.

[T.D. 9744, 80 FR 72244, Nov. 18, 2015]

§ 54.9815–2713 Coverage of preventive health services.

(a) *Services*—(1) *In general.* Beginning at the time described in paragraph (b) of this section and subject to § 54.9815–2713A, a group health plan, or a health insurance issuer offering group health insurance coverage, must provide coverage for and must not impose any cost-sharing requirements (such as a copayment, coinsurance, or a deductible) for—

(i) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved (except as otherwise provided in paragraph (c) of this section);

(ii) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);

(iii) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

(iv) With respect to women, such additional preventive care and screenings not described in paragraph (a)(1)(i) of this section as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of section 2713(a)(4) of the Public Health Service Act, subject to 45 CFR 147.131, 147.132, and 147.133.

(2) *Office visits*—(i) If an item or service described in paragraph (a)(1) of this section is billed separately (or is tracked as individual encounter data separately) from an office visit, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

(ii) If an item or service described in paragraph (a)(1) of this section is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then a plan or issuer may not impose cost-sharing requirements with respect to the office visit.

(iii) If an item or service described in paragraph (a)(1) of this section is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

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

Example 1. (i) *Facts.* An individual covered by a group health plan visits an in-network health care provider. While visiting the provider, the individual is screened for cholesterol abnormalities, which has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual. The provider bills the plan for an office visit and for the laboratory work of the cholesterol screening test.

(ii) *Conclusion.* In this *Example 1*, the plan may not impose any cost-sharing requirements with respect to the separately-billed laboratory work of the cholesterol screening test. Because the office visit is billed separately from the cholesterol screening test, the plan may impose cost-sharing requirements for the office visit.

Example 2. (i) *Facts.* Same facts as *Example 1* of this section. As the result of the screening, the individual is diagnosed with hyperlipidemia and is prescribed a course of treatment that is not included in the recommendations under paragraph (a)(1) of this section.

(ii) *Conclusion.* In this *Example 2*, because the treatment is not included in the recommendations under paragraph (a)(1) of this

section, the plan is not prohibited from imposing cost-sharing requirements with respect to the treatment.

Example 3. (i) *Facts.* An individual covered by a group health plan visits an in-network health care provider to discuss recurring abdominal pain. During the visit, the individual has a blood pressure screening, which has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual. The provider bills the plan for an office visit.

(ii) *Conclusion.* In this *Example 3,* the blood pressure screening is provided as part of an office visit for which the primary purpose was not to deliver items or services described in paragraph (a)(1) of this section. Therefore, the plan may impose a cost-sharing requirement for the office visit charge.

Example 4. (i) *Facts.* A child covered by a group health plan visits an in-network pediatrician to receive an annual physical exam described as part of the comprehensive guidelines supported by the Health Resources and Services Administration. During the office visit, the child receives additional items and services that are not described in the comprehensive guidelines supported by the Health Resources and Services Administration, nor otherwise described in paragraph (a)(1) of this section. The provider bills the plan for an office visit.

(ii) *Conclusion.* In this *Example 4,* the service was not billed as a separate charge and was billed as part of an office visit. Moreover, the primary purpose for the visit was to deliver items and services described as part of the comprehensive guidelines supported by the Health Resources and Services Administration. Therefore, the plan may not impose a cost-sharing requirement with respect to the office visit.

(3) *Out-of-network providers.* (i) Subject to paragraph (a)(3)(ii) of this section, 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.

(ii) If a plan or issuer does not have in its network a provider who can provide an item or service described in paragraph (a)(1) of this section, the plan or issuer must cover the item or service when performed by an out-of-network provider, and may not impose cost-sharing with respect to the item or service.

(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 relevant recommendation or guideline. To the extent not specified in a recommendation or guideline, a plan or issuer may rely on the relevant clinical evidence base and established reasonable medical management techniques to determine the frequency, method, treatment, or setting for coverage of a recommended preventive health service.

(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.* (i) A plan or issuer that is required to provide coverage for any items and services specified in any recommendation or guideline described in paragraph (a)(1) of this section on the first day of a plan year must provide coverage through the last day of the plan year, even if the recommendation

or guideline changes is or is no longer described in paragraph (a)(1) of this section, during the plan year.

(ii) Notwithstanding paragraph (b)(2)(i) of this section, to the extent a recommendation or guideline described in paragraph (a)(1)(i) of this section that was in effect on the first day of a plan year is downgraded to a ''D'' rating, or any item or service associated with any recommendation or guideline specified in paragraph (a)(1) of this section is subject to a safety recall or is otherwise determined to pose a significant safety concern by a federal agency authorized to regulate the item or service during a plan year, there is no requirement under this section to cover these items and services through the last day of the plan year.

(c) *Recommendations not current.* For purposes of paragraph (a)(1)(i) of this section, and for purposes of any other provision of law, recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current.

(d) *Effective/applicability date.* April 16, 2012.

[T.D. 9578, 77 FR 8729, Feb. 15, 2012, as amended by T.D. 9624, 78 FR 39892, July 2, 2013; T.D. 9726, 80 FR 41342, July 14, 2015; T.D. 9827, 82 FR 47828, Oct. 13, 2017; T.D. 9840, 83 FR 57586, Nov. 15, 2018; T.D. 9841, 83 FR 57630, Nov. 15, 2018]

§ 54.9815–2713T Coverage of preventive health services (temporary).

(a) *Services*—(1) *In general.* Beginning at the time described in paragraph (b) of this section and subject to § 54.9815–2713A, a group health plan, or a health insurance issuer offering group health insurance coverage, must provide coverage for and must not impose any cost-sharing requirements (such as a copayment, coinsurance, or a deductible) for—

(i) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved (except as otherwise provided in paragraph (c) of this section);

(ii) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for purposes of this paragraph (a)(1)(ii), a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);

(iii) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration;

(iv) With respect to women, such additional preventive care and screenings not described in paragraph (a)(1)(i) of this section as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of section 2713(a)(4) of the Public Health Service Act, subject to 45 CFR 147.131, 147.132, and 147.133; and

(v) Any qualifying coronavirus preventive service, which means an item, service, or immunization that is intended to prevent or mitigate coronavirus disease 2019 (COVID–19) and that is, with respect to the individual involved—

(A) An evidence-based item or service that has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; or

(B) An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (regardless of whether the immunization is recommended for routine use). For purposes of this paragraph (a)(1)(v)(B), a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after

it has been adopted by the Director of the Centers for Disease Control and Prevention.

(2) *Office visits.* (i) If an item or service described in paragraph (a)(1) of this section is billed separately (or is tracked as individual encounter data separately) from an office visit, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

(ii) If an item or service described in paragraph (a)(1) of this section is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then a plan or issuer may not impose cost-sharing requirements with respect to the office visit.

(iii) If an item or service described in paragraph (a)(1) of this section is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

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

(A) *Example 1—(1) Facts.* An individual covered by a group health plan visits an in-network health care provider. While visiting the provider, the individual is screened for cholesterol abnormalities, which has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual. The provider bills the plan for an office visit and for the laboratory work of the cholesterol screening test.

(*2*) *Conclusion.* In paragraph (a)(2)(iv)(A)(*1*) of this section, the plan may not impose any cost-sharing requirements with respect to the separately-billed laboratory work of the cholesterol screening test. Because the office visit is billed separately from the cholesterol screening test, the plan may impose cost-sharing requirements for the office visit.

(B) *Example 2—(1) Facts.* Same facts as in paragraph (a)(2)(iv)(A)(*1*) of this section (*Example 1*). As the result of the screening, the individual is diagnosed with hyperlipidemia and is prescribed a course of treatment that is not included in the recommendations under paragraph (a)(1) of this section.

(*2*) *Conclusion.* In paragraph (a)(2)(iv)(B)(*1*) of this section, 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.

(C) *Example 3—(1) 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.

(*2*) *Conclusion.* In paragraph (a)(2)(iv)(C)(*1*) of this section, 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.

(D) *Example 4—(1) 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.

(*2*) *Conclusion.* In paragraph (a)(2)(iv)(D)(*1*) of this section, 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.* (i) Subject to paragraphs (a)(3)(ii) and (iii) of this section, 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, or 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.

(ii) If a plan or issuer does not have in its network a provider who can provide an item or service described in paragraph (a)(1) of this section, the plan or issuer must cover the item or service when performed by an out-of-network provider, and may not impose cost-sharing with respect to the item or service.

(iii) A plan or issuer must provide coverage for and must not impose any cost-sharing requirements (such as a copayment, coinsurance, or a deductible) for any qualifying coronavirus preventive service described in paragraph (a)(1)(v) of this section, regardless of whether such service is delivered by an in-network or out-of-network provider. For purposes of this paragraph (a)(3)(iii), with respect to a qualifying coronavirus preventive service and a provider with whom the plan or issuer does not have a negotiated rate for such service (such as an out-of-network provider), the plan or issuer must reimburse the provider for such service in an amount that is reasonable, as determined in comparison to prevailing market rates for such service.

(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 relevant recommendation or guideline. To the extent not specified in a recommendation or guideline, a plan or issuer may rely on the relevant clinical evidence base and established reasonable medical management techniques to determine the frequency, method, treatment, or setting for coverage of a recommended preventive health service.

(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, except as provided in paragraph (b)(3) of this section.

(2) *Changes in recommendations or guidelines.* (i) A plan or issuer that is required to provide coverage for any items and services specified in any recommendation or guideline described in paragraph (a)(1) of this section on the first day of a plan year, or as otherwise provided in paragraph (b)(3) of this section, must provide coverage through the last day of the plan or policy year, even if the recommendation or guideline changes or is no longer described in paragraph (a)(1) of this section, during the applicable plan or policy year.

(ii) Notwithstanding paragraph (b)(2)(i) of this section, to the extent a recommendation or guideline described in paragraph (a)(1)(i) of this section that was in effect on the first day of a plan year, or as otherwise provided in paragraph (b)(3) of this section, is downgraded to a ''D'' rating, or any item or service associated with any

recommendation or guideline specified in paragraph (a)(1) of this section is subject to a safety recall or is otherwise determined to pose a significant safety concern by a Federal agency authorized to regulate the item or service during a plan or policy year, there is no requirement under this section to cover these items and services through the last day of the applicable plan or policy year.

(3) *Rapid coverage of preventive services for coronavirus.* In the case of a qualifying coronavirus preventive service described in paragraph (a)(1)(v) of this section, a plan or issuer must provide coverage for such item, service, or immunization in accordance with this section by the date that is 15 business days after the date on which a recommendation specified in paragraph (a)(1)(v)(A) or (B) of this section is made relating to such item, service, or immunization.

(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 paragraphs (a)(1)(i) through (iv), (a)(2), (a)(3)(i) and (ii), (a)(4) through (5), (b)(1) and (2), and (c) of this section are applicable as of April 16, 2012.

(e) *Sunset date.* The provisions of paragraphs (a)(1)(v), (a)(3)(iii), and (b)(3) of this section will not apply with respect to a qualifying coronavirus preventive service furnished on or after the expiration of the public health emergency determined on January 31, 2020, to exist nationwide as of January 27, 2020, by the Secretary of Health and Human Services pursuant to section 319 of the Public Health Service Act, as a result of COVID–19, including any subsequent renewals of that determination.

[T.D. 9931, 85 FR 71193, Nov. 6, 2020]

§ 54.9815–2713A Accommodations in connection with coverage of preventive health services.

(a) *Eligible organizations for optional accommodation.* An eligible organization is an organization that meets the criteria of paragraphs (a)(1) through (4) of this section.

(1) The organization is an objecting entity described in 45 CFR 147.132(a)(1)(i) or (ii), or 45 CFR 147.133(a)(1)(i) or (ii);

(2) Notwithstanding its status under paragraph (a)(1) of this section and under 45 CFR 147.132(a) or 147.133(a), the organization voluntarily seeks to be considered an eligible organization to invoke the optional accommodation under paragraph (b) or (c) of this section as applicable; and

(3) [Reserved]

(4) The organization self-certifies in the form and manner specified by the Secretary of Labor or provides notice to the Secretary of the Department of Health and Human Services as described in paragraph (b) or (c) of this section. To qualify as an eligible organization, the organization must make such self-certification or notice 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 or notice must be executed by a person authorized to make the certification or provide the notice on behalf of the organization, and must be maintained in a manner consistent with the record retention requirements under section 107 of ERISA.

(5) An eligible organization may revoke its use of the accommodation process, and its issuer or third party administrator must provide participants and beneficiaries written notice of such revocation, as specified herein.

(i) *Transitional rule*—If contraceptive coverage is being offered on the date on which these final rules go into effect, by an issuer or third party administrator through the accommodation process, an eligible organization may give 60-days notice pursuant to section 2715(d)(4) of the PHS Act and § 54.9815–2715(b), if applicable, to revoke its use of the accommodation process (to allow for the provision of notice to plan participants in cases where contraceptive benefits will no longer be provided). Alternatively, such eligible organization may revoke its use of the accommodation process effective on the first day of the first plan year that

begins on or after 30 days after the date of the revocation.

(ii) *General rule*—In plan years that begin after the date on which these final rules go into effect, if contraceptive coverage is being offered by an issuer or third party administrator through the accommodation process, an eligible organization's revocation of use of the accommodation process will be effective no sooner than the first day of the first plan year that begins on or after 30 days after the date of the revocation.

(b) *Optional accommodation—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 may voluntarily elect an optional accommodation under which its third party administrator(s) will provide or arrange payments for all or a subset of contraceptive services for one or more plan years. To invoke the optional accommodation process:

(i) The eligible organization or its plan must contract with one or more third party administrators.

(ii) The eligible organization must provide either a copy of the self-certification to each third party administrator or a notice to the Secretary of the Department of Health and Human Services that it is an eligible organization and of its objection as described in 45 CFR 147.132 or 147.133 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 29 CFR 2510.3–16 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; a statement that it objects as described in 45 CFR 147.132 or 147.133 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), but that it would like to elect the optional accommodation process; the plan name and type (that is, 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 section 3(33) of ERISA); and the name and contact information for any of the plan's third party administrators. If there is a change in any of the information required to be included in the notice, the eligible organization must provide updated information to the Secretary of the Department of Health and Human Services for the optional accommodation process to remain in effect. The Department of Labor (working with the Department of Health and Human Services) will send a separate notification to each of the plan's third party administrators informing the third party administrator that the Secretary of the Department 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 29 CFR 2510.3–16 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 is willing to enter into or remain in a contractual relationship with the eligible organization or its plan to provide administrative services for the plan, then the third party administrator will provide or arrange payments for contraceptive services, using one of the following methods—

(i) Provide payments for the contraceptive services for plan participants and beneficiaries without imposing any cost-sharing requirements (such as a copayment, coinsurance, or a deductible), 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 the contraceptive services for plan participants and beneficiaries without imposing any cost-sharing requirements (such as a copayment, coinsurance, or a deductible), 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.

(5) Where an otherwise eligible organization does not contract with a third party administrator and files a self-certification or notice under paragraph (b)(1)(ii) of this section, the obligations under paragraph (b)(2) of this section do not apply, and the otherwise eligible organization is under no requirement to provide coverage or payments for contraceptive services to which it objects. The plan administrator for that otherwise eligible organization may, if it and the otherwise eligible organization choose, arrange for payments for contraceptive services from an issuer or other entity in accordance with paragraph (b)(2)(ii) of this section, and such issuer or other entity may receive reimbursements in accordance with paragraph (b)(3) of this section.

(6) Where an otherwise eligible organization is an ERISA-exempt church plan within the meaning of section 3(33) of ERISA and it files a self-certification or notice under paragraph (b)(1)(ii) of this section, the obligations under paragraph (b)(2) of this section do not apply, and the otherwise eligible organization is under no requirement to provide coverage or payments for contraceptive services to which it objects. The third party administrator for that otherwise eligible organization may, if it and the otherwise eligible organization choose, provide or arrange payments for contraceptive services in accordance with paragraphs (b)(2)(i) or (ii) of this section, and receive reimbursements in accordance with paragraph (b)(3) of this section.

(c) *Optional accommodation—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 may voluntarily elect an optional accommodation under which its health insurance issuer(s) will provide payments for all or a subset of contraceptive services for one or more plan years. To invoke the optional accommodation process—

(i) The eligible organization or its plan must contract with one or more health insurance issuers.

(ii) The eligible organization must provide either a copy of the self-certification to each issuer providing coverage in connection with the plan or a notice to the Secretary of the Department of Health and Human Services that it is an eligible organization and of its objection as described in 45 CFR 147.132 or 147.133 to coverage for all or a subset of contraceptive services.

(A) When a self-certification is provided directly to an issuer, the issuer has sole responsibility for providing such coverage in accordance with § 54.9815–2713.

(B) When a notice is provided to the Secretary of the Department Health and Human Services, the notice must include the name of the eligible organization; a statement that it objects as described in 45 CFR 147.132 or 147.133 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) but that it would like to elect the optional accommodation process; the plan name and type (that is, 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 section 3(33) of ERISA); and the name and contact information for any of the plan's health insurance issuers. If there is a change in any of the information required to be included in the notice, the eligible organization must provide updated information to the Secretary of Department of Health and Human

Services for the optional accommodation process to remain in effect. 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 the Department Health and Human Services has received a notice under paragraph (c)(2)(ii) of this section and describing the obligations of the issuer under this section.

(2) If an issuer receives a copy of the self-certification from an eligible organization or the notification from the Department of Health and Human Services as described in paragraph (c)(2)(ii) of this section and does not have its own objection as described in 45 CFR 147.132 or 147.133 to providing the contraceptive services to which the eligible organization objects, then the issuer will provide payments for contraceptive services as follows—

(i) The issuer must expressly exclude contraceptive coverage from the group health insurance coverage provided in connection with the group health plan and provide separate payments for any contraceptive services required to be covered under § 54.9815–2713(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 9815 of the PHS Act. 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 § 54.9815–2713(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.

(3) A health insurance issuer may not require any documentation other than a copy of the self-certification from the eligible organization or the notification from the Department of Health and Human Services described in paragraph (c)(1)(ii) of this section.

(d) *Notice of availability of separate payments for contraceptive services—self-insured and insured group health plans.* For each plan year to which the optional 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 or arranges 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 applicable requirement under § 54.9815–2713(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 applicable requirement under § 54.9815–2713(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.

(f) *Definition*. For the purposes of this section, reference to ''contraceptive'' services, benefits, or coverage includes contraceptive or sterilization items, procedures, or services, or related patient education or counseling, to the extent specified for purposes of § 54.9815–2713(a)(1)(iv).

(g) *Severability*. Any provision of this section held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to continue to give maximum effect to the provision permitted by law, unless such holding shall be one of utter invalidity or unenforceability, in which event the provision shall be severable from this section and shall not affect the remainder thereof or the application of the provision to persons not similarly situated or to dissimilar circumstances.

[T.D. 9840, 83 FR 57586, Nov. 15, 2018, as amended by T.D. 9841, 83 FR 57630, Nov. 15, 2018]

§ 54.9815–2714 Eligibility of children until at least age 26.

(a) *In general*—(1) A group health plan, or a health insurance issuer offering group health insurance coverage, that makes available dependent coverage of children must make such coverage available for children until attainment of 26 years of age.

(2) The rule of this paragraph (a) is illustrated by the following example:

Example. (i) *Facts*. For the plan year beginning January 1, 2011, a group health plan provides health coverage for employees, employees' spouses, and employees' children until the child turns 26. On the birthday of a child of an employee, July 17, 2011, the child turns 26. The last day the plan covers the child is July 16, 2011.

(ii) *Conclusion*. In this *Example*, the plan satisfies the requirement of this paragraph (a) with respect to the child.

(b) *Restrictions on plan definition of dependent*—(1) *In general*. With respect to a child who has not attained age 26, a plan or issuer may not define dependent for purposes of eligibility for dependent coverage of children other than in terms of a relationship between a child and the participant. Thus, for example, a plan or issuer may not deny or restrict dependent coverage for a child who has not attained age 26 based on the presence or absence of the child's financial dependency (upon the participant or any other person); residency with the participant or with any other person; whether the child lives, works, or resides in an HMO's service area or other network service area; marital status; student status; employment; eligibility for other coverage; or any combination of those factors. (Other requirements of Federal or State law, including section 609 of ERISA or section 1908 of the Social Security Act, may require coverage of certain children.)

(2) *Construction*. A plan or issuer will not fail to satisfy the requirements of this section if the plan or issuer limits dependent child coverage to children

under age 26 who are described in section 152(f)(1) . For an individual not described in section 152(f)(1), such as a grandchild or niece, a plan may impose additional conditions on eligibility for dependent child health coverage, such as a condition that the individual be a dependent for income tax purposes.

(c) *Coverage of grandchildren not required*. Nothing in this section requires a plan or issuer to make coverage available for the child of a child receiving dependent coverage.

(d) *Uniformity irrespective of age*. The terms of the plan or health insurance coverage providing dependent coverage of children cannot vary based on age (except for children who are age 26 or older).

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

Example 1. (i) *Facts*. A group health plan offers a choice of self-only or family health coverage. Dependent coverage is provided under family health coverage for children of participants who have not attained age 26. The plan imposes an additional premium surcharge for children who are older than age 18.

(ii) *Conclusion*. In this *Example 1*, the plan violates the requirement of paragraph (d) of this section because the plan varies the terms for dependent coverage of children based on age.

Example 2. (i) *Facts*. A group health plan offers a choice among the following tiers of health coverage: Self-only, self-plus-one, self-plus-two, and self-plus-three-or-more. The cost of coverage increases based on the number of covered individuals. The plan provides dependent coverage of children who have not attained age 26.

(ii) *Conclusion*. In this *Example 2*, the plan does not violate the requirement of paragraph (d) of this section that the terms of dependent coverage for children not vary based on age. Although the cost of coverage increases for tiers with more covered individuals, the increase applies without regard to the age of any child.

Example 3. (i) *Facts*. A group health plan offers two benefit packages—an HMO option and an indemnity option. Dependent coverage is provided for children of participants who have not attained age 26. The plan limits children who are older than age 18 to the HMO option.

(ii) *Conclusion*. In this *Example 3*, the plan violates the requirement of paragraph (d) of this section because the plan, by limiting children who are older than age 18 to the HMO option, varies the terms for dependent coverage of children based on age.

Example 4. (i) *Facts*. A group health plan sponsored by a large employer normally charges a copayment for physician visits that do not constitute preventive services. The plan charges this copayment to individuals age 19 and over, including employees, spouses, and dependent children, but waives it for those under age 19.

(ii) *Conclusion*. In this *Example 4*, 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. While the requirement of paragraph (d) of this section generally prohibits distinctions based upon age in dependent coverage of children, it does not prohibit distinctions based upon age that apply to all coverage under the plan, including coverage for employees and spouses as well as dependent children. In this *Example 4*, the copayments charged to dependent children are the same as those charged to employees and spouses. Accordingly, the arrangement described in this *Example 4* (including waiver, for individuals under age 19, of the generally applicable copayment) does not violate the requirement of paragraph (d) of this section.

(f) *Applicability date*. The provisions of this section are applicable to group health plans and health insurance issuers for plan years beginning on or after January 1, 2017. Until the applicability date for this regulation, plans and issuers are required to continue to comply with the interim final regulations promulgated by the Department of Labor at 29 CFR part 2590, contained in the 29 CFR, parts 1927 to end, edition revised as of July 1, 2015.

[T.D. 9744, 80 FR 72245, Nov. 18, 2015]

§ 54.9815–2715 Summary of benefits and coverage and uniform glossary.

(a) *Summary of benefits and coverage*—(1) *In general*. A group health plan (and its administrator as defined in section 3(16)(A) of ERISA)), and a health insurance issuer offering group health insurance coverage, is required to provide a written summary of benefits and coverage (SBC) for each benefit package without charge to entities and individuals described in this paragraph (a)(1) in accordance with the rules of this section.

(i) *SBC provided by a group health insurance issuer to a group health plan*—(A) *Upon application*. A health insurance issuer offering group health insurance coverage must provide the SBC to

a group health plan (or its sponsor) upon application for health coverage, as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application. If an SBC was provided before application pursuant to paragraph (a)(1)(i)(D) 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:

(*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, 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 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 the rules of 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 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.

(D) *Special enrollees.* The plan or issuer must provide the SBC to special enrollees (as described in § 54.9801–6) no later than the date by which a summary plan description is required to be provided under the timeframe set forth in ERISA section 104(b)(1)(A) and its implementing regulations, which is 90 days from enrollment.

(E) *Upon renewal, 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, 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.

(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)(iii) of this section, the SBC must include the following:

(A) Uniform definitions of standard insurance terms and medical terms so that consumers may compare health coverage and understand the terms of (or exceptions to) their coverage, in accordance with guidance as specified by the Secretary;

(B) A description of the coverage, including cost sharing, for each category of benefits identified by the Secretary in guidance;

(C) The exceptions, reductions, and limitations of the coverage;

(D) The cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations;

(E) The renewability and continuation of coverage provisions;

(F) Coverage examples, in accordance with 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 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;

(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 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.* (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.

(*1*) In accordance with the Department of Labor's disclosure regulations at 29 CFR 2520.104b–1;

(*2*) In connection with online enrollment or online renewal of coverage under the plan; or

(*3*) In response to an online request made by a participant or beneficiary for the SBC.

(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 29 CFR 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 co-payment, medically necessary, network, non-preferred provider, out-of-network co-insurance, out-of-network co-payment, out-of-pocket limit, physician services, plan, preauthorization, preferred provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, reconstructive surgery, rehabilitation services, skilled nursing care, specialist, usual customary and reasonable (UCR), and urgent care; and

(ii) Such other terms as the Secretary determines are important to define so that individuals and employers may compare and understand the terms of coverage and medical benefits (including any exceptions to those benefits), as specified in guidance.

(3) *Appearance.* A group health plan, and a health insurance issuer, must provide the uniform glossary with the appearance specified by the Secretary in guidance to ensure the uniform glossary is presented in a uniform format and uses terminology understandable by the average plan enrollee.

(4) *Form and manner.* A plan or issuer must make the uniform glossary described in this paragraph (c) available upon request, in either paper or electronic form (as requested), within seven business days after receipt of the request.

(d) *Preemption.* State laws that 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 section 4980D of the Code.

(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 42 U.S.C. Chapter 7, Subchapter XVIII, Part C.

(g) *Applicability date.* (1) This section is applicable to group health plans and group health insurance issuers in accordance with this paragraph (g). (See 29 CFR 2590.715–1251(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 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.

[T.D. 9724, 80 FR 34304, June 16, 2015]

§ 54.9815–2715A1 Transparency in coverage—definitions.

(a) *Scope and definitions*—(1) *Scope*. This section sets forth definitions for the price transparency requirements for group health plans and health insurance issuers offering group health insurance coverage established in this section and §§ 54.9815–2715A2 and 54.9815–2715A3.

(2) *Definitions*. For purposes of this section and §§ 54.9815–2715A2 and 54.9815–2715A3, the following definitions apply:

(i) *Accumulated amounts* means:

(A) The amount of financial responsibility a participant or beneficiary has incurred at the time a request for cost-sharing information is made, with respect to a deductible or out-of-pocket limit. If an individual is enrolled in other than self-only coverage, these accumulated amounts shall include the financial responsibility a participant or beneficiary has incurred toward meeting his or her individual deductible or out-of-pocket limit, as well as the amount of financial responsibility that all the individuals enrolled under the plan or coverage have incurred, in aggregate, toward meeting the other than self-only deductible or out-of-pocket limit, as applicable. Accumulated amounts include any expense that counts toward a deductible or out-of-pocket limit (such as a copayment or coinsurance), but exclude any expense that does not count toward a deductible or out-of-pocket limit (such as any premium payment, out-of-pocket expense for out-of-network services, or amount for items or services not covered under the group health plan or health insurance coverage); and

(B) To the extent a group health plan or health insurance issuer imposes a cumulative treatment limitation on a particular covered item or service (such as a limit on the number of items, days, units, visits, or hours covered in a defined time period) independent of individual medical necessity determinations, the amount that has accrued toward the limit on the item or service (such as the number of items, days, units, visits, or hours the participant or beneficiary, has used within that time period).

(ii) *Beneficiary* has the meaning given the term under section 3(8) of the Employee Retirement Income Security Act of 1974 (ERISA).

(iii) *Billed charge* means the total charges for an item or service billed to a group health plan or health insurance issuer by a provider.

(iv) *Billing code* means the code used by a group health plan or health insurance issuer or provider to identify health care items or services for purposes of billing, adjudicating, and paying claims for a covered item or service, including the Current Procedural Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS) code, Diagnosis-Related Group (DRG) code, National Drug Code (NDC), or other common payer identifier.

(v) *Bundled payment arrangement* means a payment model under which a provider is paid a single payment for all covered items and services provided to a participant or beneficiary for a specific treatment or procedure.

(vi) *Copayment assistance* means the financial assistance a participant or beneficiary receives from a prescription drug or medical supply manufacturer towards the purchase of a covered item or service.

(vii) *Cost-sharing liability* means the amount a participant or beneficiary is responsible for paying for a covered item or service under the terms of the group health plan or health insurance coverage. Cost-sharing liability generally includes deductibles, coinsurance, and copayments, but does not include premiums, balance billing amounts by out-of-network providers,

or the cost of items or services that are not covered under a group health plan or health insurance coverage.

(viii) *Cost-sharing information* means information related to any expenditure required by or on behalf of a participant or beneficiary with respect to health care benefits that are relevant to a determination of the participant's or beneficiary's cost-sharing liability for a particular covered item or service.

(ix) *Covered items or services* means those items or services, including prescription drugs, the costs for which are payable, in whole or in part, under the terms of a group health plan or health insurance coverage.

(x) *Derived amount* means the price that a group health plan or health insurance issuer assigns to an item or service for the purpose of internal accounting, reconciliation with providers, or submitting data in accordance with the requirements of 45 CFR 153.710(c).

(xi) *Historical net price* means the retrospective average amount a group health plan or health insurance issuer paid for a prescription drug, inclusive of any reasonably allocated rebates, discounts, chargebacks, fees, and any additional price concessions received by the plan or issuer with respect to the prescription drug. The allocation shall be determined by dollar value for non-product specific and product-specific rebates, discounts, chargebacks, fees, and other price concessions to the extent that the total amount of any such price concession is known to the group health plan or health insurance issuer at the time of publication of the historical net price in a machine-readable file in accordance with § 54.9815–2715A3. However, to the extent that the total amount of any non-product specific and product-specific rebates, discounts, chargebacks, fees, or other price concessions is not known to the group health plan or health insurance issuer at the time of file publication, then the plan or issuer shall allocate such rebates, discounts, chargebacks, fees, and other price concessions by using a good faith, reasonable estimate of the average price concessions based on the rebates, discounts, chargebacks, fees, and other price concessions received over a time period prior to the current reporting period and of equal duration to the current reporting period, as determined under § 54.9815–2715A3(b)(1)(iii)(D)(*3*).

(xii) *In-network provider* means any provider of any item or service with which a group health plan or health insurance issuer, or a third party for the plan or issuer, has a contract setting forth the terms and conditions on which a relevant item or service is provided to a participant or beneficiary.

(xiii) *Items or services* means all encounters, procedures, medical tests, supplies, prescription drugs, durable medical equipment, and fees (including facility fees), provided or assessed in connection with the provision of health care.

(xiv) *Machine-readable file* means a digital representation of data or information in a file that can be imported or read by a computer system for further processing without human intervention, while ensuring no semantic meaning is lost.

(xv) *National Drug Code* means the unique 10- or 11-digit 3-segment number assigned by the Food and Drug Administration, which provides a universal product identifier for drugs in the United States.

(xvi) *Negotiated rate* means the amount a group health plan or health insurance issuer has contractually agreed to pay an in-network provider, including an in-network pharmacy or other prescription drug dispenser, for covered items and services, whether directly or indirectly, including through a third-party administrator or pharmacy benefit manager.

(xvii) *Out-of-network allowed amount* means the maximum amount a group health plan or health insurance issuer will pay for a covered item or service furnished by an out-of-network provider.

(xviii) *Out-of-network provider* means a provider of any item or service that does not have a contract under a participant's or beneficiary's group health plan or health insurance coverage to provide items or services.

(xix) *Out-of-pocket limit* means the maximum amount that a participant or beneficiary is required to pay during a coverage period for his or her share of

the costs of covered items and services under his or her group health plan or health insurance coverage, including for self-only and other than self-only coverage, as applicable.

(xx) *Plain language* means written and presented in a manner calculated to be understood by the average participant or beneficiary.

(xxi) *Prerequisite* means concurrent review, prior authorization, and step-therapy or fail-first protocols related to covered items and services that must be satisfied before a group health plan or health insurance issuer will cover the item or service. The term prerequisite does not include medical necessity determinations generally or other forms of medical management techniques.

(xxii) *Underlying fee schedule rate* means the rate for a covered item or service from a particular in-network provider, or providers that a group health plan or health insurance issuer uses to determine a participant's or beneficiary's cost-sharing liability for the item or service, when that rate is different from the negotiated rate or derived amount.

(b) [Reserved]

[T.D. 9922, 85 FR 72295, Nov. 12, 2020]

§ 54.9815–2715A2 Transparency in coverage—required disclosures to participants and beneficiaries.

(a) *Scope and definitions*—(1) *Scope.* This section establishes price transparency requirements for group health plans and health insurance issuers offering group health insurance coverage for the timely disclosure of information about costs related to covered items and services under a group plan or health insurance coverage.

(2) *Definitions.* For purposes of this section, the definitions in § 54.9815–2715A1 apply.

(b) *Required disclosures to participants and beneficiaries.* At the request of a participant or beneficiary who is enrolled in a group health plan, the plan must provide to the participant or beneficiary the information required under paragraph (b)(1) of this section, in accordance with the method and format requirements set forth in paragraph (b)(2) of this section.

(1) *Required cost-sharing information.* The information required under this paragraph (b)(1) is the following cost-sharing information, which is accurate at the time the request is made, with respect to a participant's or beneficiary's cost-sharing liability for covered items and services:

(i) An estimate of the participant's or beneficiary's cost-sharing liability for a requested covered item or service furnished by a provider or providers that is calculated based on the information described in paragraphs (b)(1)(ii) through (iv) of this section.

(A) If the request for cost-sharing information relates to items and services that are provided within a bundled payment arrangement, and the bundled payment arrangement includes items or services that have a separate cost-sharing liability, the group health plan or health insurance issuer must provide estimates of the cost-sharing liability for the requested covered item or service, as well as an estimate of the cost-sharing liability for each of the items and services in the bundled payment arrangement that have separate cost-sharing liabilities. While group health plans and health insurance issuers are not required to provide estimates of cost-sharing liability for a bundled payment arrangement where the cost-sharing is imposed separately for each item and service included in the bundled payment arrangement, nothing prohibits plans or issuers from providing estimates for multiple items and services in situations where such estimates could be relevant to participants or beneficiaries, as long as the plan or issuer also discloses information about the relevant items or services individually, as required in paragraph (b)(1)(v) of this section.

(B) For requested items and services that are recommended preventive services under section 2713 of the Public Health Service Act (PHS Act), if the group health plan or health insurance issuer cannot determine whether the request is for preventive or non-preventive purposes, the plan or issuer must display the cost-sharing liability that applies for non-preventive purposes. As an alternative, a group health plan or health insurance issuer may allow a participant or beneficiary to request

cost-sharing information for the specific preventive or non-preventive item or service by including terms such as ''preventive'', ''non-preventive'' or ''diagnostic'' as a means to request the most accurate cost-sharing information.

(ii) Accumulated amounts.

(iii) In-network rate, comprised of the following elements, as applicable to the group health plan's or health insurance issuer's payment model:

(A) Negotiated rate, reflected as a dollar amount, for an in-network provider or providers for the requested covered item or service; this rate must be disclosed even if it is not the rate the plan or issuer uses to calculate cost-sharing liability; and

(B) Underlying fee schedule rate, reflected as a dollar amount, for the requested covered item or service, to the extent that it is different from the negotiated rate.

(iv) Out-of-network allowed amount or any other rate that provides a more accurate estimate of an amount a group health plan or health insurance issuer will pay for the requested covered item or service, reflected as a dollar amount, if the request for cost-sharing information is for a covered item or service furnished by an out-of-network provider; provided, however, that in circumstances in which a plan or issuer reimburses an out-of-network provider a percentage of the billed charge for a covered item or service, the out-of-network allowed amount will be that percentage.

(v) If a participant or beneficiary requests information for an item or service subject to a bundled payment arrangement, a list of the items and services included in the bundled payment arrangement for which cost-sharing information is being disclosed.

(vi) If applicable, notification that coverage of a specific item or service is subject to a prerequisite.

(vii) A notice that includes the following information in plain language:

(A) A statement that out-of-network providers may bill participants or beneficiaries for the difference between a provider's billed charges and the sum of the amount collected from the group health plan or health insurance issuer and from the participant or beneficiary in the form of a copayment or coinsurance amount (the difference referred to as balance billing), and that the cost-sharing information provided pursuant to this paragraph (b)(1) does not account for these potential additional amounts. This statement is only required if balance billing is permitted under state law;

(B) A statement that the actual charges for a participant's or beneficiary's covered item or service may be different from an estimate of cost-sharing liability provided pursuant to paragraph (b)(1)(i) of this section, depending on the actual items or services the participant or beneficiary receives at the point of care;

(C) A statement that the estimate of cost-sharing liability for a covered item or service is not a guarantee that benefits will be provided for that item or service;

(D) A statement disclosing whether the plan counts copayment assistance and other third-party payments in the calculation of the participant's or beneficiary's deductible and out-of-pocket maximum;

(E) For items and services that are recommended preventive services under section 2713 of the PHS Act, a statement that an in-network item or service may not be subject to cost-sharing if it is billed as a preventive service if the group health plan or health insurance issuer cannot determine whether the request is for a preventive or non-preventive item or service; and

(F) Any additional information, including other disclaimers, that the group health plan or health insurance issuer determines is appropriate, provided the additional information does not conflict with the information required to be provided by this paragraph (b)(1).

(2) *Required methods and formats for disclosing information to participants and beneficiaries.* The methods and formats for the disclosure required under this paragraph (b) are as follows:

(i) *Internet-based self-service tool.* Information provided under this paragraph (b) must be made available in plain language, without subscription or other fee, through a self-service tool on an internet website that provides real-

time responses based on cost-sharing information that is accurate at the time of the request. Group health plans and health insurance issuers must ensure that the self-service tool allows users to:

(A) Search for cost-sharing information for a covered item or service provided by a specific in-network provider or by all in-network providers by inputting:

(*1*) A billing code (such as CPT code 87804) or a descriptive term (such as ''rapid flu test''), at the option of the user;

(*2*) The name of the in-network provider, if the user seeks cost-sharing information with respect to a specific in-network provider; and

(*3*) Other factors utilized by the plan or issuer that are relevant for determining the applicable cost-sharing information (such as location of service, facility name, or dosage).

(B) Search for an out-of-network allowed amount, percentage of billed charges, or other rate that provides a reasonably accurate estimate of the amount a group health plan or health insurance issuer will pay for a covered item or service provided by out-of-network providers by inputting:

(*1*) A billing code or descriptive term, at the option of the user; and

(*2*) Other factors utilized by the plan or issuer that are relevant for determining the applicable out-of-network allowed amount or other rate (such as the location in which the covered item or service will be sought or provided).

(C) Refine and reorder search results based on geographic proximity of in-network providers, and the amount of the participant's or beneficiary's estimated cost-sharing liability for the covered item or service, to the extent the search for cost-sharing information for covered items or services returns multiple results.

(ii) *Paper method.* Information provided under this paragraph (b) must be made available in plain language, without a fee, in paper form at the request of the participant or beneficiary. In responding to such a request, the group health plan or health insurance issuer may limit the number of providers with respect to which cost-sharing information for covered items and services is provided to no fewer than 20 providers per request. The group health plan or health insurance issuer is required to:

(A) Disclose the applicable provider-per-request limit to the participant or beneficiary;

(B) Provide the cost-sharing information in paper form pursuant to the individual's request, in accordance with the requirements in paragraphs (b)(2)(i)(A) through (C) of this section; and

(C) Mail the cost-sharing information in paper form no later than 2 business days after an individual's request is received.

(D) To the extent participants or beneficiaries request disclosure other than by paper (for example, by phone or email), plans and issuers may provide the disclosure through another means, provided the participant or beneficiary agrees that disclosure through such means is sufficient to satisfy the request and the request is fulfilled at least as rapidly as required for the paper method.

(3) *Special rule to prevent unnecessary duplication*—(i) *Special rule for insured group health plans.* To the extent coverage under a group health plan consists of group health insurance coverage, the plan satisfies the requirements of this paragraph (b) if the plan requires the health insurance issuer offering the coverage to provide the information required by this paragraph (b) in compliance with this section pursuant to a written agreement. Accordingly, if a health insurance issuer and a plan sponsor enter into a written agreement under which the issuer agrees to provide the information required under this paragraph (b) in compliance with this section, and the issuer fails to do so, then the issuer, but not the plan, violates the transparency disclosure requirements of this paragraph (b).

(ii) *Other contractual arrangements.* A group health plan or health insurance issuer may satisfy the requirements under this paragraph (b) by entering into a written agreement under which another party (such as a pharmacy benefit manager or other third-party) provides the information required by this paragraph (b) in compliance with

this section. Notwithstanding the preceding sentence, if a group health plan or health insurance issuer chooses to enter into such an agreement and the party with which it contracts fails to provide the information in compliance with this paragraph (b), the plan or issuer violates the transparency disclosure requirements of this paragraph (b).

(c) *Applicability*. (1) The provisions of this section apply for plan years beginning on or after January 1, 2023 with respect to the 500 items and services to be posted on a publicly available website, and with respect to all covered items and services, for plan years beginning on or after January 1, 2024.

(2) As provided under § 54.9815–1251, this section does not apply to grandfathered health plans. This section also does not apply to health reimbursement arrangements or other account-based group health plans as defined in § 54.9815–2711(d)(6) or short-term, limited-duration insurance as defined in § 54.9801–2.

(3) Nothing in this section alters or otherwise affects a group health plan's or health insurance issuer's duty to comply with requirements under other applicable state or Federal laws, including those governing the accessibility, privacy, or security of information required to be disclosed under this section, or those governing the ability of properly authorized representatives to access participant or beneficiary information held by plans and issuers.

(4) A group health plan or health insurance issuer will not fail to comply with this section solely because it, acting in good faith and with reasonable diligence, makes an error or omission in a disclosure required under paragraph (b) of this section, provided that the plan or issuer corrects the information as soon as practicable.

(5) A group health plan or health insurance issuer will not fail to comply with this section solely because, despite acting in good faith and with reasonable diligence, its internet website is temporarily inaccessible, provided that the plan or issuer makes the information available as soon as practicable.

(6) To the extent compliance with this section requires a group health plan or health insurance issuer to obtain information from any other entity, the plan or issuer will not fail to comply with this section because it relied in good faith on information from the other entity, unless the plan or issuer knows, or reasonably should have known, that the information is incomplete or inaccurate.

(d) *Severability*. Any provision of this section held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, or stayed pending further agency action, shall be severable from this section and shall not affect the remainder thereof or the application of the provision to persons not similarly situated or to dissimilar circumstances.

[T.D. 9922, 85 FR 72295, Nov. 12, 2020]

§ 54.9815–2715A3 Transparency in coverage—requirements for public disclosure.

(a) *Scope and definitions*—(1) *Scope*. This section establishes price transparency requirements for group health plans and health insurance issuers offering group health insurance coverage for the timely disclosure of information about costs related to covered items and services under a group plan or health insurance coverage.

(2) *Definitions*. For purposes of this section, the definitions in § 54.9815–2715A1 apply.

(b) *Requirements for public disclosure of in-network provider rates for covered items and services, out-of-network allowed amounts and billed charges for covered items and services, and negotiated rates and historical net prices for covered prescription drugs*. A group health plan or health insurance issuer must make available on an internet website the information required under paragraph (b)(1) of this section in three machine-readable files, in accordance with the method and format requirements described in paragraph (b)(2) of this section, and that are updated as required under paragraph (b)(3) of this section.

(1) *Required information*. Machine-readable files required under this paragraph (b) that are made available to the public by a group health plan or health insurance issuer must include:

(i) An in-network rate machine-readable file that includes the required information under this paragraph (b)(1)(i) for all covered items and services, except for prescription drugs that are subject to a fee-for-service reimbursement arrangement, which must be reported in the prescription drug machine-readable file pursuant to paragraph (b)(1)(iii) of this section. The in-network rate machine-readable file must include:

(A) For each coverage option offered by a group health plan or health insurance issuer, the name and the 14-digit Health Insurance Oversight System (HIOS) identifier, or, if the 14-digit HIOS identifier is not available, the 5-digit HIOS identifier, or if no HIOS identifier is available, the Employer Identification Number (EIN);

(B) A billing code, which in the case of prescription drugs must be an NDC, and a plain language description for each billing code for each covered item or service under each coverage option offered by a plan or issuer; and

(C) All applicable rates, which may include one or more of the following: negotiated rates, underlying fee schedule rates, or derived amounts. If a group health plan or health insurance issuer does not use negotiated rates for provider reimbursement, then the plan or issuer should disclose derived amounts to the extent these amounts are already calculated in the normal course of business. If the group health plan or health insurance issuer uses underlying fee schedule rates for calculating cost sharing, then the plan or issuer should include the underlying fee schedule rates in addition to the negotiated rate or derived amount. Applicable rates, including for both individual items and services and items and services in a bundled payment arrangement, must be:

(*1*) Reflected as dollar amounts, with respect to each covered item or service that is furnished by an in-network provider. If the negotiated rate is subject to change based upon participant or beneficiary-specific characteristics, these dollar amounts should be reflected as the base negotiated rate applicable to the item or service prior to adjustments for participant or beneficiary-specific characteristics;

(*2*) Associated with the National Provider Identifier (NPI), Tax Identification Number (TIN), and Place of Service Code for each in-network provider;

(*3*) Associated with the last date of the contract term or expiration date for each provider-specific applicable rate that applies to each covered item or service; and

(*4*) Indicated with a notation where a reimbursement arrangement other than a standard fee-for-service model (such as capitation or a bundled payment arrangement) applies.

(ii) An out-of-network allowed amount machine-readable file, including:

(A) For each coverage option offered by a group health plan or health insurance issuer, the name and the 14-digit HIOS identifier, or, if the 14-digit HIOS identifier is not available, the 5-digit HIOS identifier, or, if no HIOS identifier is available, the EIN;

(B) A billing code, which in the case of prescription drugs must be an NDC, and a plain language description for each billing code for each covered item or service under each coverage option offered by a plan or issuer; and

(C) Unique out-of-network allowed amounts and billed charges with respect to covered items or services, furnished by out-of-network providers during the 90-day time period that begins 180 days prior to the publication date of the machine-readable file (except that a group health plan or health insurance issuer must omit such data in relation to a particular item or service and provider when compliance with this paragraph (b)(1)(ii)(C) would require the plan or issuer to report payment of out-of-network allowed amounts in connection with fewer than 20 different claims for payments under a single plan or coverage). Consistent with paragraph (c)(3) of this section, nothing in this paragraph (b)(1)(ii)(C) requires the disclosure of information that would violate any applicable health information privacy law. Each unique out-of-network allowed amount must be:

(*1*) Reflected as a dollar amount, with respect to each covered item or service that is furnished by an out-of-network provider; and

(*2*) Associated with the NPI, TIN, and Place of Service Code for each out-of-network provider.

(iii) A prescription drug machine-readable file, including:

(A) For each coverage option offered by a group health plan or health insurance issuer, the name and the 14-digit HIOS identifier, or, if the 14-digit HIOS identifier is not available, the 5-digit HIOS identifier, or, if no HIOS identifier is available, the EIN;

(B) The NDC and the proprietary and nonproprietary name assigned to the NDC by the Food and Drug Administration (FDA) for each covered item or service that is a prescription drug under each coverage option offered by a plan or issuer;

(C) The negotiated rates which must be:

(*1*) Reflected as a dollar amount, with respect to each NDC that is furnished by an in-network provider, including an in-network pharmacy or other prescription drug dispenser;

(*2*) Associated with the NPI, TIN, and Place of Service Code for each in-network provider, including each in-network pharmacy or other prescription drug dispenser; and

(*3*) Associated with the last date of the contract term for each provider-specific negotiated rate that applies to each NDC; and

(D) Historical net prices that are:

(*1*) Reflected as a dollar amount, with respect to each NDC that is furnished by an in-network provider, including an in-network pharmacy or other prescription drug dispenser;

(*2*) Associated with the NPI, TIN, and Place of Service Code for each in-network provider, including each in-network pharmacy or other prescription drug dispenser; and

(*3*) Associated with the 90-day time period that begins 180 days prior to the publication date of the machine-readable file for each provider-specific historical net price that applies to each NDC (except that a group health plan or health insurance issuer must omit such data in relation to a particular NDC and provider when compliance with this paragraph (b)(1)(iii)(D) would require the plan or issuer to report payment of historical net prices calculated using fewer than 20 different claims for payment). Consistent with paragraph (c)(3) of this section, nothing in this paragraph (b)(1)(iii)(D) requires the disclosure of information that would violate any applicable health information privacy law.

(2) *Required method and format for disclosing information to the public.* The machine-readable files described in this paragraph (b) must be available in a form and manner as specified in guidance issued by the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services. The machine-readable files must be publicly available and accessible to any person free of charge and without conditions, such as establishment of a user account, password, or other credentials, or submission of personally identifiable information to access the file.

(3) *Timing.* A group health plan or health insurance issuer must update the machine-readable files and information required by this paragraph (b) monthly. The group health plan or health insurance issuer must clearly indicate the date that the files were most recently updated.

(4) *Special rules to prevent unnecessary duplication*—(i) *Special rule for insured group health plans.* To the extent coverage under a group health plan consists of group health insurance coverage, the plan satisfies the requirements of this paragraph (b) if the plan requires the health insurance issuer offering the coverage to provide the information pursuant to a written agreement. Accordingly, if a health insurance issuer and a group health plan sponsor enter into a written agreement under which the issuer agrees to provide the information required under this paragraph (b) in compliance with this section, and the issuer fails to do so, then the issuer, but not the plan, violates the transparency disclosure requirements of this paragraph (b).

(ii) *Other contractual arrangements.* A group health plan or health insurance issuer may satisfy the requirements under this paragraph (b) by entering into a written agreement under which another party (such as a third-party administrator or health care claims clearinghouse) will provide the information required by this paragraph (b)

in compliance with this section. Notwithstanding the preceding sentence, if a group health plan or health insurance issuer chooses to enter into such an agreement and the party with which it contracts fails to provide the information in compliance with this paragraph (b), the plan or issuer violates the transparency disclosure requirements of this paragraph (b).

(iii) *Aggregation permitted for out-of-network allowed amounts.* Nothing in this section prohibits a group health plan or health insurance issuer from satisfying the disclosure requirement described in paragraph (b)(1)(ii) of this section by disclosing out-of-network allowed amounts made available by, or otherwise obtained from, an issuer, a service provider, or other party with which the plan or issuer has entered into a written agreement to provide the information, provided the minimum claim threshold described in paragraph (b)(1)(ii)(C) of this section is independently met for each item or service and for each plan or coverage included in an aggregated Allowed Amount File. Under such circumstances, health insurance issuers, service providers, or other parties with which the group health plan or issuer has contracted may aggregate out-of-network allowed amounts for more than one plan or insurance policy or contract. Additionally, nothing in this section prevents the Allowed Amount File from being hosted on a third-party website or prevents a plan administrator or issuer from contracting with a third party to post the file. However, if a plan or issuer chooses not to also host the file separately on its own website, it must provide a link on its own public website to the location where the file is made publicly available.

(c) *Applicability.* (1) The provisions of this section apply for plan years beginning on or after January 1, 2022.

(2) As provided under § 54.9815–1251, this section does not apply to grandfathered health plans. This section also does not apply to health reimbursement arrangements or other account-based group health plans as defined in § 54.9815–2711(d)(6) or short term limited duration insurance as defined in § 54.9801–2.

(3) Nothing in this section alters or otherwise affects a group health plan's or health insurance issuer's duty to comply with requirements under other applicable state or Federal laws, including those governing the accessibility, privacy, or security of information required to be disclosed under this section, or those governing the ability of properly authorized representatives to access participant, or beneficiary information held by plans and issuers.

(4) A group health plan or health insurance issuer will not fail to comply with this section solely because it, acting in good faith and with reasonable diligence, makes an error or omission in a disclosure required under paragraph (b) of this section, provided that the plan or issuer corrects the information as soon as practicable.

(5) A group health plan or health insurance issuer will not fail to comply with this section solely because, despite acting in good faith and with reasonable diligence, its internet website is temporarily inaccessible, provided that the plan or issuer makes the information available as soon as practicable.

(6) To the extent compliance with this section requires a group health plan or health insurance issuer to obtain information from any other entity, the plan or issuer will not fail to comply with this section because it relied in good faith on information from the other entity, unless the plan or issuer knows, or reasonably should have known, that the information is incomplete or inaccurate.

(d) *Severability.* Any provision of this section held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, or stayed pending further agency action, shall be severable from this section and shall not affect the remainder thereof or the application of the provision to persons not similarly situated or to dissimilar circumstances.

[T.D. 9922, 85 FR 72295, Nov. 12, 2020]

§ 54.9815–2719 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 §54.9815–1251. 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.

(2) *Definitions.* For purposes of this section, the following definitions apply—

(i) *Adverse benefit determination.* An *adverse benefit determination* means an adverse benefit determination as defined in 29 CFR 2560.503–1, as well as any rescission of coverage, as described in §54.9815–2712(a)(2) (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time).

(ii) *Appeal (or internal appeal).* An *appeal* or *internal appeal* means review by a plan or issuer of an adverse benefit determination, as required in paragraph (b) of this section.

(iii) *Claimant. Claimant* means an individual who makes a claim under this section. For purposes of this section, references to claimant include a claimant's authorized representative.

(iv) *External review. External review* means a review of an adverse benefit determination (including a final internal adverse benefit determination) conducted pursuant to an applicable State external review process described in paragraph (c) of this section or the Federal external review process of paragraph (d) of this section.

(v) *Final internal adverse benefit determination.* A *final internal adverse benefit determination* means an adverse benefit determination that has been upheld by a plan or issuer at the completion of the internal appeals process applicable under paragraph (b) of this section (or an adverse benefit determination with respect to which the internal appeals process has been exhausted under the deemed exhaustion rules of paragraph (b)(2)(ii)(F) of this section).

(vi) *Final external review decision.* A *final external review decision* means a determination by an independent review organization at the conclusion of an external review.

(vii) *Independent review organization (or IRO).* An *independent review organization* (or *IRO*) means an entity that conducts independent external reviews of adverse benefit determinations and final internal adverse benefit determinations pursuant to paragraph (c) or (d) of this section.

(viii) *NAIC Uniform Model Act.* The *NAIC Uniform Model Act* means the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners in place on July 23, 2010.

(b) *Internal claims and appeals process*—(1) *In general.* A group health plan and a health insurance issuer offering group health insurance coverage must implement an effective internal claims and appeals process, as described in this paragraph (b).

(2) *Requirements for group health plans and group health insurance issuers.* A group health plan and a health insurance issuer offering group health insurance coverage must comply with all the requirements of this paragraph (b)(2). In the case of health insurance coverage offered in connection with a group health plan, if either the plan or the issuer complies with the internal claims and appeals process of this paragraph (b)(2), then the obligation to comply with this paragraph (b)(2) is satisfied for both the plan and the issuer with respect to the health insurance coverage.

(i) *Minimum internal claims and appeals standards.* A group health plan and a health insurance issuer offering group health insurance coverage must comply with all the requirements applicable to group health plans under 29 CFR 2560.503–1, except to the extent those requirements are modified by

paragraph (b)(2)(ii) of this section. Accordingly, under this paragraph (b), with respect to health insurance coverage offered in connection with a group health plan, the group health insurance issuer is subject to the requirements in 29 CFR 2560.503–1 to the same extent as the group health plan.

(ii) *Additional standards.* In addition to the requirements in paragraph (b)(2)(i) of this section, the internal claims and appeals processes of a group health plan and a health insurance issuer offering group health insurance coverage must meet the requirements of this paragraph (b)(2)(ii).

(A) *Clarification of meaning of adverse benefit determination.* For purposes of this paragraph (b)(2), an ''adverse benefit determination'' includes an adverse benefit determination as defined in paragraph (a)(2)(i) of this section. Accordingly, in complying with 29 CFR 2560.503–1, as well as the other provisions of this paragraph (b)(2), a plan or issuer must treat a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at that time) as an adverse benefit determination. (Rescissions of coverage are subject to the requirements of § 54.9815–2712.)

(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 the receipt of the claim) continue to apply to the plan and issuer. For purposes of this paragraph (b)(2)(ii)(B), a claim involving urgent care has the meaning given in 29 CFR 2560.503–1(m)(1), as determined by the attending provider, and the plan or issuer shall defer to such determination of the attending provider.

(C) *Full and fair review.* A plan and issuer must allow a claimant to review the claim file and to present evidence and testimony as part of the internal claims and appeals process. Specifically, in addition to complying with the requirements of 29 CFR 2560.503–1(h)(2)—

(*1*) The plan or issuer must provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan or issuer (or at the direction of the plan or issuer) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided under 29 CFR 2560.503–1(i) to give the claimant a reasonable opportunity to respond prior to that date; and

(*2*) Before the plan or issuer can issue a final internal adverse benefit determination based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided under 29 CFR 2560.503–1(i) to give the claimant a reasonable opportunity to respond prior to that date. Notwithstanding the rules of 29 CFR 2560.503–1(i), if the new or additional evidence is received so late that it would be impossible to provide it to the claimant in time for the claimant to have a reasonable opportunity to respond, the period for providing a notice of final internal adverse benefit determination is tolled until such time as the claimant has a reasonable opportunity to respond. After the claimant responds, or has a reasonable opportunity to respond but fails to do so, the plan administrator shall notify the claimant of the plan's benefit determination as soon as a plan acting in a reasonable and prompt fashion can provide the notice, taking into account the medical exigencies.

(D) *Avoiding conflicts of interest.* In addition to the requirements of 29 CFR 2560.503–1(b) and (h) regarding full and fair review, the plan and issuer must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based

upon the likelihood that the individual will support the denial of benefits.

(E) *Notice.* A plan and issuer must provide notice to individuals, in a culturally and linguistically appropriate manner (as described in paragraph (e) of this section) that complies with the requirements of 29 CFR 2560.503–1(g) and (j). The plan and issuer must also comply with the additional requirements of this paragraph (b)(2)(ii)(E).

(*1*) The plan and issuer must ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

(*2*) The plan and issuer must provide to participants and beneficiaries, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse benefit determination or final internal adverse benefit determination. The plan or issuer must not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal under this paragraph (b) or an external review under paragraphs (c) and (d) of this section.

(*3*) The plan and issuer must ensure that the reason or reasons for the adverse benefit determination or final internal adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the plan's or issuer's standard, if any, that was used in denying the claim. In the case of a notice of final internal adverse benefit determination, this description must include a discussion of the decision.

(*4*) The plan and issuer must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

(*5*) The plan and issuer must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist individuals with the internal claims and appeals and external review processes.

(F) *Deemed exhaustion of internal claims and appeals processes*—(*1*) In the case of a plan or issuer that fails to strictly 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. Where a self-insured plan is not subject to an applicable State external review process, but the State has chosen to expand access to its process for plans that are not subject to the applicable State laws, the plan may choose to comply with either the applicable State external review process or 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, a State external review process that expressly authorizes, as of November 18, 2015, a nominal filing fee may continue to permit such fees. For this purpose, to be considered nominal, a filing fee must not exceed $25; it must be refunded to the claimant if the adverse benefit determination (or final internal adverse benefit determination) is reversed through external review; it must be waived if payment of the fee would impose an undue financial hardship; and the annual limit on filing fees for any claimant within a single plan year must not exceed $75.

(v) The State process may not impose a restriction on the minimum dollar amount of a claim for it to be eligible for external review. Thus, the process may not impose, for example, a $500 minimum claims threshold.

(vi) The State process must allow at least four months after the receipt of a notice of an adverse benefit determination or final internal adverse benefit determination for a request for an external review to be filed.

(vii) The State process must provide that IROs will be assigned on a random basis or another method of assignment that assures the independence and impartiality of the assignment process (such as rotational assignment) by a State or independent entity, and in no event selected by the issuer, plan, or the individual.

(viii) The State process must provide for maintenance of a list of approved IROs qualified to conduct the external review based on the nature of the health care service that is the subject of the review. The State process must provide for approval only of IROs that are accredited by a nationally recognized private accrediting organization.

(ix) The State process must provide that any approved IRO has no conflicts of interest that will influence its independence. Thus, the IRO may not own or control, or be owned or controlled by a health insurance issuer, a group health plan, the sponsor of a group health plan, a trade association of plans or issuers, or a trade association of health care providers. The State process must further provide that the IRO and the clinical reviewer assigned to conduct an external review may not have a material professional, familial, or financial conflict of interest with the issuer or plan that is the subject of the external review; the claimant (and any related parties to the claimant) whose treatment is the subject of the external review; any officer, director, or management employee of the issuer; the plan administrator, plan fiduciaries, or plan employees; the health care provider, the health care provider's group, or practice association recommending the treatment that is subject to the external review; the facility at which the recommended treatment would be provided; or the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended.

(x) The State process allows the claimant at least five business days to submit to the IRO in writing additional information that the IRO must consider when conducting the external review, and it requires that the claimant is notified of the right to do so. The process must also require that any additional information submitted by the claimant to the IRO must be forwarded to the issuer (or, if applicable, the plan) within one business day of receipt by the IRO.

(xi) The State process must provide that the decision is binding on the plan or issuer, as well as the claimant except to the extent the other remedies are available under State or Federal law, and except that the requirement that the decision be binding shall not preclude the plan or issuer from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise

fails to require such payment or benefits. For this purpose, the plan or issuer must provide benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the plan or issuer intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

(xii) The State process must require, for standard external review, that the IRO provide written notice to the issuer (or, if applicable, the plan) and the claimant of its decision to uphold or reverse the adverse benefit determination (or final internal adverse benefit determination) within no more than 45 days after the receipt of the request for external review by the IRO.

(xiii) The State process must provide for an expedited external review if the adverse benefit determination (or final internal adverse benefit determination) concerns an admission, availability of care, continued stay, or health care service for which the claimant received emergency services, but has not been discharged from a facility; or involves a medical condition for which the standard external review time frame would seriously jeopardize the life or health of the claimant or jeopardize the claimant's ability to regain maximum function. As expeditiously as possible but within no more than 72 hours after the receipt of the request for expedited external review by the IRO, the IRO must make its decision to uphold or reverse the adverse benefit determination (or final internal adverse benefit determination) and notify the claimant and the issuer (or, if applicable, the plan) of the determination. If the notice is not in writing, the IRO must provide written confirmation of the decision within 48 hours after the date of the notice of the decision.

(xiv) The State process must require that issuers (or, if applicable, plans) include a description of the external review process in or attached to the summary plan description, policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to participants, beneficiaries, or enrollees, substantially similar to what is set forth in section 17 of the NAIC Uniform Model Act.

(xv) The State process must require that IROs maintain written records and make them available upon request to the State, substantially similar to what is set forth in section 15 of the NAIC Uniform Model Act.

(xvi) The State process follows procedures for external review of adverse benefit determinations (or final internal adverse benefit determinations) involving experimental or investigational treatment, substantially similar to what is set forth in section 10 of the NAIC Uniform Model Act.

(3) *Transition period for external review processes*—(i) Through December 31, 2017, 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, 2017, 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) An applicable State external review process must apply 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, 2018. The Federal external review process will apply to such internal adverse benefit determinations 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. Through December 31, 2017, a State external review process applicable to a health insurance issuer or group health plan may be considered to meet the minimum standards of paragraph (c)(2) of this section, if it meets the temporary standards established by the Secretary in guidance for a process similar to the NAIC Uniform Model Act.

(d) *Federal external review process.* A plan or issuer not subject to an applicable State external review process under paragraph (c) of this section

must provide an effective Federal external review process in accordance with this paragraph (d) (except to the extent, in the case of a plan, the plan is described in paragraph (c)(1)(i) of this section as not having to comply with this paragraph (d)). In the case of health insurance coverage offered in connection with a group health plan, if either the plan or the issuer complies with the Federal external review process of this paragraph (d), then the obligation to comply with this paragraph (d) is satisfied for both the plan and the issuer with respect to the health insurance coverage. A Multi State Plan or MSP, as defined by 45 CFR 800.20, must provide an effective Federal external review process in accordance with this paragraph (d). In such circumstances, the requirement to provide external review under this paragraph (d) is satisfied when a Multi State Plan or MSP complies with standards established by the Office of Personnel Management.

(1) *Scope*—(i) *In general.* The Federal external review process established pursuant to this paragraph (d) applies to the following:

(A) An adverse benefit determination (including a final internal adverse benefit determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is experimental or investigational; its determination whether a participant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; or its determination whether a plan or issuer is complying with the nonquantitative treatment limitation provisions of Code section 9812 and §54.9812, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer. (A denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan or health insurance coverage is not eligible for the Federal external review process under this paragraph (d)); and

(B) A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

(ii) *Examples.* The rules of paragraph (d)(1)(i) 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 under paragraph (d)(1)(i) of this section. Moreover, the plan's notification of final internal adverse benefit determination is inadequate under paragraphs (b)(2)(i) and (b)(2)(ii)(E)(*3*) of this section because it fails to make clear that the plan will pay for more than 30 visits if the service is preauthorized pursuant to an approved treatment plan that takes into account medical necessity using the plan's definition of the term. Accordingly, the notice of final internal adverse benefit determination should refer to the plan provision governing the 31st visit and should describe the plan's standard for medical necessity, as well as how the treatment fails to meet the plan's standard.

Example 2. (i) *Facts.* A group health plan does not provide coverage for services provided out of network, unless the service cannot effectively be provided in network. Individual *B* seeks coverage for a specialized medical procedure from an out-of-network provider because *B* believes that the procedure cannot be effectively provided in network. *B* receives a notice of final internal adverse benefit determination stating that the claim is denied because the provider is out-of-network.

(ii) *Conclusion.* In this *Example 2*, the plan's denial of benefits is based on whether a service can effectively be provided in network and, therefore, involves medical judgment. Accordingly, the claim is eligible for external review under paragraph (d)(1)(i) of this section. Moreover, the plan's notice of final internal adverse benefit determination is inadequate under paragraphs (b)(2)(i) and (b)(2)(ii)(E)(*3*) of this section because the

plan does provide benefits for services on an out-of-network basis if the services cannot effectively be provided in network. Accordingly, the notice of final internal adverse benefit determination is required to refer to the exception to the out-of-network exclusion and should describe the plan's standards for determining effectiveness of services, as well as how services available to the claimant within the plan's network meet the plan's standard for effectiveness of services.

(2) *External review process standards.* The Federal external review process established pursuant to this paragraph (d) is considered similar to the process set forth in the NAIC Uniform Model Act and, therefore satisfies the requirements of paragraph (d)(2), if such process provides the following.

(i) *Request for external review.* A group health plan or health insurance issuer must allow a claimant to file a request for an external review with the plan or issuer if the request is filed within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

(ii) *Preliminary review*—(A) *In general.* Within five business days following the date of receipt of the external review request, the group health plan or health insurance issuer must complete a preliminary review of the request to determine whether:

(*1*) The claimant is or was covered under the plan or coverage at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan or coverage at the time the health care item or service was provided;

(*2*) The adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the group health plan or health insurance coverage (e.g., worker classification or similar determination);

(*3*) The claimant has exhausted the plan's or issuer's internal appeal process unless the claimant is not required to exhaust the internal appeals process under paragraph (b)(1) of this section; and

(*4*) The claimant has provided all the information and forms required to process an external review.

(B) Within one business day after completion of the preliminary review, the plan or issuer must issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and current contact information, including the phone number, for the Employee Benefits Security Administration. If the request is not complete, such notification must describe the information or materials needed to make the request complete, and the plan or issuer must allow a claimant to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

(iii) *Referral to Independent Review Organization*—(A) *In general.* The group health plan or health insurance issuer must assign an IRO that is accredited by URAC or by similar nationally-recognized accrediting organization to conduct the external review. The IRO referral process must provide for the following:

(*1*) The plan or issuer must ensure that the IRO process is not biased and ensures independence;

(*2*) The plan or issuer must contract with at least three (3) IROs for assignments under the plan or coverage and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection); and

(*3*) The IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

(*4*) The IRO process may not impose any costs, including filing fees, on the claimant requesting the external review.

(B) *IRO contracts.* A group health plan or health insurance issuer must include the following standards in the contract between the plan or issuer and the IRO:

(*1*) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the plan or coverage.

(*2*) The assigned IRO will timely notify a claimant in writing whether the request is eligible for external review. This notice will include a statement that the claimant may submit in writing to the assigned IRO, within ten business days following the date of receipt of the notice, additional information. This additional information must be considered by the IRO when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

(*3*) Within five business days after the date of assignment of the IRO, the plan or issuer must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the plan or issuer to timely provide the documents and information must not delay the conduct of the external review. If the plan or issuer fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO must notify the claimant and the plan.

(*4*) Upon receipt of any information submitted by the claimant, the assigned IRO must within one business day forward the information to the plan or issuer. Upon receipt of any such information, the plan or issuer may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the plan or issuer must not delay the external review. The external review may be terminated as a result of the reconsideration only if the plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the plan must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the plan or issuer.

(*5*) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the plan's or issuer's internal claims and appeals process applicable under paragraph (b). In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(*i*) The claimant's medical records;

(*ii*) The attending health care professional's recommendation;

(*iii*) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, claimant, or the claimant's treating provider;

(*iv*) The terms of the claimant's plan or coverage to ensure that the IRO's decision is not contrary to the terms of the plan or coverage, unless the terms are inconsistent with applicable law;

(*v*) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(*vi*) Any applicable clinical review criteria developed and used by the plan or issuer, unless the criteria are inconsistent with the terms of the plan or coverage or with applicable law; and

(*vii*) To the extent the final IRO decision maker is different from the IRO's clinical reviewer, the opinion of such clinical reviewer, after considering information described in this notice, to the extent the information or documents are available and the clinical reviewer or reviewers consider such information or documents appropriate.

(*6*) The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of the final external review decision to the claimant and the plan or issuer.

(*7*) The assigned IRO's written notice of the final external review decision must contain the following:

(*i*) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates 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, the treatment code and its corresponding meaning, and the reason for the plan's or issuer's denial);

(*ii*) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(*iii*) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(*iv*) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(*v*) A statement that the IRO's determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or health insurance issuer or to the claimant, or to the extent the health plan or health insurance issuer voluntarily makes payment on the claim or otherwise provides benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits;

(*vi*) A statement that judicial review may be available to the claimant; and

(*vii*) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

(*viii*) After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the claimant, plan, issuer, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

(iv) *Reversal of plan's or issuer's decision.* Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final adverse benefit determination, the plan or issuer immediately must provide coverage or payment (including immediately authorizing care or immediately paying benefits) for the claim.

(3) *Expedited external review.* A group health plan or health insurance issuer must comply with the following standards with respect to an expedited external review:

(i) *Request for external review.* A group health plan or health insurance issuer must allow a claimant to make a request for an expedited external review with the plan or issuer at the time the claimant receives:

(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; 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 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 item or service for which the claimant received emergency services, but has not been discharged from the facility.

(ii) *Preliminary review.* Immediately upon receipt of the request for expedited external review, the plan or issuer must determine whether the request meets the reviewability requirements set forth in paragraph (d)(2)(ii)

of this section for standard external review. The plan or issuer must immediately send a notice that meets the requirements set forth in paragraph (d)(2)(ii)(B) for standard review to the claimant of its eligibility determination.

(iii) *Referral to independent review organization.* (A) Upon a determination that a request is eligible for expedited external review following the preliminary review, the plan or issuer will assign an IRO pursuant to the requirements set forth in paragraph (d)(2)(iii) of this section for standard review. The plan or issuer must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

(B) The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the plan's or issuer's internal claims and appeals process.

(iv) *Notice of final external review decision.* The plan's or issuer's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in paragraph (d)(2)(iii)(B) of this section, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the plan or issuer.

(4) *Alternative, Federally-administered external review process.* Insured coverage not subject to an applicable State external review process under paragraph (c) of this section may elect to use either the Federal external review process, as set forth under paragraph (d) of this section or the Federally-administered external review process, as set forth by HHS in guidance. In such circumstances, the requirement to provide external review under this paragraph (d) is satisfied.

(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 includes answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language;

(ii) The plan or issuer must provide, upon request, a notice in any applicable non-English language; and

(iii) The plan or issuer must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the plan or issuer.

(3) *Applicable non-English language.* With respect to an address in any United States county to which a notice is sent, a non-English language is an applicable non-English language if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary.

(f) *Secretarial authority.* The Secretary may determine that the external review process of a group health plan or health insurance issuer, in operation as of March 23, 2010, is considered in compliance with the applicable process established under paragraph (c) or (d) of this section if it substantially meets the requirements of paragraph (c) or (d) of this section, as applicable.

(g) *Applicability date.* The provisions of this section are applicable to group

health plans and health insurance issuers for plan years beginning on or after January 1, 2017. Until the applicability date for this regulation, plans and issuers are required to continue to comply with the interim final regulations promulgated by the Department of Labor at 29 CFR part 2590, contained in the 29 CFR, parts 1927 to end, edition revised as of July 1, 2015.

[T.D. 9744, 80 FR 72246, Nov. 18, 2015]

§ 54.9815–2719T Internal claims and appeals and external review processes (temporary).

(a) *Scope and definitions*—(1) *Scope*—(i) *In general*. This section sets forth requirements with respect to internal claims and appeals and external review processes for group health plans and health insurance issuers. 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.

(ii) *Application to grandfathered health plans and health insurance coverage*. The provisions of this section generally do not apply to coverage offered by health insurance issuers and group health plans that are grandfathered health plans, as defined under § 54.9815–1251. However, the external review process requirements under paragraphs (c) and (d) of this section, and related notice requirements under paragraph (e) of this section, apply to grandfathered health plans or coverage with respect to adverse benefit determinations involving items and services within the scope of the requirements for out-of-network emergency services, non-emergency services performed by non-participating providers at participating facilities, and air ambulance services furnished by nonparticipating providers of air ambulance services under sections 9816 and 9817 and §§ 54.9816–4T through 54.9816–5T and 54.9817–1T.

(2) *Definitions*. For purposes of this section, the following definitions apply—

(i) *Adverse benefit determination*. An *adverse benefit determination* means an adverse benefit determination as defined in 29 CFR 2560.503–1, as well as any rescission of coverage, as described in § 54.9815–2712(a)(2) (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time).

(ii) *Appeal (or internal appeal)*. An *appeal* or *internal appeal* means review by a plan or issuer of an adverse benefit determination, as required in paragraph (b) of this section.

(iii) *Claimant*. *Claimant* means an individual who makes a claim under this section. For purposes of this section, references to claimant include a claimant's authorized representative.

(iv) *External review*. *External review* means a review of an adverse benefit determination (including a final internal adverse benefit determination) conducted pursuant to an applicable State external review process described in paragraph (c) of this section or the Federal external review process of paragraph (d) of this section.

(v) *Final internal adverse benefit determination*. A *final internal adverse benefit determination* means an adverse benefit determination that has been upheld by a plan or issuer at the completion of the internal appeals process applicable under paragraph (b) of this section (or an adverse benefit determination with respect to which the internal appeals process has been exhausted under the deemed exhaustion rules of paragraph (b)(2)(ii)(F) of this section).

(vi) *Final external review decision*. A *final external review decision* means a determination by an independent review organization at the conclusion of an external review.

(vii) *Independent review organization (or IRO)*. An *independent review organization* (or *IRO*) means an entity that conducts independent external reviews

of adverse benefit determinations and final internal adverse benefit determinations pursuant to paragraph (c) or (d) of this section.

(viii) *NAIC Uniform Model Act*. The *NAIC Uniform Model Act* means the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners in place on July 23, 2010.

(b) *Internal claims and appeals process*—(1) *In general*. A group health plan and a health insurance issuer offering group health insurance coverage must implement an effective internal claims and appeals process, as described in this paragraph (b).

(2) *Requirements for group health plans and group health insurance issuers*. A group health plan and a health insurance issuer offering group health insurance coverage must comply with all the requirements of this paragraph (b)(2). In the case of health insurance coverage offered in connection with a group health plan, if either the plan or the issuer complies with the internal claims and appeals process of this paragraph (b)(2), then the obligation to comply with this paragraph (b)(2) is satisfied for both the plan and the issuer with respect to the health insurance coverage.

(i) *Minimum internal claims and appeals standards*. A group health plan and a health insurance issuer offering group health insurance coverage must comply with all the requirements applicable to group health plans under 29 CFR 2560.503–1, except to the extent those requirements are modified by paragraph (b)(2)(ii) of this section. Accordingly, under this paragraph (b), with respect to health insurance coverage offered in connection with a group health plan, the group health insurance issuer is subject to the requirements in 29 CFR 2560.503–1 to the same extent as the group health plan.

(ii) *Additional standards*. In addition to the requirements in paragraph (b)(2)(i) of this section, the internal claims and appeals processes of a group health plan and a health insurance issuer offering group health insurance coverage must meet the requirements of this paragraph (b)(2)(ii).

(A) *Clarification of meaning of adverse benefit determination*. For purposes of this paragraph (b)(2), an ''adverse benefit determination'' includes an adverse benefit determination as defined in paragraph (a)(2)(i) of this section. Accordingly, in complying with 29 CFR 2560.503–1, as well as the other provisions of this paragraph (b)(2), a plan or issuer must treat a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at that time) as an adverse benefit determination. (Rescissions of coverage are subject to the requirements of §54.9815–2712.)

(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 the receipt of the claim) continue to apply to the plan and issuer. For purposes of this paragraph (b)(2)(ii)(B), a claim involving urgent care has the meaning given in 29 CFR 2560.503–1(m)(1), as determined by the attending provider, and the plan or issuer shall defer to such determination of the attending provider.

(C) *Full and fair review*. A plan and issuer must allow a claimant to review the claim file and to present evidence and testimony as part of the internal claims and appeals process. Specifically, in addition to complying with the requirements of 29 CFR 2560.503–1(h)(2)—

(*1*) The plan or issuer must provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan or issuer (or at the direction of the plan or issuer) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided under 29 CFR 2560.503–1(i) to give the claimant a reasonable opportunity to respond prior to that date; and

(*2*) Before the plan or issuer can issue a final internal adverse benefit determination based on a new or additional

rationale, the claimant must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided under 29 CFR 2560.503–1(i) to give the claimant a reasonable opportunity to respond prior to that date. Notwithstanding the rules of 29 CFR 2560.503–1(i), if the new or additional evidence is received so late that it would be impossible to provide it to the claimant in time for the claimant to have a reasonable opportunity to respond, the period for providing a notice of final internal adverse benefit determination is tolled until such time as the claimant has a reasonable opportunity to respond. After the claimant responds, or has a reasonable opportunity to respond but fails to do so, the plan administrator shall notify the claimant of the plan's benefit determination as soon as a plan acting in a reasonable and prompt fashion can provide the notice, taking into account the medical exigencies.

(D) *Avoiding conflicts of interest.* In addition to the requirements of 29 CFR 2560.503–1(b) and (h) regarding full and fair review, the plan and issuer must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

(E) *Notice.* A plan and issuer must provide notice to individuals, in a culturally and linguistically appropriate manner (as described in paragraph (e) of this section) that complies with the requirements of 29 CFR 2560.503–1(g) and (j). The plan and issuer must also comply with the additional requirements of this paragraph (b)(2)(ii)(E).

(*1*) The plan and issuer must ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

(*2*) The plan and issuer must provide to participants and beneficiaries, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse benefit determination or final internal adverse benefit determination. The plan or issuer must not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal under this paragraph (b) or an external review under paragraphs (c) and (d) of this section.

(*3*) The plan and issuer must ensure that the reason or reasons for the adverse benefit determination or final internal adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the plan's or issuer's standard, if any, that was used in denying the claim. In the case of a notice of final internal adverse benefit determination, this description must include a discussion of the decision.

(*4*) The plan and issuer must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

(*5*) The plan and issuer must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist individuals with the internal claims and appeals and external review processes.

(F) *Deemed exhaustion of internal claims and appeals processes.* (*1*) In the case of a plan or issuer that fails to strictly 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. Where a self-insured plan is not subject to an applicable State external review process, but the State has chosen to expand access to its process for plans that are not subject to the applicable State laws, the plan may choose to comply with either the applicable State external review process or 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 (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, as well as a consideration of whether a plan or issuer is complying with the surprise billing and cost-sharing protections under sections 9816 and 9817 and §§ 54.9816–1T through 54.9816–6T and 54.9817–1T.

(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, a State external review process that expressly authorizes, as of November 18, 2015, a nominal filing fee may continue to permit such fees. For this purpose, to be considered nominal, a filing fee must not exceed $25; it must be refunded to the claimant if the adverse benefit determination (or final internal adverse benefit determination) is reversed through external review; it must be waived if payment of the fee would impose an undue financial hardship; and the annual limit on filing fees for any claimant within a single plan year must not exceed $75.

(v) The State process may not impose a restriction on the minimum dollar amount of a claim for it to be eligible for external review. Thus, the process may not impose, for example, a $500 minimum claims threshold.

(vi) The State process must allow at least four months after the receipt of a notice of an adverse benefit determination or final internal adverse benefit determination for a request for an external review to be filed.

(vii) The State process must provide that IROs will be assigned on a random basis or another method of assignment that assures the independence and impartiality of the assignment process (such as rotational assignment) by a State or independent entity, and in no event selected by the issuer, plan, or the individual.

(viii) The State process must provide for maintenance of a list of approved IROs qualified to conduct the external review based on the nature of the health care service that is the subject of the review. The State process must provide for approval only of IROs that are accredited by a nationally recognized private accrediting organization.

(ix) The State process must provide that any approved IRO has no conflicts of interest that will influence its independence. Thus, the IRO may not own or control, or be owned or controlled by a health insurance issuer, a group health plan, the sponsor of a group health plan, a trade association of plans or issuers, or a trade association of health care providers. The State

process must further provide that the IRO and the clinical reviewer assigned to conduct an external review may not have a material professional, familial, or financial conflict of interest with the issuer or plan that is the subject of the external review; the claimant (and any related parties to the claimant) whose treatment is the subject of the external review; any officer, director, or management employee of the issuer; the plan administrator, plan fiduciaries, or plan employees; the health care provider, the health care provider's group, or practice association recommending the treatment that is subject to the external review; the facility at which the recommended treatment would be provided; or the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended.

(x) The State process allows the claimant at least five business days to submit to the IRO in writing additional information that the IRO must consider when conducting the external review, and it requires that the claimant is notified of the right to do so. The process must also require that any additional information submitted by the claimant to the IRO must be forwarded to the issuer (or, if applicable, the plan) within one business day of receipt by the IRO.

(xi) The State process must provide that the decision is binding on the plan or issuer, as well as the claimant except to the extent the other remedies are available under State or Federal law, and except that the requirement that the decision be binding shall not preclude the plan or issuer from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits. For this purpose, the plan or issuer must provide benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the plan or issuer intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

(xii) The State process must require, for standard external review, that the IRO provide written notice to the issuer (or, if applicable, the plan) and the claimant of its decision to uphold or reverse the adverse benefit determination (or final internal adverse benefit determination) within no more than 45 days after the receipt of the request for external review by the IRO.

(xiii) The State process must provide for an expedited external review if the adverse benefit determination (or final internal adverse benefit determination) concerns an admission, availability of care, continued stay, or health care service for which the claimant received emergency services, but has not been discharged from a facility; or involves a medical condition for which the standard external review time frame would seriously jeopardize the life or health of the claimant or jeopardize the claimant's ability to regain maximum function. As expeditiously as possible but within no more than 72 hours after the receipt of the request for expedited external review by the IRO, the IRO must make its decision to uphold or reverse the adverse benefit determination (or final internal adverse benefit determination) and notify the claimant and the issuer (or, if applicable, the plan) of the determination. If the notice is not in writing, the IRO must provide written confirmation of the decision within 48 hours after the date of the notice of the decision.

(xiv) The State process must require that issuers (or, if applicable, plans) include a description of the external review process in or attached to the summary plan description, policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to participants, beneficiaries, or enrollees, substantially similar to what is set forth in section 17 of the NAIC Uniform Model Act.

(xv) The State process must require that IROs maintain written records and make them available upon request to the State, substantially similar to what is set forth in section 15 of the NAIC Uniform Model Act.

(xvi) The State process follows procedures for external review of adverse benefit determinations (or final internal adverse benefit determinations) involving experimental or investigational treatment, substantially similar

to what is set forth in section 10 of the NAIC Uniform Model Act.

(3) *Transition period for external review processes.* (i) Through December 31, 2017, 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, 2017, 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) An applicable State external review process must apply 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, 2018. The Federal external review process will apply to such internal adverse benefit determinations 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. Through December 31, 2017, a State external review process applicable to a health insurance issuer or group health plan may be considered to meet the minimum standards of paragraph (c)(2), if it meets the temporary standards established by the Secretary in guidance for a process similar to the NAIC Uniform Model Act.

(d) *Federal external review process.* A plan or issuer not subject to an applicable State external review process under paragraph (c) of this section must provide an effective Federal external review process in accordance with this paragraph (d) (except to the extent, in the case of a plan, the plan is described in paragraph (c)(1)(i) of this section as not having to comply with this paragraph (d)). In the case of health insurance coverage offered in connection with a group health plan, if either the plan or the issuer complies with the Federal external review process of this paragraph (d), then the obligation to comply with this paragraph (d) is satisfied for both the plan and the issuer with respect to the health insurance coverage. A Multi State Plan or MSP, as defined by 45 CFR 800.20, must provide an effective Federal external review process in accordance with this paragraph (d). In such circumstances, the requirement to provide external review under this paragraph (d) is satisfied when a Multi State Plan or MSP complies with standards established by the Office of Personnel Management.

(1) *Scope*—(i) *In general.* The Federal external review process established pursuant to this paragraph (d) applies to the following:

(A) An adverse benefit determination (including a final internal adverse benefit determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is experimental or investigational; its determination whether a participant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; its determination whether a plan or issuer is complying with the nonquantitative treatment limitation provisions of Code section 9812 and § 54.9812–1, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer. (A denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan or health insurance coverage is not eligible for the Federal external review process under this paragraph (d));

(B) An adverse benefit determination that involves consideration of whether a plan or issuer is complying with the surprise billing and cost-sharing protections set forth in sections 9816 and 9817 and §§ 54.9816–4T through 54.9816–5T and 54.9817–1T; and

(C) A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

(ii) *Examples*. The rules of paragraph (d)(1)(i) of this section are illustrated by the following examples:

(A) *Example 1—(1) 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.

(*2*) *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 under paragraph (d)(1)(i) of this section. Moreover, the plan's notification of final internal adverse benefit determination is inadequate under paragraphs (b)(2)(i) and (b)(2)(ii)(E)(3) of this section because it fails to make clear that the plan will pay for more than 30 visits if the service is preauthorized pursuant to an approved treatment plan that takes into account medical necessity using the plan's definition of the term. Accordingly, the notice of final internal adverse benefit determination should refer to the plan provision governing the 31st visit and should describe the plan's standard for medical necessity, as well as how the treatment fails to meet the plan's standard.

(B) *Example 2—(1) Facts*. A group health plan does not provide coverage for services provided out of network, unless the service cannot effectively be provided in network. Individual *B* seeks coverage for a specialized medical procedure from an out-of-network provider because *B* believes that the procedure cannot be effectively provided in network. *B* receives a notice of final internal adverse benefit determination stating that the claim is denied because the provider is out-of-network.

(*2*) *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 under paragraph (d)(1)(i) of this section. Moreover, the plan's notice of final internal adverse benefit determination is inadequate under paragraphs (b)(2)(i) and (b)(2)(ii)(E)(*3*) of this section because the plan does provide benefits for services on an out-of-network basis if the services cannot effectively be provided in network. Accordingly, the notice of final internal adverse benefit determination is required to refer to the exception to the out-of-network exclusion and should describe the plan's standards for determining effectiveness of services, as well as how services available to the claimant within the plan's network meet the plan's standard for effectiveness of services.

(C) *Example 3—(1) Facts*. A group health plan generally provides benefits for services in an emergency department of a hospital or independent free-standing emergency department. Individual *C* receives pre-stabilization emergency treatment in an out-of-network emergency department of a hospital. The group health plan determines that protections for emergency services under §54.9816–4T do not apply because the treatment did not involve ''emergency services'' within the meaning of §54.9816–4T(c)(2)(i). *C* receives an adverse benefit determination, and the plan imposes cost-sharing requirements that are greater than the requirements that would apply if the same services were provided in an in-network emergency department.

(*2*) *Conclusion*. In this *Example 3*, the plan's determination that treatment received by *C* did not include emergency services involves medical judgment and consideration of whether the plan complied with §54.9816–4T. Accordingly, the claim is eligible for external review under paragraph (d)(1)(i) of this section.

(D) *Example 4—(1) Facts*. A group health plan generally provides benefits for anesthesiology services. Individual *D* undergoes a surgery at an in-network health care facility and during the

course of the surgery, receives anesthesiology services from an out-of-network provider. The plan decides the claim for these services without regard to the protections related to items and services furnished by out-of-network providers at in-network facilities under § 54.9816–5T. As a result, *D* receives an adverse benefit determination for the services and is subject to cost-sharing liability that is greater than it would be if cost sharing had been calculated in a manner consistent with the requirements of § 54.9816–5T.

(*2*) *Conclusion*. In this *Example 4*, whether the plan was required to decide the claim in a manner consistent with the requirements of § 54.9816–5T involves considering whether the plan complied with § 54.9816–5T, as well as medical judgment, because it requires consideration of the health care setting and level of care. Accordingly, the claim is eligible for external review under paragraph (d)(1)(i) of this section.

(E) *Example 5*—(*1*) *Facts*. A group health plan generally provides benefits for services in an emergency department of a hospital or independent freestanding emergency department. Individual *E* receives emergency services in an out-of-network emergency department of a hospital, including certain post-stabilization services. The plan processes the claim for the post-stabilization services as not being for emergency services under § 54.9816–4T(c)(2)(ii) based on representations made by the treating provider that *E* was in a condition to receive notice from the provider about cost-sharing and surprise billing protections for these services, and subsequently gave informed consent to waive those protections. *E* receives an adverse benefit determination and is subject to cost-sharing requirements that are greater than the cost-sharing requirements that would apply if the services were processed in a manner consistent with § 54.9816–4T.

(*2*) *Conclusion*. In this *Example 5*, whether *E* was in a condition to receive notice about the availability of cost-sharing and surprise billing protections and give informed consent to waive those protections involves medical judgment and consideration of whether the plan complied with the requirements under § 54.9816–4T(c)(2)(ii). Accordingly, the claim is eligible for external review under paragraph (d)(1)(i) of this section.

(F) *Example 6*—(*1*) *Facts*. Individual *F* gives birth to a baby at an in-network hospital. The baby is born prematurely and receives certain neonatology services from a nonparticipating provider during the same visit as the birth. *F* was given notice about cost-sharing and surprise billing protections for these services, and subsequently gave informed consent to waive those protections. The claim for the neonatology services is coded as a claim for routine post-natal services and the plan decides the claim without regard to the requirements under § 54.9816–5T(a) and the fact that those protections may not be waived for neonatology services under § 54.9816–5T(b).

(*2*) *Conclusion*. In this *Example 6*, medical judgment is necessary to determine whether the correct code was used and compliance with § 54.9816–5T(a) and (b) must also be considered. Accordingly, the claim is eligible for external review under paragraph (d)(1)(i) of this section. The Departments also note that, to the extent the nonparticipating provider balance bills Individual *F* for the outstanding amounts not paid by the plan for the neonatology services, such provider would be in violation of PHS Act section 2799B–2 and its implementing regulations at 45 CFR 149.420(a).

(G) *Example 7*—(*1*) *Facts*. A group health plan generally provides benefits to cover knee replacement surgery. Individual *G* receives a knee replacement surgery at an in-network facility and, after receiving proper notice about the availability of cost-sharing and surprise billing protections, provides informed consent to waive those protections. However, during the surgery, certain anesthesiology services are provided by an out-of-network nurse anesthetist. The claim for these anesthesiology services is decided by the plan without regard to the requirements under § 54.9816–5T(a) or to the fact that those protections may not be waived for ancillary services such as anesthesiology services provided by an

out-of-network provider at an in-network facility under § 54.9816–5T(b). *G* receives an adverse benefit determination and is subject to cost-sharing requirements that are greater than the cost-sharing requirements that would apply if the services were provided in a manner consistent with § 54.9816–5T(a) and (b).

(*2*) *Conclusion*. In this *Example 7*, consideration of whether the plan complied with the requirements in § 54.9816–5T(a) and (b) is necessary to determine whether cost-sharing requirements were applied appropriately. Accordingly, the claim is eligible for external review under paragraph (d)(1)(i) of this section.

(2) *External review process standards*. The Federal external review process established pursuant to this paragraph (d) is considered similar to the process set forth in the NAIC Uniform Model Act and, therefore satisfies the requirements of paragraph (d)(2) if such process provides the following.

(i) *Request for external review*. A group health plan or health insurance issuer must allow a claimant to file a request for an external review with the plan or issuer if the request is filed within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

(ii) *Preliminary review*—(A) *In general*. Within five business days following the date of receipt of the external review request, the group health plan or health insurance issuer must complete a preliminary review of the request to determine whether:

(*1*) The claimant is or was covered under the plan or coverage at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan or coverage at the time the health care item or service was provided;

(*2*) The adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the group health plan or health insurance coverage (*e.g.*, worker classification or similar determination);

(*3*) The claimant has exhausted the plan's or issuer's internal appeal process unless the claimant is not required to exhaust the internal appeals process under paragraph (b)(1) of this section; and

(*4*) The claimant has provided all the information and forms required to process an external review.

(B) Within one business day after completion of the preliminary review, the plan or issuer must issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and current contact information, including the phone number, for the Employee Benefits Security Administration. If the request is not complete, such notification must describe the information or materials needed to make the request complete, and the plan or issuer must allow a claimant to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

(iii) *Referral to Independent Review Organization*—(A) *In general*. The group health plan or health insurance issuer must assign an IRO that is accredited by URAC or by similar nationally-recognized accrediting organization to conduct the external review. The IRO referral process must provide for the following:

(*1*) The plan or issuer must ensure that the IRO process is not biased and ensures independence;

(*2*) The plan or issuer must contract with at least three (3) IROs for assignments under the plan or coverage and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection); and

(*3*) The IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

(*4*) The IRO process may not impose any costs, including filing fees, on the claimant requesting the external review.

(B) *IRO contracts.* A group health plan or health insurance issuer must include the following standards in the contract between the plan or issuer and the IRO:

(*1*) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the plan or coverage.

(*2*) The assigned IRO will timely notify a claimant in writing whether the request is eligible for external review. This notice will include a statement that the claimant may submit in writing to the assigned IRO, within ten business days following the date of receipt of the notice, additional information. This additional information must be considered by the IRO when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

(*3*) Within five business days after the date of assignment of the IRO, the plan or issuer must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the plan or issuer to timely provide the documents and information must not delay the conduct of the external review. If the plan or issuer fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO must notify the claimant and the plan.

(*4*) Upon receipt of any information submitted by the claimant, the assigned IRO must within one business day forward the information to the plan or issuer. Upon receipt of any such information, the plan or issuer may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the plan or issuer must not delay the external review. The external review may be terminated as a result of the reconsideration only if the plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the plan must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the plan or issuer.

(*5*) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the plan's or issuer's internal claims and appeals process applicable under paragraph (b) of this section. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(*i*) The claimant's medical records;

(*ii*) The attending health care professional's recommendation;

(*iii*) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, claimant, or the claimant's treating provider;

(*iv*) The terms of the claimant's plan or coverage to ensure that the IRO's decision is not contrary to the terms of the plan or coverage, unless the terms are inconsistent with applicable law;

(*v*) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal Government, national or professional medical societies, boards, and associations;

(*vi*) Any applicable clinical review criteria developed and used by the plan or issuer, unless the criteria are inconsistent with the terms of the plan or coverage or with applicable law; and

(*vii*) To the extent the final IRO decision maker is different from the IRO's clinical reviewer, the opinion of such clinical reviewer, after considering information described in this notice, to the extent the information or documents are available and the clinical reviewer or reviewers consider such information or documents appropriate.

(*6*) The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of the final external review decision to the claimant and the plan or issuer.

(*7*) The assigned IRO's written notice of the final external review decision must contain the following:

(*i*) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates 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, the treatment code and its corresponding meaning, and the reason for the plan's or issuer's denial);

(*ii*) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(*iii*) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(*iv*) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(*v*) A statement that the IRO's determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or health insurance issuer or to the claimant, or to the extent the health plan or health insurance issuer voluntarily makes payment on the claim or otherwise provides benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits;

(*vi*) A statement that judicial review may be available to the claimant; and

(*vii*) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

(*viii*) After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the claimant, plan, issuer, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

(iv) *Reversal of plan's or issuer's decision*. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final adverse benefit determination, the plan or issuer immediately must provide coverage or payment (including immediately authorizing care or immediately paying benefits) for the claim.

(3) *Expedited external review*. A group health plan or health insurance issuer must comply with the following standards with respect to an expedited external review:

(i) *Request for external review*. A group health plan or health insurance issuer must allow a claimant to make a request for an expedited external review with the plan or issuer at the time the claimant receives:

(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; 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 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 item or service for which the claimant received emergency services, but has not been discharged from the facility.

(ii) *Preliminary review.* Immediately upon receipt of the request for expedited external review, the plan or issuer must determine whether the request meets the reviewability requirements set forth in paragraph (d)(2)(ii) of this section for standard external review. The plan or issuer must immediately send a notice that meets the requirements set forth in paragraph (d)(2)(ii)(B) for standard review to the claimant of its eligibility determination.

(iii) *Referral to independent review organization.* (A) Upon a determination that a request is eligible for expedited external review following the preliminary review, the plan or issuer will assign an IRO pursuant to the requirements set forth in paragraph (d)(2)(iii) of this section for standard review. The plan or issuer must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

(B) The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the plan's or issuer's internal claims and appeals process.

(iv) *Notice of final external review decision.* The plan's or issuer's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in paragraph (d)(2)(iii)(B) of this section, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the plan or issuer.

(4) *Alternative, federally-administered external review process.* Insured coverage not subject to an applicable State external review process under paragraph (c) of this section may elect to use either the Federal external review process, as set forth under paragraph (d) of this section or the federally-administered external review process, as set forth by HHS in guidance. In such circumstances, the requirement to provide external review under this paragraph (d) is satisfied.

(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 includes answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language;

(ii) The plan or issuer must provide, upon request, a notice in any applicable non-English language; and

(iii) The plan or issuer must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the plan or issuer.

(3) *Applicable non-English language.* With respect to an address in any United States county to which a notice is sent, a non-English language is an applicable non-English language if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary.

(f) *Secretarial authority*. The Secretary may determine that the external review process of a group health plan or health insurance issuer, in operation as of March 23, 2010, is considered in compliance with the applicable process established under paragraph (c) or (d) of this section if it substantially meets the requirements of paragraph (c) or (d) of this section, as applicable.

(g) *Applicability date*. The provisions of this section generally are applicable to group health plans and health insurance issuers for plan years beginning on or after January 1, 2017. The external review scope provision at paragraph (d)(1)(i)(B) of this section is applicable for plan years beginning on or after January 1, 2022. The external review provisions described in paragraphs (c) and (d) of this section are applicable to grandfathered health plans, with respect to the types of claims specified under paragraph (a)(1)(ii) of this section, for plan years beginning on or after January 1, 2022.

[T.D. 9955, 86 FR 56092, Oct. 7, 2021]

§ 54.9815–2719A Patient protections.

(a) *Choice of health care professional*—(1) *Designation of primary care provider*—(i) *In general*. If a group health plan, or a health insurance issuer offering group health insurance coverage, requires or provides for designation by a participant or beneficiary of a participating primary care provider, then the plan or issuer must permit each participant or beneficiary to designate any participating primary care provider who is available to accept the participant or beneficiary. In such a case, the plan or issuer must comply with the rules of paragraph (a)(4) of this section by informing each participant of the terms of the plan or health insurance coverage regarding designation of a primary care provider.

(ii) *Construction*. Nothing in paragraph (a)(1)(i) of this section is to be construed to prohibit the application of reasonable and appropriate geographic limitations with respect to the selection of primary care providers, in accordance with the terms of the plan or coverage, the underlying provider contracts, and applicable State law.

(iii) *Example*. The rules of this paragraph (a)(1) are illustrated by the following example:

Example. (i) *Facts*. A group health plan requires individuals covered under the plan to designate a primary care provider. The plan permits each individual to designate any primary care provider participating in the plan's network who is available to accept the individual as the individual's primary care provider. If an individual has not designated a primary care provider, the plan designates one until one has been designated by the individual. The plan provides a notice that satisfies the requirements of paragraph (a)(4) of this section regarding the ability to designate a primary care provider.

(ii) *Conclusion*. In this *Example*, the plan has satisfied the requirements of paragraph (a) of this section.

(2) *Designation of pediatrician as primary care provider*—(i) *In general*. If a group health plan, or a health insurance issuer offering group health insurance coverage, requires or provides for the designation of a participating primary care provider for a child by a participant or beneficiary, the plan or issuer must permit the participant or beneficiary to designate a physician (allopathic or osteopathic) who specializes in pediatrics (including pediatric subspecialties, based on the scope of that provider's license under applicable State law) as the child's primary care provider if the provider participates in the network of the plan or issuer and is available to accept the child. In such a case, the plan or issuer must comply with the rules of paragraph (a)(4) of this section by informing each participant of the terms of the plan or health insurance coverage regarding designation of a pediatrician as the child's primary care provider.

(ii) *Construction*. Nothing in paragraph (a)(2)(i) of this section is to be construed to waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.

(iii) *Examples*. The rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) *Facts*. A group health plan's HMO designates for each participant a physician who specializes in internal medicine to serve as the primary care provider for the

participant and any beneficiaries. Participant *A* requests that Pediatrician *B* be designated as the primary care provider for *A*'s child. *B* is a participating provider in the HMO's network and is available to accept the child.

(ii) *Conclusion.* In this *Example 1,* the HMO must permit *A*'s designation of *B* as the primary care provider for *A*'s child in order to comply with the requirements of this paragraph (a)(2).

Example 2. (i) *Facts.* Same facts as *Example 1,* except that *A* takes *A*'s child to *B* for treatment of the child's severe shellfish allergies. *B* wishes to refer *A*'s child to an allergist for treatment. The HMO, however, does not provide coverage for treatment of food allergies, nor does it have an allergist participating in its network, and it therefore refuses to authorize the referral.

(ii) *Conclusion.* In this *Example 2,* the HMO has not violated the requirements of this paragraph (a)(2) because the exclusion of treatment for food allergies is in accordance with the terms of *A*'s coverage.

(3) *Patient access to obstetrical and gynecological care*—(i) *General rights*—(A) *Direct access.* A group health plan, or a health insurance issuer offering group health insurance coverage, described in paragraph (a)(3)(ii) of this section may not require authorization or referral by the plan, issuer, or any person (including a primary care provider) in the case of a female participant or beneficiary who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. In such a case, the plan or issuer must comply with the rules of paragraph (a)(4) of this section by informing each participant that the plan may not require authorization or referral for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology. The plan or issuer may require such a professional to agree to otherwise adhere to the plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer. For purposes of this paragraph (a)(3), a health care professional who specializes in obstetrics or gynecology is any individual (including a person other than a physician) who is authorized under applicable State law to provide obstetrical or gynecological care.

(B) *Obstetrical and gynecological care.* A group health plan or health insurance issuer described in paragraph (a)(3)(ii) of this section must treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under paragraph (a)(3)(i)(A) of this section, by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

(ii) *Application of paragraph.* A group health plan, or a health insurance issuer offering group health insurance coverage, is described in this paragraph (a)(3) if the plan or issuer—

(A) Provides coverage for obstetrical or gynecological care; and

(B) Requires the designation by a participant or beneficiary of a participating primary care provider.

(iii) *Construction.* Nothing in paragraph (a)(3)(i) of this section is to be construed to—

(A) Waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

(B) Preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.

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

Example 1. (i) *Facts.* A group health plan requires each participant to designate a physician to serve as the primary care provider for the participant and the participant's family. Participant *A,* a female, requests a gynecological exam with Physician *B,* an in-network physician specializing in gynecological care. The group health plan requires prior authorization from *A*'s designated primary care provider for the gynecological exam.

(ii) *Conclusion.* In this *Example 1,* the group health plan has violated the requirements of this paragraph (a)(3) because the plan requires prior authorization from *A*'s primary care provider prior to obtaining gynecological services.

Example 2. (i) *Facts.* Same facts as *Example 1* except that *A* seeks gynecological services from *C*, an out-of-network provider.

(ii) *Conclusion.* In this *Example 2,* the group health plan has not violated the requirements of this paragraph (a)(3) by requiring prior authorization because *C* is not a participating health care provider.

Example 3. (i) *Facts.* Same facts as *Example 1* except that the group health plan only requires *B* to inform *A*'s designated primary care physician of treatment decisions.

(ii) *Conclusion.* In this *Example 3,* the group health plan has not violated the requirements of this paragraph (a)(3) because *A* has direct access to *B* without prior authorization. The fact that the group health plan requires notification of treatment decisions to the designated primary care physician does not violate this paragraph (a)(3).

Example 4. (i) *Facts.* A group health plan requires each participant to designate a physician to serve as the primary care provider for the participant and the participant's family. The group health plan requires prior authorization before providing benefits for uterine fibroid embolization.

(ii) *Conclusion.* In this *Example 4,* the plan requirement for prior authorization before providing benefits for uterine fibroid embolization does not violate the requirements of this paragraph (a)(3) because, though the prior authorization requirement applies to obstetrical services, it does not restrict access to any providers specializing in obstetrics or gynecology.

(4) *Notice of right to designate a primary care provider*—(i) *In general.* If a group health plan or health insurance issuer requires the designation by a participant or beneficiary of a primary care provider, the plan or issuer must provide a notice informing each participant of the terms of the plan or health insurance coverage regarding designation of a primary care provider and of the rights—

(A) Under paragraph (a)(1)(i) of this section, that any participating primary care provider who is available to accept the participant or beneficiary can be designated;

(B) Under paragraph (a)(2)(i) of this section, with respect to a child, that any participating physician who specializes in pediatrics can be designated as the primary care provider; and

(C) Under paragraph (a)(3)(i) of this section, that the plan may not require authorization or referral for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology.

(ii) *Timing.* The notice described in paragraph (a)(4)(i) of this section must be included whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage.

(iii) *Model language.* The following model language can be used to satisfy the notice requirement described in paragraph (a)(4)(i) of this section:

(A) For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:

> [Name of group health plan or health insurance issuer] generally [requires/allows] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan or health insurance issuer] designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the [plan administrator or issuer] at [insert contact information].

(B) For plans and issuers that require or allow for the designation of a primary care provider for a child, add:

> For children, you may designate a pediatrician as the primary care provider.

(C) For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:

> You do not need prior authorization from [name of group health plan or issuer] or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the [plan administrator or issuer] at [insert contact information].

(b) *Coverage of emergency services*—(1) *Scope.* If a group health plan, or a health insurance issuer offering group

health insurance coverage, provides any benefits with respect to services in an emergency department of a hospital, the plan or issuer must cover emergency services (as defined in paragraph (b)(4)(ii) of this section) consistent with the rules of this paragraph (b).

(2) *General rules.* A plan or issuer subject to the requirements of this paragraph (b) must provide coverage for emergency services in the following manner—

(i) Without the need for any prior authorization determination, even if the emergency services are provided on an out-of-network basis;

(ii) Without regard to whether the health care provider furnishing the emergency services is a participating network provider with respect to the services;

(iii) If the emergency services are provided out of network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from in-network providers;

(iv) If the emergency services are provided out of network, by complying with the cost-sharing requirements of paragraph (b)(3) of this section; and

(v) Without regard to any other term or condition of the coverage, other than—

(A) The exclusion of or coordination of benefits;

(B) An affiliation or waiting period permitted under part 7 of ERISA, part A of title XXVII of the PHS Act, or chapter 100 of the Internal Revenue Code; or

(C) Applicable cost sharing.

(3) *Cost-sharing requirements*—(i) *Copayments and coinsurance.* Any cost-sharing requirement expressed as a copayment amount or coinsurance rate imposed with respect to a participant or beneficiary for out-of-network emergency services cannot exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if the services were provided in-network. However, a participant or beneficiary may be required to pay, in addition to the in-network cost sharing, the excess of the amount the out-of-network provider charges over the amount the plan or issuer is required to pay under this paragraph (b)(3)(i). A group health plan or health insurance issuer complies with the requirements of this paragraph (b)(3) if it provides benefits with respect to an emergency service in an amount at least equal to the greatest of the three amounts specified in paragraphs (b)(3)(i)(A), (B), and (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) *Special rules regarding out-of-network minimum payment standards*—(A) The minimum payment standards set forth under paragraph (b)(3) of this section do not apply in cases where State law prohibits a participant or beneficiary from being 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 provides in benefits, or where a group health plan or health insurance issuer is contractually responsible for such amounts. Nonetheless, in such cases, a plan or issuer may not impose any copayment or coinsurance requirement for out-of-network emergency services that is higher than the copayment or coinsurance requirement that would apply if the services were provided in network.

(B) A group health plan and health insurance issuer must provide a participant or beneficiary adequate and prominent notice of their lack of financial responsibility with respect to the amounts described under this paragraph (b)(3)(iii), to prevent inadvertent payment by the participant or beneficiary.

(iv) *Examples.* The rules of this paragraph (b)(3) are illustrated by the following examples. In all of these examples, the group health plan covers benefits with respect to emergency services.

Example 1. (i) *Facts.* A group health plan imposes a 25% coinsurance responsibility on individuals who are furnished emergency services, whether provided in network or out of network. If a covered individual notifies the plan within two business days after the day an individual receives treatment in an emergency department, the plan reduces the coinsurance rate to 15%.

(ii) *Conclusion.* In this *Example 1*, the requirement to notify the plan in order to receive a reduction in the coinsurance rate does not violate the requirement that the plan cover emergency services without the need for any prior authorization determination. This is the result even if the plan required that it be notified before or at the time of receiving services at the emergency department in order to receive a reduction in the coinsurance rate.

Example 2. (i) *Facts.* A group health plan imposes a $60 copayment on emergency services without preauthorization, whether provided in network or out of network. If emergency services are preauthorized, the plan waives the copayment, even if it later determines the medical condition was not an emergency medical condition.

(ii) *Conclusion.* In this *Example 2*, by requiring an individual to pay more for emergency services if the individual does not obtain prior authorization, the plan violates the requirement that the plan cover emergency services without the need for any prior authorization determination. (By contrast, if, to have the copayment waived, the plan merely required that it be notified rather than a prior authorization, then the plan would not violate the requirement that the plan cover emergency services without the need for any prior authorization determination.)

Example 3. (i) *Facts.* A group health plan covers individuals who receive emergency services with respect to an emergency medical condition from an out-of-network provider. The plan has agreements with in-network providers with respect to a certain emergency service. Each provider has agreed to provide the service for a certain amount. Among all the providers for the service: One has agreed to accept $85, two have agreed to accept $100, two have agreed to accept $110, three have agreed to accept $120, and one has agreed to accept $150. Under the agreement, the plan agrees to pay the providers 80% of

the agreed amount, with the individual receiving the service responsible for the remaining 20%.

(ii) *Conclusion*. In this *Example 3*, the values taken into account in determining the median are $85, $100, $100, $110, $110, $120, $120, $120, and $150. Therefore, the median amount among those agreed to for the emergency service is $110, and the amount under paragraph (b)(3)(i)(A) of this section is 80% of $110 ($88).

Example 4. (i) *Facts*. Same facts as *Example 3*. Subsequently, the plan adds another provider to its network, who has agreed to accept $150 for the emergency service.

(ii) *Conclusion*. In this *Example 4*, the median amount among those agreed to for the emergency service is $115. (Because there is no one middle amount, the median is the average of the two middle amounts, $110 and $120.) Accordingly, the amount under paragraph (b)(3)(i)(A) of this section is 80% of $115 ($92).

Example 5. (i) *Facts*. Same facts as *Example 4*. An individual covered by the plan receives the emergency service from an out-of-network provider, who charges $125 for the service. With respect to services provided by out-of-network providers generally, the plan reimburses covered individuals 50% of the reasonable amount charged by the provider for medical services. For this purpose, the reasonable amount for any service is based on information on charges by all providers collected by a third party, on a zip code by zip code basis, with the plan treating charges at a specified percentile as reasonable. For the emergency service received by the individual, the reasonable amount calculated using this method is $116. The amount that would be paid under Medicare for the emergency service, excluding any copayment or coinsurance for the service, is $80.

(ii) *Conclusion*. In this *Example 5*, the plan is responsible for paying $92.80, 80% of $116. The median amount among those agreed to for the emergency service is $115 and the amount the plan would pay is $92 (80% of $115); the amount calculated using the same method the plan uses to determine payments for out-of-network services—$116—excluding the in-network 20% coinsurance, is $92.80; and the Medicare payment is $80. Thus, the greatest amount is $92.80. The individual is responsible for the remaining $32.20 charged by the out-of-network provider.

Example 6. (i) *Facts*. Same facts as *Example 5*. The group health plan generally imposes a $250 deductible for in-network health care. With respect to all health care provided by out-of-network providers, the plan imposes a $500 deductible. (Covered in-network claims are credited against the deductible.) The individual has incurred and submitted $260 of covered claims prior to receiving the emergency service out of network.

(ii) *Conclusion*. In this *Example 6*, the plan is not responsible for paying anything with respect to the emergency service furnished by the out-of-network provider because the covered individual has not satisfied the higher deductible that applies generally to all health care provided out of network. However, the amount the individual is required to pay is credited against the deductible.

(4) *Definitions*. The definitions in this paragraph (b)(4) govern in applying the provisions of this paragraph (b).

(i) *Emergency medical condition*. The term *emergency medical condition* means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). (In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.)

(ii) *Emergency services*. The term *emergency services* means, with respect to an emergency medical condition—

(A) A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

(B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

(iii) *Stabilize*. The term *to stabilize*, with respect to an emergency medical condition (as defined in paragraph (b)(4)(i) of this section) has the meaning given in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(c) *Applicability date*. The provisions of this section are applicable to group health plans and health insurance issuers for plan years beginning on or after January 1, 2017. Until the applicability date for this regulation, plans and issuers are required to continue to comply with the interim final regulations promulgated by the Department of Labor at 29 CFR part 2590, contained in the 29 CFR, parts 1927 to end, edition revised as of July 1, 2015.

[T.D. 9744, 80 FR 72252, Nov. 18, 2015]

§ 54.9815–2719AT Patient protections (temporary).

(a)–(b) [Reserved]

(c) *Applicability date*. The provisions of this section are applicable to group health plans and health insurance issuers for plan years beginning before January 1, 2022. *See also* §§ 54.9816–4T through 54.9816–7T, 54.9817–1T, and 54.9822–1T for rules applicable with respect to plan years beginning on or after January 1, 2022.

[T.D. 9951, 86 FR 36950, July 13, 2021]

§ 54.9816–1T Basis and scope (temporary).

(a) *Basis*. This section and §§ 54.9816–2T through 54.9816–8T, 54.9817–1T, 54.9817–2T, and 54.9822–1T implement subchapter B of chapter 100 of the Internal Revenue Code of 1986.

(b) *Scope*. This part establishes standards for group health plans with respect to surprise medical bills, transparency in health care coverage, and additional patient protections. This part also establishes an independent dispute resolution process and standards for certifying independent dispute resolution entities.

[T.D. 9955, 86 FR 56099, Oct. 7, 2021]

§ 54.9816–2T Applicability (temporary).

(a) *In general*. (1) The requirements in §§ 54.9816–4T through 54.9816–7T, 54.9817–1T, and 54.9822–1T apply to group health plans (including grandfathered health plans as defined in § 54.9815–1251), except as specified in paragraph (b) of this section.

(2) The requirements in §§ 54.9816–8T and 54.9817–2T apply to certified IDR entities and group health plans (including grandfathered health plans as defined in § 54.9815–1251) except as specified in paragraph (b) of this section.

(b) *Exceptions*. The requirements in §§ 54.9816–4T through 54.9816–8T, 54.9817–1T, 54.9817–2T, and 54.9822–1T do not apply to the following:

(1) Excepted benefits as described in § 54.9831–1(c).

(2) Short-term, limited-duration insurance as defined in § 54.9801–2.

(3) Health reimbursement arrangements or other account-based group health plans as described in § 54.9815–2711(d).

[T.D. 9951, 86 FR 36950, July 13, 2021, as amended by T.D. 9955, 86 FR 56100, Oct. 7, 2021]

§ 54.9816–3T Definitions (temporary).

The definitions in § 54.9801–2T apply to §§ 54.9816–4T through 54.9816–7T, 54.9817–1T, and 54.9822–1T unless otherwise specified. In addition, for purposes of §§ 54.9816–4T through 54.9816–7T, 54.9817–1T, and 54.9822–1T, the following definitions apply:

Air ambulance service means medical transport by a rotary wing air ambulance, as defined in 42 CFR 414.605, or fixed wing air ambulance, as defined in 42 CFR 414.605, for patients.

Cost sharing means the amount a participant, beneficiary, or enrollee is responsible for paying for a covered item or service under the terms of the group health plan or health insurance coverage. Cost sharing generally includes copayments, coinsurance, and amounts paid towards deductibles, but does not include amounts paid towards premiums, balance billing by out-of-network providers, or the cost of items or services that are not covered under a group health plan or health insurance coverage.

Emergency department of a hospital includes a hospital outpatient department that provides emergency services.

Emergency medical condition has the meaning given the term in § 54.9816–4T(c)(1).

Emergency services has the meaning given the term in § 54.9816–4T(c)(2).

Health care facility, with respect to a group health plan, in the context of non-emergency services, is each of the following:

(1) A hospital (as defined in section 1861(e) of the Social Security Act);

(2) A hospital outpatient department;

(3) A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and

(4) An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

Independent freestanding emergency department means a health care facility (not limited to those described in the definition of health care facility with respect to non-emergency services) that—

(1) Is geographically separate and distinct and licensed separately from a hospital under applicable State law; and

(2) Provides any emergency services as described in § 54.9816–4T(c)(2)(i).

Nonparticipating emergency facility means an emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to services that pursuant to § 54.9816–4T(c)(2)(ii) are included as emergency services), that does not have a contractual relationship directly or indirectly with a group health plan, with respect to the furnishing of an item or service under the plan.

Nonparticipating provider means any physician or other health care provider who does not have a contractual relationship directly or indirectly with a group health plan, with respect to the furnishing of an item or service under the plan.

Notice of denial of payment means, with respect to an item or service for which benefits subject to the protections of §§ 54.9816–4T, 54.9816–5T, and 54.9817–1T are provided or covered, a written notice from the plan to the health care provider, facility, or provider of air ambulance services, as applicable, that payment for such item or service will not be made by the plan and which explains the reason for denial. The term notice of denial of payment does not include a notice of benefit denial due to an adverse benefit determination as defined in 29 CFR 2560.503–1.

Out-of-network rate means, with respect to an item or service furnished by a nonparticipating provider, nonparticipating emergency facility, or nonparticipating provider of air ambulance services—

(1) Subject to paragraph (3) of this definition, in a State that has in effect a specified State law, the amount determined in accordance with such law;

(2) Subject to paragraph (3) of this definition, in a State that does not have in effect a specified State law—

(i) Subject to paragraph (2)(ii) of this definition, if the nonparticipating provider or nonparticipating emergency facility and the plan agree on an amount of payment (including if the amount agreed upon is the initial payment sent by the plan under § 54.9816–4T(b)(3)(iv)(A), § 54.9816–5T(c)(3), or § 54.9817–1T(b)(4)(i); 29 CFR 2590.716–4(b)(3)(iv)(A), 2590.716–5(c)(3), or 2590.717–1(b)(4)(i); or 45 CFR 149.110(b)(3)(iv)(A), 149.120(c)(3), or 149.130(b)(4)(i), as applicable, or is agreed on through negotiations with respect to such item or service), such agreed on amount; or

(ii) If the nonparticipating provider or nonparticipating emergency facility and the plan enter into the independent dispute resolution (IDR) process under section 9816(c) or 9817(b) of the Internal Revenue Code, section 716(c) or 717(b) of ERISA, or section 2799A–1(c) or 2799A–2(b) of the PHS Act, as applicable, and do not agree before the date on which a certified IDR entity makes a determination with respect to such item or service under such subsection, the amount of such determination; or

(3) In a State that has an All-Payer Model Agreement under section 1115A of the Social Security Act that applies with respect to the plan; the nonparticipating provider or nonparticipating emergency facility; and the item or service, the amount that the State approves under the All-Payer Model Agreement for the item or service.

Participating emergency facility means any emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to services that pursuant to § 54.9816–4T(c)(2)(ii) are included as emergency services), that has a contractual relationship directly or indirectly with a group health plan setting forth the terms and conditions on

which a relevant item or service is provided to a participant or beneficiary under the plan. A single case agreement between an emergency facility and a plan that is used to address unique situations in which a participant or beneficiary requires services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition, and is limited to the parties to the agreement.

Participating health care facility means any health care facility described in this section that has a contractual relationship directly or indirectly with a group health plan setting forth the terms and conditions on which a relevant item or service is provided to a participant or beneficiary under the plan. A single case agreement between a health care facility and a plan that is used to address unique situations in which a participant or beneficiary requires services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition, and is limited to the parties to the agreement.

Participating provider means any physician or other health care provider who has a contractual relationship directly or indirectly with a group health plan setting forth the terms and conditions on which a relevant item or service is provided to a participant or beneficiary under the plan.

Physician or health care provider means a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law, but does not include a provider of air ambulance services.

Provider of air ambulance services means an entity that is licensed under applicable State and Federal law to provide air ambulance services.

Same or similar item or service has the meaning given the term in § 54.9816–6T(a)(13).

Service code has the meaning given the term in § 54.9816–6T(a)(14).

Qualifying payment amount has the meaning given the term in § 54.9816–6T(a)(16).

Recognized amount means, with respect to an item or service furnished by a nonparticipating provider or nonparticipating emergency facility—

(1) Subject to paragraph (3) of this definition, in a State that has in effect a specified State law, the amount determined in accordance with such law.

(2) Subject to paragraph (3) of this definition, in a State that does not have in effect a specified State law, the lesser of—

(i) The amount that is the qualifying payment amount (as determined in accordance with § 54.9816–6T); or

(ii) The amount billed by the provider or facility.

(3) In a State that has an All-Payer Model Agreement under section 1115A of the Social Security Act that applies with respect to the plan; the nonparticipating provider or nonparticipating emergency facility; and the item or service, the amount that the State approves under the All-Payer Model Agreement for the item or service.

Specified State law means a State law that provides for a method for determining the total amount payable under a group health plan to the extent such State law applies for an item or service furnished by a nonparticipating provider or nonparticipating emergency facility (including where it applies because the State has allowed a plan that is not otherwise subject to applicable State law an opportunity to opt in, subject to section 514 of the Employee Retirement Income Security Act of 1974). A group health plan that opts into such a specified State law must do so for all items and services to which the specified State law applies and in a manner determined by the applicable State authority, and must prominently display in its plan materials describing the coverage of out-of-network services a statement that the plan has opted into the specified State law, identify the relevant State (or States), and include a general description of the items and services provided by nonparticipating facilities and providers that are covered by the specified State law.

State means each of the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Treating provider is a physician or health care provider who has evaluated the individual.

Visit, with respect to items and services furnished to an individual at a health care facility, includes, in addition to items and services furnished by a provider at the facility, equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services, regardless of whether the provider furnishing such items or services is at the facility.

[T.D. 9951, 86 FR 36950, July 13, 2021]

§ 54.9816–4T Preventing surprise medical bills for emergency services (temporary).

(a) *In general.* If a group health plan provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department, the plan must cover emergency services, as defined in paragraph (c)(2) of this section, and this coverage must be provided in accordance with paragraph (b) of this section.

(b) *Coverage requirements.* A plan described in paragraph (a) of this section must provide coverage for emergency services in the following manner—

(1) Without the need for any prior authorization determination, even if the services are provided on an out-of-network basis.

(2) Without regard to whether the health care provider furnishing the emergency services is a participating provider or a participating emergency facility, as applicable, with respect to the services.

(3) If the emergency services are provided by a nonparticipating provider or a nonparticipating emergency facility—

(i) 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 participating providers and participating emergency facilities.

(ii) Without imposing cost-sharing requirements that are greater than the requirements that would apply if the services were provided by a participating provider or a participating emergency facility.

(iii) By calculating the cost-sharing requirement as if the total amount that would have been charged for the services by such participating provider or participating emergency facility were equal to the recognized amount for such services.

(iv) The plan—

(A) Not later than 30 calendar days after the bill for the services is transmitted by the provider or facility (or, in cases where the recognized amount is determined by a specified State law or All-Payer Model Agreement, such other timeframe as specified by the State law or All-Payer Model Agreement), determines whether the services are covered under the plan and, if the services are covered, sends to the provider or facility, as applicable, an initial payment or a notice of denial of payment. For purposes of this paragraph (b)(3)(iv)(A), the 30-calendar-day period begins on the date the plan receives the information necessary to decide a claim for payment for the services.

(B) Pays a total plan payment directly to the nonparticipating provider or nonparticipating facility that is equal to the amount by which the out-of-network rate for the services exceeds the cost-sharing amount for the services (as determined in accordance with paragraphs (b)(3)(ii) and (iii) of this section), less any initial payment amount made under paragraph (b)(3)(iv)(A) of this section. The total plan payment must be made in accordance with the timing requirement described in section 9816(c)(6), or in cases where the out-of-network rate is determined under a specified State law or All-Payer Model Agreement, such other timeframe as specified by the State law or All-Payer Model Agreement.

(v) By counting any cost-sharing payments made by the participant or beneficiary with respect to the emergency services toward any in-network deductible or in-network out-of-pocket maximums (including the annual limitation on cost sharing under section 2707(b) of the Public Health Service Act) (as applicable) applied under the plan (and

the in-network deductible and in-network out-of-pocket maximums must be applied) in the same manner as if the cost-sharing payments were made with respect to emergency services furnished by a participating provider or a participating emergency facility.

(4) Without limiting what constitutes an emergency medical condition (as defined in paragraph (c)(1) of this section) solely on the basis of diagnosis codes.

(5) Without regard to any other term or condition of the coverage, other than—

(i) The exclusion or coordination of benefits (to the extent not inconsistent with benefits for an emergency medical condition, as defined in paragraph (c)(1) of this section).

(ii) An affiliation or waiting period (each as defined in §54.9801–2).

(iii) Applicable cost sharing.

(c) *Definitions*. In this section—

(1) *Emergency medical condition* means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such 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.)

(2) *Emergency services* means, with respect to an emergency medical condition—

(i) *In general*. (A) An appropriate medical screening examination (as required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

(B) Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

(ii) *Inclusion of additional services*. (A) Subject to paragraph (c)(2)(ii)(B) of this section, items and services—

(*1*) For which benefits are provided or covered under the plan; and

(*2*) That are furnished by a nonparticipating provider or nonparticipating emergency facility (regardless of the department of the hospital in which such items or services are furnished) after the participant or beneficiary is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described in paragraph (c)(2)(i) of this section are furnished.

(B) Items and services described in paragraph (c)(2)(ii)(A) of this section are not included as emergency services if all of the conditions in 45 CFR 149.410(b) are met.

(3) *To stabilize*, with respect to an emergency medical condition, has the meaning given such term in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(d) *Applicability date*. The provisions of this section are applicable with respect to plan years beginning on or after January 1, 2022.

[T.D. 9951, 86 FR 36950, July 13, 2021]

§ 54.9816–5T Preventing surprise medical bills for non-emergency services performed by nonparticipating providers at certain participating facilities (temporary).

(a) *In general.* If a group health plan provides or covers any benefits with respect to items and services described in paragraph (b) of this section, the plan must cover the items and services when furnished by a nonparticipating provider in accordance with paragraph (c) of this section.

(b) *Items and services described.* The items and services described in this paragraph (b) are items and services (other than emergency services) furnished to a participant or beneficiary by a nonparticipating provider with respect to a visit at a participating health care facility, unless the provider has satisfied the notice and consent criteria of 45 CFR 149.420(c) through (i) with respect to such items and services.

(c) *Coverage requirements.* In the case of items and services described in paragraph (b) of this section, the plan—

(1) Must not impose a cost-sharing requirement for the items and services that is greater than the cost-sharing requirement that would apply if the items or services had been furnished by a participating provider.

(2) Must calculate the cost-sharing requirements as if the total amount that would have been charged for the items and services by such participating provider were equal to the recognized amount for the items and services.

(3) Not later than 30 calendar days after the bill for the items or services is transmitted by the provider (or in cases where the recognized amount is determined by a specified State law or All-Payer Model Agreement, such other timeframe as specified under the State law or All-Payer Model Agreement), must determine whether the items and services are covered under the plan and, if the items and services are covered, send to the provider an initial payment or a notice of denial of payment. For purposes of this paragraph (c)(3), the 30-calendar-day period begins on the date the plan receives the information necessary to decide a claim for payment for the items or services.

(4) Must pay a total plan payment directly to the nonparticipating provider that is equal to the amount by which the out-of-network rate for the items and services involved exceeds the cost-sharing amount for the items and services (as determined in accordance with paragraphs (c)(1) and (2) of this section), less any initial payment amount made under paragraph (c)(3) of this section. The total plan payment must be made in accordance with the timing requirement described in section 9816(c)(6) or in cases where the out-of-network rate is determined under a specified State law or All-Payer Model Agreement, such other timeframe as specified by the State law or All-Payer Model Agreement.

(5) Must count any cost-sharing payments made by the participant or beneficiary toward any in-network deductible and in-network out-of-pocket maximums (including the annual limitation on cost sharing under section 2707(b) of the Public Health Service Act) (as applicable) applied under the plan (and the in-network deductible and out-of-pocket maximums must be applied) in the same manner as if such cost-sharing payments were made with respect to items and services furnished by a participating provider.

(d) *Applicability date.* The provisions of this section are applicable with respect to plan years beginning on or after January 1, 2022.

[T.D. 9951, 86 FR 36950, July 13, 2021]

§ 54.9816–6T Methodology for calculating qualifying payment amount (temporary).

(a) *Definitions.* For purposes of this section, the following definitions apply:

(1) *Contracted rate* means the total amount (including cost sharing) that a group health plan has contractually agreed to pay a participating provider, facility, or provider of air ambulance services for covered items and services, whether directly or indirectly, including through a third-party administrator or pharmacy benefit manager. Solely for purposes of this definition, a

single case agreement, letter of agreement, or other similar arrangement between a provider, facility, or air ambulance provider and a plan, used to supplement the network of the plan for a specific participant or beneficiary in unique circumstances, does not constitute a contract.

(2) *Derived amount* has the meaning given the term in §54.9815–2715A1.

(3) *Eligible database* means—

(i) A State all-payer claims database; or

(ii) Any third-party database which—

(A) Is not affiliated with, or owned or controlled by, any health insurance issuer, or a health care provider, facility, or provider of air ambulance services (or any member of the same controlled group as, or under common control with, such an entity). For purposes of this paragraph (a)(3)(ii)(A), the term controlled group means a group of two or more persons that is treated as a single employer under sections 52(a), 52(b), 414(m), or 414(o) of the Internal Revenue Code of 1986, as amended;

(B) Has sufficient information reflecting in-network amounts paid by group health plans or health insurance issuers offering group or individual health insurance coverage to providers, facilities, or providers of air ambulance services for relevant items and services furnished in the applicable geographic region; and

(C) Has the ability to distinguish amounts paid to participating providers and facilities by commercial payers, such as group health plans and health insurance issuers offering group or individual health insurance coverage, from all other claims data, such as amounts billed by nonparticipating providers or facilities and amounts paid by public payers, including the Medicare program under title XVIII of the Social Security Act, the Medicaid program under title XIX of the Social Security Act (or a demonstration project under title XI of the Social Security Act), or the Children's Health Insurance Program under title XXI of the Social Security Act.

(4) *Facility of the same or similar facility type* means, with respect to emergency services, either—

(i) An emergency department of a hospital; or

(ii) An independent freestanding emergency department.

(5) *First coverage year* means, with respect to an item or service for which coverage is not offered in 2019 under a group health plan, the first year after 2019 for which coverage for such item or service is offered under that plan.

(6) *First sufficient information year* means, with respect to a group health plan—

(i) In the case of an item or service for which the plan does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section in 2019, the first year after 2022 for which the plan has sufficient information to calculate the median of such contracted rates in the year immediately preceding that first year after 2022; and

(ii) In the case of a newly covered item or service, the first year after the first coverage year for such item or service with respect to such plan for which the plan has sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section in the year immediately preceding that first year.

(7) *Geographic region* means—

(i) For items and services other than air ambulance services—

(A) Subject to paragraphs (a)(7)(i)(B) and (C) of this section, one region for each metropolitan statistical area, as described by the U.S. Office of Management and Budget and published by the U.S. Census Bureau, in a State, and one region consisting of all other portions of the State.

(B) If a plan does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section for an item or service provided in a geographic region described in paragraph (a)(7)(i)(A) of this section, one region consisting of all metropolitan statistical areas, as described by the U.S. Office of Management and Budget and published by the U.S. Census Bureau, in the State, and one region consisting of all other portions of the State.

(C) If a plan does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section for an item or service provided in a geographic region

described in paragraph (a)(7)(i)(B) of this section, one region consisting of all metropolitan statistical areas, as described by the U.S. Office of Management and Budget and published by the U.S. Census Bureau, in each Census division and one region consisting of all other portions of the Census division, as described by the U.S. Census Bureau.

(ii) For air ambulance services—

(A) Subject to paragraph (a)(7)(ii)(B) of this section, one region consisting of all metropolitan statistical areas, as described by the U.S. Office of Management and Budget and published by the U.S. Census Bureau, in the State, and one region consisting of all other portions of the State, determined based on the point of pick-up (as defined in 42 CFR 414.605).

(B) If a plan does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section for an air ambulance service provided in a geographic region described in paragraph (a)(7)(ii)(A) of this section, one region consisting of all metropolitan statistical areas, as described by the U.S. Office of Management and Budget and published by the U.S. Census Bureau, in each Census division and one region consisting of all other portions of the Census division, as described by the U.S. Census Bureau, determined based on the point of pick-up (as defined in 42 CFR 414.605).

(8) *Insurance market* is, irrespective of the State, one of the following:

(i) The individual market (other than short-term, limited-duration insurance or individual health insurance coverage that consists solely of excepted benefits).

(ii) The large group market (other than coverage that consists solely of excepted benefits).

(iii) The small group market (other than coverage that consists solely of excepted benefits).

(iv) In the case of a self-insured group health plan, all self-insured group health plans (other than account-based plans, as defined in § 54.9815–2711(d)(6)(i), and plans that consist solely of excepted benefits) of the same plan sponsor, or at the option of the plan sponsor, all self-insured group health plans administered by the same entity (including a third-party administrator contracted by the plan), to the extent otherwise permitted by law, that is responsible for calculating the qualifying payment amount on behalf of the plan.

(9) *Modifiers* mean codes applied to the service code that provide a more specific description of the furnished item or service and that may adjust the payment rate or affect the processing or payment of the code billed.

(10) *Newly covered item or service* means an item or service for which coverage was not offered in 2019 under a group health plan, but that is offered under the plan in a year after 2019.

(11) *New service code* means a service code that was created or substantially revised in a year after 2019.

(12) *Provider in the same or similar specialty* means the practice specialty of a provider, as identified by the plan consistent with the plan's usual business practice, except that, with respect to air ambulance services, all providers of air ambulance services are considered to be a single provider specialty.

(13) *Same or similar item or service* means a health care item or service billed under the same service code, or a comparable code under a different procedural code system.

(14) *Service code* means the code that describes an item or service using the Current Procedural Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS), or Diagnosis-Related Group (DRG) codes.

(15) *Sufficient information* means, for purposes of determining whether a group health plan has sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section—

(i) The plan has at least three contracted rates on January 31, 2019, to calculate the median of the contracted rates in accordance with paragraph (b) of this section; or

(ii) For an item or service furnished during a year after 2022 that is used to determine the first sufficient information year—

(A) The plan has at least three contracted rates on January 31 of the year immediately preceding that year to calculate the median of the contracted

rates in accordance with paragraph (b) of this section; and

(B) The contracted rates under paragraph (a)(15)(ii)(A) of this section account (or are reasonably expected to account) for at least 25 percent of the total number of claims paid for that item or service for that year with respect to all plans of the sponsor (or the administering entity as provided in paragraph (a)(8)(iv) of this section, if applicable) that are offered in the same insurance market.

(16) *Qualifying payment amount* means, with respect to a sponsor of a group health plan, the amount calculated using the methodology described in paragraph (c) of this section.

(17) *Underlying fee schedule rate* means the rate for a covered item or service from a particular participating provider, providers, or facility that a group health plan uses to determine a participant's or beneficiary's cost-sharing liability for the item or service, when that rate is different from the contracted rate.

(b) *Methodology for calculation of median contracted rate*—(1) *In general.* The median contracted rate for an item or service is calculated by arranging in order from least to greatest the contracted rates of all group health plans of the plan sponsor (or the administering entity as provided in paragraph (a)(8)(iv) of this section, if applicable) in the same insurance market for the same or similar item or service that is provided by a provider in the same or similar specialty or facility of the same or similar facility type and provided in the geographic region in which the item or service is furnished and selecting the middle number. If there are an even number of contracted rates, the median contracted rate is the average of the middle two contracted rates. In determining the median contracted rate, the amount negotiated under each contract is treated as a separate amount. If a plan or issuer has a contract with a provider group or facility, the rate negotiated with that provider group or facility under the contract is treated as a single contracted rate if the same amount applies with respect to all providers of such provider group or facility under the single contract. However, if a plan or issuer has a contract with multiple providers, with separate negotiated rates with each particular provider, each unique contracted rate with an individual provider constitutes a single contracted rate. Further, if a plan or issuer has separate contracts with individual providers, the contracted rate under each such contract constitutes a single contracted rate (even if the same amount is paid to multiple providers under separate contracts).

(2) *Calculation rules.* In calculating the median contracted rate, a plan must:

(i) Calculate the median contracted rate with respect to all plans of such sponsor (or the administering entity as provided in paragraph (a)(8)(iv) of this section, if applicable) that are offered in the same insurance market;

(ii) Calculate the median contracted rate using the full contracted rate applicable to the service code, except that the plan must—

(A) Calculate separate median contracted rates for CPT code modifiers ''26'' (professional component) and ''TC'' (technical component);

(B) For anesthesia services, calculate a median contracted rate for the anesthesia conversion factor for each service code;

(C) For air ambulance services, calculate a median contracted rate for the air mileage service codes (A0435 and A0436); and

(D) Where contracted rates otherwise vary based on applying a modifier code, calculate a separate median contracted rate for each such service code-modifier combination;

(iii) In the case of payments made by a plan that are not on a fee-for-service basis (such as bundled or capitation payments), calculate a median contracted rate for each item or service using the underlying fee schedule rates for the relevant items or services. If the plan does not have an underlying fee schedule rate for the item or service, it must use the derived amount to calculate the median contracted rate; and

(iv) Exclude risk sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments.

(3) *Provider specialties; facility types.* (i) If a plan has contracted rates that vary based on provider specialty for a service code, the median contracted rate is calculated separately for each provider specialty, as applicable.

(ii) If a plan has contracted rates for emergency services that vary based on facility type for a service code, the median contracted rate is calculated separately for each facility of the same or similar facility type.

(c) *Methodology for calculation of the qualifying payment amount*—(1) *In general.* (i) For an item or service (other than items or services described in paragraphs (c)(1)(iii) through (vii) of this section) furnished during 2022, the plan must calculate the qualifying payment amount by increasing the median contracted rate (as determined in accordance with paragraph (b) of this section) for the same or similar item or service under such plans, on January 31, 2019, by the combined percentage increase as published by the Department of the Treasury and the Internal Revenue Service to reflect the percentage increase in the CPI–U over 2019, such percentage increase over 2020, and such percentage increase over 2021.

(A) The combined percentage increase for 2019, 2020, and 2021 will be published in guidance by the Internal Revenue Service. The Department of the Treasury and the Internal Revenue Service will calculate the percentage increase using the CPI–U published by the Bureau of Labor Statistics of the Department of Labor.

(B) For purposes of this paragraph (c)(1)(i), the CPI–U for each calendar year is the average of the CPI–U as of the close of the 12-month period ending on August 31 of the calendar year, rounded to 10 decimal places.

(C) The combined percentage increase for 2019, 2020, and 2021 will be calculated as:

(CPI–U 2019/CPI–U 2018) × (CPI–U 2020/CPI–U 2019) × (CPI–U 2021/CPI–U 2020)

(ii) For an item or service (other than items or services described in paragraphs (c)(1)(iii) through (vii) of this section) furnished during 2023 or a subsequent year, the plan must calculate the qualifying payment amount by increasing the qualifying payment amount determined under paragraph (c)(1)(i) of this section, for such an item or service furnished in the immediately preceding year, by the percentage increase as published by the Department of the Treasury and the Internal Revenue Service.

(A) The percentage increase for any year after 2022 will be published in guidance by the Internal Revenue Service. The Department of the Treasury and Internal Revenue Service will calculate the percentage increase using the CPI–U published by the Bureau of Labor Statistics of the Department of Labor.

(B) For purposes of this paragraph (c)(1)(ii), the CPI–U for each calendar year is the average of the CPI–U as of the close of the 12-month period ending on August 31 of the calendar year, rounded to 10 decimal places.

(C) The combined percentage increase for any year will be calculated as CPI–U present year/CPI–U prior year.

(iii) For anesthesia services furnished during 2022, the plan must calculate the qualifying payment amount by first increasing the median contracted rate for the anesthesia conversion factor (as determined in accordance with paragraph (b) of this section) for the same or similar item or service under such plans, on January 31, 2019, in accordance with paragraph (c)(1)(i) of this section (referred to in this section as the indexed median contracted rate for the anesthesia conversion factor). The plan must then multiply the indexed median contracted rate for the anesthesia conversion factor by the sum of the base unit, time unit, and physical status modifier units of the participant or beneficiary to whom anesthesia services are furnished to determine the qualifying payment amount.

(A) The base units for an anesthesia service code are the base units for that service code specified in the most recent edition (as of the date of service) of the American Society of Anesthesiologists Relative Value Guide.

(B) The time unit is measured in 15-minute increments or a fraction thereof.

(C) The physical status modifier on a claim is a standard modifier describing

the physical status of the patient and is used to distinguish between various levels of complexity of the anesthesia services provided, and is expressed as a unit with a value between zero (0) and three (3).

(D) The anesthesia conversion factor is expressed in dollars per unit and is a contracted rate negotiated with the plan.

(iv) For anesthesia services furnished during 2023 or a subsequent year, the plan must calculate the qualifying payment amount by first increasing the indexed median contracted rate for the anesthesia conversion factor, determined under paragraph (c)(1)(iii) of this section for such services furnished in the immediately preceding year, in accordance with paragraph (c)(1)(ii) of this section. The plan must then multiply that amount by the sum of the base unit, time unit, and physical status modifier units for the participant or beneficiary to whom anesthesia services are furnished to determine the qualifying payment amount.

(v) For air ambulance services billed using the air mileage service codes (A0435 and A0436) that are furnished during 2022, the plan must calculate the qualifying payment amount for services billed using the air mileage service codes by first increasing the median contracted rate (as determined in accordance with paragraph (b) of this section), in accordance with paragraph (c)(1)(i) of this section (referred to in this section as the indexed median air mileage rate). The plan must then multiply the indexed median air mileage rate by the number of loaded miles provided to the participant or beneficiary to determine the qualifying payment amount.

(A) The air mileage rate is expressed in dollars per loaded mile flown, is expressed in statute miles (not nautical miles), and is a contracted rate negotiated with the plan.

(B) The number of loaded miles is the number of miles a patient is transported in the air ambulance vehicle.

(C) The qualifying payment amount for other service codes associated with air ambulance services is calculated in accordance with paragraphs (c)(1)(i) and (ii) of this section.

(vi) For air ambulance services billed using the air mileage service codes (A0435 and A0436) that are furnished during 2023 or a subsequent year, the plan must calculate the qualifying payment amount by first increasing the indexed median air mileage rate, determined under paragraph (c)(1)(v) of this section for such services furnished in the immediately preceding year, in accordance with paragraph (c)(1)(ii) of this section. The plan must then multiply the indexed median air mileage rate by the number of loaded miles provided to the participant or beneficiary to determine the qualifying payment amount.

(vii) For any other items or services for which a plan generally determines payment for the same or similar items or services by multiplying a contracted rate by another unit value, the plan must calculate the qualifying payment amount using a methodology that is similar to the methodology required under paragraphs (c)(1)(iii) through (vi) of this section and reasonably reflects the payment methodology for same or similar items or services.

(2) *New plans.* With respect to a sponsor of a group health plan in a geographic region in which the sponsor did not offer any group health plan during 2019—

(i) For the first year in which the group health plan is offered in such region—

(A) If the plan has sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section, the plan must calculate the qualifying payment amount in accordance with paragraph (c)(1) of this section for items and services that are covered by the plan and furnished during the first year; and

(B) If the plan does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section for an item or service provided in a geographic region, the plan must determine the qualifying payment amount for the item or service in accordance with paragraph (c)(3)(i) of this section.

(ii) For each subsequent year the group health plan is offered in the region, the plan must calculate the qualifying payment amount by increasing

the qualifying payment amount determined under this paragraph (c)(2) for the items and services furnished in the immediately preceding year, in accordance with paragraph (c)(1)(ii), (iv), or (vi) of this section, as applicable.

(3) *Insufficient information; newly covered items and services.* In the case of a plan that does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section in 2019 (or, in the case of a newly covered item or service, in the first coverage year for such item or service with respect to such plan or coverage if the plan does not have sufficient information) for an item or service provided in a geographic region—

(i) For an item or service furnished during 2022 (or, in the case of a newly covered item or service, during the first coverage year for the item or service with respect to the plan or coverage), the plan must calculate the qualifying payment amount by first identifying the rate that is equal to the median of the in-network allowed amounts for the same or similar item or service provided in the geographic region in the year immediately preceding the year in which the item or service is furnished (or, in the case of a newly covered item or service, the year immediately preceding such first coverage year) determined by the plan through use of any eligible database, and then increasing that rate by the percentage increase in the CPI–U over such preceding year. For purposes of this section, in cases in which an eligible database is used to determine the qualifying payment amount with respect to an item or service furnished during a calendar year, the plan must use the same database for determining the qualifying payment amount for that item or service furnished through the last day of the calendar year, and if a different database is selected for some items or services, the basis for that selection must be one or more factors not directly related to the rate of those items or services (such as sufficiency of data for those items or services).

(ii) For an item or service furnished in a subsequent year (before the first sufficient information year for such item or service with respect to such plan), the plan must calculate the qualifying payment amount by increasing the qualifying payment amount determined under paragraph (c)(3)(i) of this section or this paragraph (c)(3)(ii), as applicable, for such item or service for the year immediately preceding such subsequent year, by the percentage increase in CPI–U over such preceding year;

(iii) For an item or service furnished in the first sufficient information year for such item or service with respect to such plan, the plan must calculate the qualifying payment amount in accordance with paragraph (c)(1)(i), (iii), or (v) of this section, as applicable, except that in applying such paragraph to such item or service, the reference to 'furnished during 2022' is treated as a reference to furnished during such first sufficient information year, the reference to 'in 2019' is treated as a reference to such sufficient information year, and the increase described in such paragraph is not applied; and

(iv) For an item or service furnished in any year subsequent to the first sufficient information year for such item or service with respect to such plan, the plan must calculate the qualifying payment amount in accordance with paragraph (c)(1)(ii), (iv), or (vi) of this section, as applicable, except that in applying such paragraph to such item or service, the reference to 'furnished during 2023 or a subsequent year' is treated as a reference to furnished during the year after such first sufficient information year or a subsequent year.

(4) *New service codes.* In the case of a plan that does not have sufficient information to calculate the median of the contracted rates described in paragraph (b) of this section and determine the qualifying payment amount under paragraphs (c)(1) through (3) of this section because the item or service furnished is billed under a new service code—

(i) For an item or service furnished during 2022 (or, in the case of a newly covered item or service, during the first coverage year for the item or service with respect to the plan), the plan must identify a reasonably related service code that existed in the immediately preceding year and—

(A) If the Centers for Medicare & Medicaid Services has established a Medicare payment rate for the item or service billed under the new service code, the plan must calculate the qualifying payment amount by first calculating the ratio of the rate that Medicare pays for the item or service billed under the new service code compared to the rate that Medicare pays for the item or service billed under the related service code, and then multiplying the ratio by the qualifying payment amount for an item or service billed under the related service code for the year in which the item or service is furnished.

(B) If the Centers for Medicare & Medicaid Services has not established a Medicare payment rate for the item or service billed under the new service code, the plan must calculate the qualifying payment amount by first calculating the ratio of the rate that the plan reimburses for the item or service billed under the new service code compared to the rate that the plan reimburses for the item or service billed under the related service code, and then multiplying the ratio by the qualifying payment amount for an item or service billed under the related service code.

(ii) For an item or service furnished in a subsequent year (before the first sufficient information year for such item or service with respect to such plan or coverage or before the first year for which an eligible database has sufficient information to a calculate a rate under paragraph (c)(3)(i) of this section in the immediately preceding year), the plan must calculate the qualifying payment amount by increasing the qualifying payment amount determined under paragraph (c)(4)(i) of this section or this paragraph (c)(4)(ii), as applicable, for such item or service for the year immediately preceding such subsequent year, by the percentage increase in CPI–U over such preceding year;

(iii) For an item or service furnished in the first sufficient information year for such item or service with respect to such plan or the first year for which an eligible database has sufficient information to calculate a rate under paragraph (c)(3)(i) of this section in the immediately preceding year, the plan or issuer must calculate the qualifying payment amount in accordance with paragraph (c)(3) of this section.

(d) *Information to be shared about qualifying payment amount.* In cases in which the recognized amount with respect to an item or service furnished by a nonparticipating provider, nonparticipating emergency facility, or nonparticipating provider of air ambulance services is the qualifying payment amount, the plan must provide in writing, in paper or electronic form, to the provider or facility, as applicable—

(1) With an initial payment or notice of denial of payment under § 54.9816–4T, § 54.9816–5T, or § 54.9817–1T:

(i) The qualifying payment amount for each item or service involved;

(ii) A statement to certify that, based on the determination of the plan—

(A) The qualifying payment amount applies for purposes of the recognized amount (or, in the case of air ambulance services, for calculating the participant's, beneficiary's, or enrollee's cost sharing); and

(B) Each qualifying payment amount shared with the provider or facility was determined in compliance with this section;

(iii) A statement that if the provider or facility, as applicable, wishes to initiate a 30-day open negotiation period for purposes of determining the amount of total payment, the provider or facility may contact the appropriate person or office to initiate open negotiation, and that if the 30-day negotiation period does not result in a determination, generally, the provider or facility may initiate the independent dispute resolution process within 4 days after the end of the open negotiation period; and

(iv) Contact information, including a telephone number and email address, for the appropriate person or office to initiate open negotiations for purposes of determining an amount of payment (including cost sharing) for such item or service.

(2) In a timely manner upon request of the provider or facility:

(i) Information about whether the qualifying payment amount for items

and services involved included contracted rates that were not on a fee-for-service basis for those specific items and services and whether the qualifying payment amount for those items and services was determined using underlying fee schedule rates or a derived amount;

(ii) If a plan uses an eligible database under paragraph (c)(3) of this section to determine the qualifying payment amount, information to identify which database was used; and

(iii) If a related service code was used to determine the qualifying payment amount for an item or service billed under a new service code under paragraph (c)(4)(i) or (ii) of this section, information to identify the related service code; and

(iv) If applicable, a statement that the plan's contracted rates include risk-sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments for the items and services involved (as applicable) that were excluded for purposes of calculating the qualifying payment amount.

(e) *Certain access fees to databases.* In the case of a plan that, pursuant to this section, uses an eligible database to determine the qualifying payment amount for an item or service, the plan is responsible for any costs associated with accessing such database.

(f) *Audits.* See 45 CFR 149.140(f) for audit procedures that apply with respect to ensuring that a plan is in compliance with the requirement of applying a qualifying payment amount under §§ 54.9816–4T, 54.9816–5T, 54.9817–1T, and this section, and ensuring that such amount so applied satisfies the requirements under this section, as applicable.

(g) *Applicability date.* The provisions of this section are applicable with respect to plan years beginning on or after January 1, 2022.

[T.D. 9951, 86 FR 36950, July 13, 2021]

§ 54.9816–7T Complaints process for surprise medical bills regarding group health plans (temporary).

See 45 CFR 149.150 for the process to receive and resolve complaints that a specific group health plan may be failing to meet the requirement of applying a qualifying payment amount under §§ 54.9816–4T, 54.9816–5T, 54.9816–6T, and 54.9817–1T, which may warrant an investigation.

[T.D. 9951, 86 FR 36950, July 13, 2021]

§ 54.9816–8T Independent dispute resolution process (temporary).

(a) *Scope and definitions*—(1) *Scope.* This section sets forth requirements with respect to the independent dispute resolution (IDR) process (referred to in this section as the Federal IDR process) under which a nonparticipating provider, nonparticipating emergency facility, or nonparticipating provider of air ambulance services (as applicable); and a group health plan complete a requisite open negotiation period, and at least one party submits a notification under paragraph (b) of this section to initiate the Federal IDR process under paragraph (c) of this section, and under which an IDR entity (as certified under paragraph (e) of this section) determines the amount of payment under the plan for an item or service furnished by the provider or facility.

(2) *Definitions.* Unless otherwise stated, the definitions in § 54.9816–3T apply to this section. Additionally, for purposes of this section, the following definitions apply:

(i) *Batched items and services* means multiple qualified IDR items or services that are considered jointly as part of one payment determination by a certified IDR entity for purposes of the Federal IDR process. In order for a qualified IDR item or service to be included in a batched item or service, the qualified IDR item or service must meet the criteria set forth in paragraph (c)(3) of this section.

(ii) *Breach* means the acquisition, access, use, or disclosure of individually identifiable health information (IIHI) in a manner not permitted under paragraph (e)(2)(v) of this section that compromises the security or privacy of the IIHI.

(A) Breach excludes:

(*1*) Any unintentional acquisition, access, or use of IIHI by personnel, a contractor, or a subcontractor of a certified IDR entity that is acting under the authority of that certified IDR entity, if the acquisition, access, or use

was made in good faith and within the scope of that authority and that does not result in further use or disclosure in a manner not permitted under paragraph (e)(2)(v) of this section.

(*2*) Any inadvertent disclosure by a person who is authorized to access IIHI at a certified IDR entity to another person authorized to access IIHI at the same certified IDR entity, and the information received as a result of the disclosure is not further used or disclosed in a manner not permitted under paragraph (e)(2)(v) of this section.

(*3*) A disclosure of IIHI in which a certified IDR entity has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

(B) Except as provided in paragraph (a)(2)(ii)(A) of this section, access, use, or disclosure of IIHI in a manner not permitted under paragraph (e)(2)(v) of this section is presumed to be a breach unless the certified IDR entity demonstrates that there is a low probability that the security or privacy of the IIHI has been compromised based on a risk assessment encompassing at least the following factors:

(*1*) The nature and extent of the IIHI involved, including the types of identifiers and the likelihood of re-identification;

(*2*) The unauthorized person who used the IIHI or to whom the disclosure was made;

(*3*) Whether the IIHI was actually acquired or viewed; and

(*4*) The extent to which the risk to the IIHI has been mitigated.

(iii) *Certified IDR entity* means an entity responsible for conducting determinations under paragraph (c) of this section that meets the certification criteria specified in paragraph (e) of this section and that has been certified by the Secretary, jointly with the Secretaries of Health and Human Services and Labor.

(iv) *Conflict of interest* means, with respect to a party to a payment determination or certified IDR entity, a material relationship, status, or condition of the party or certified IDR entity that impacts the ability of the certified IDR entity to make an unbiased and impartial payment determination. For purposes of this section, a conflict of interest exists when a certified IDR entity is:

(A) A group health plan; a health insurance issuer offering group health insurance coverage, individual health insurance coverage, or short-term, limited-duration insurance; a carrier offering a health benefits plan under 5 U.S.C. 8902; or a provider, a facility or a provider of air ambulance services;

(B) An affiliate or a subsidiary of a group health plan; a health insurance issuer offering group health insurance coverage, individual health insurance coverage, or short-term, limited-duration insurance; a carrier offering a health benefits plan under 5 U.S.C. 8902; or a provider, a facility, or a provider of air ambulance services;

(C) An affiliate or subsidiary of a professional or trade association representing group health plans; health insurance issuers offering group health insurance coverage, individual health insurance coverage, or short-term, limited-duration insurance; carriers offering a health benefits plan under 5 U.S.C. 8902; or providers, facilities, or providers of air ambulance services.

(D) A certified IDR entity that has, or that has any personnel, contractors, or subcontractors assigned to a determination who have, a material familial, financial, or professional relationship with a party to the payment determination being disputed, or with any officer, director, or management employee of the plan, issuer, or carrier offering a health benefits plan under 5 U.S.C. 8902; the plan administrator, plan fiduciaries, or plan, issuer, or carrier employees; the health care provider, the health care provider's group or practice association; the provider of air ambulance services, the provider of air ambulance services' group or practice association, or the facility that is a party to the dispute.

(v) *Credible information* means information that upon critical analysis is worthy of belief and is trustworthy.

(vi) *IDR entity* means an entity that may apply or has applied for certification to conduct determinations under paragraph (c) of this section, and that currently is not certified by the Secretary, jointly with the Secretaries of Health and Human Services and

Labor, pursuant to paragraph (e) of this section.

(vii) *Individually identifiable health information (IIHI)* means any information, including demographic data, that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

(A) That identifies the individual; or

(B) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

(viii) *Material difference* means a substantial likelihood that a reasonable person with the training and qualifications of a certified IDR entity making a payment determination would consider the submitted information significant in determining the out of network rate and would view the information as showing that the qualifying payment amount is not the appropriate out-of-network rate.

(ix) *Material familial relationship* means any relationship as a spouse, domestic partner, child, parent, sibling, spouse's or domestic partner's parent, spouse's or domestic partner's sibling, spouse's or domestic partner's child, child's parent, child's spouse or domestic partner, or sibling's spouse or domestic partner.

(x) *Material financial relationship* means any financial interest of more than five percent of total annual revenue or total annual income of a certified IDR entity, or an officer, director, or manager thereof, or of a reviewer or reviewing physician employed or engaged by a certified IDR entity to conduct or participate in any review in the Federal IDR process. The terms annual revenue and annual income do not include mediation fees received by mediators who are also arbitrators, provided that the mediator acts in the capacity of a mediator and does not represent a party in the mediation.

(xi) *Material professional relationship* means any physician-patient relationship, any partnership or employment relationship, any shareholder or similar ownership interest in a professional corporation, partnership, or other similar entity; or any independent contractor arrangement that constitutes a material financial relationship with any expert used by the certified IDR entity or any officer or director of the certified IDR entity.

(xii) *Qualified IDR item or service* means an item or service:

(A) That is an emergency service furnished by a nonparticipating provider or nonparticipating facility subject to the protections of § 54.9816–4T, 29 CFR 2590.716–4, or 45 CFR 149.110, as applicable, for which the conditions of 45 CFR 149.410(b) are not met, or an item or service furnished by a nonparticipating provider at a participating health care facility, subject to the requirements of § 54.9816–5T, 29 CFR 2590.716–5, or 45 CFR 149.120, as applicable, for which the conditions of 45 CFR 149.420(c) through (i) are not met, or air ambulance services furnished by a nonparticipating provider of air ambulance services subject to the protections of § 54.9817–1T, 29 CFR 2590.717–1, or 45 CFR 149.130, as applicable, and for which the out-of-network rate is not determined by reference to an All-Payer Model Agreement under section 1115A of the Social Security Act or a specified State law as defined in § 54.9816–3T;

(B) With respect to which a provider or facility (as applicable) or group health plan submits a notification under paragraph (b)(2) of this section;

(C) That is not an item or service that is the subject of an open negotiation under paragraph (b)(1) of this section; and

(D) That is not an item or service for which a notification under paragraph (b)(2) of this section is submitted during the 90-calendar-day period under paragraph (c)(4)(vi)(B) of this section, but that may include such an item or service if the notification is submitted during the subsequent 30-business-day period under paragraph (c)(4)(vi)(C) of this section.

(xiii) *Unsecured IIHI* means IIHI that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary, jointly with the Secretary of Health and Human Services and the Secretary of Labor.

(b) *Determination of payment amount through open negotiation and initiation of the Federal IDR process*—(1) *Determination of payment amount through open negotiation*—(i) *In general*. With respect to an item or service that meets the requirements of paragraph (a)(2)(xii)(A) of this section, the provider, facility, or provider of air ambulance services or the group health plan may, during the 30-business-day period beginning on the day the provider, facility, or provider of air ambulance services receives an initial payment or notice of denial of payment regarding the item or service, initiate an open negotiation period for purposes of determining the out-of-network rate for such item or service. To initiate the open negotiation period, a party must send a notice to the other party (open negotiation notice) in accordance with paragraph (b)(1)(ii) of this section.

(ii) *Open negotiation notice*—(A) *Content*. The open negotiation notice must include information sufficient to identify the item(s) and service(s) (including the date(s) the item(s) or service(s) were furnished, the service code, and initial payment amount, if applicable), an offer of an out-of-network rate, and contact information for the party sending the open negotiation notice.

(B) *Manner*. The open negotiation notice must be provided, using the standard form developed by the Secretary, in writing within 30 business days beginning on the day the provider, facility, or provider of air ambulance services receives an initial payment or a notice of denial of payment from the plan regarding the item or service. The day on which the open negotiation notice is first sent by a party is the date the 30-business-day open negotiation period begins. This notice may be provided to the other party electronically (such as by email) if the following two conditions are satisfied:

(*1*) The party sending the open negotiation notice has a good faith belief that the electronic method is readily accessible by the other party; and

(*2*) The notice is provided in paper form free of charge upon request.

(2) *Initiating the Federal IDR process*—(i) *In general*. With respect to an item or service for which the parties do not agree upon an out-of-network rate by the last day of the open negotiation period under paragraph (b)(1) of this section, either party may initiate the Federal IDR process. To initiate the Federal IDR process, a party must submit a written notice of IDR initiation to the other party and to the Secretary, using the standard form developed by the Secretary, during the 4-business-day period beginning on the 31st business day after the start of the open negotiation period.

(ii) *Exception for items and services provided by certain nonparticipating providers and facilities*. A party may not initiate the Federal IDR process with respect to an item or service if, with respect to that item or service, the party knows (or reasonably should have known) that the provider or facility provided notice and received consent under 45 CFR 149.410(b) or 149.420(c) through (i).

(iii) *Notice of IDR initiation*—(A) *Content*. The notice of IDR initiation must include:

(*1*) Information sufficient to identify the qualified IDR items or services under dispute (and whether the qualified IDR items or services are designated as batched items and services as described in paragraph (c)(3) of this section), including the date(s) and location the item or service was furnished, the type of item or service (such as whether the qualified IDR item or service is an emergency service as defined in §54.9816–4T(c)(2)(i), 29 CFR 2590.716–4(c)(2)(i), or 45 CFR 149.110(c)(2)(i), as applicable, an emergency service as defined in §54.9816–4T(c)(2)(ii), 29 CFR 2590.716–4(c)(2)(ii), or 45 CFR 149.110(c)(2)(ii), as applicable, or a non-emergency service; and whether any service is a professional service or facility-based service), corresponding service codes, place of service code, the amount of cost sharing allowed, and the amount of the initial payment made for the qualified IDR item or service, if applicable;

(*2*) Names of the parties involved and contact information, including name, email address, phone number, and mailing address;

(*3*) State where the qualified IDR item or service was furnished;

(*4*) Commencement date of the open negotiation period under paragraph (b)(1) of this section;

(*5*) Preferred certified IDR entity;

(*6*) An attestation that the items and services under dispute are qualified IDR items or services;

(*7*) Qualifying payment amount;

(*8*) Information about the qualifying payment amount as described in § 54.9816–6T(d); and

(*9*) General information describing the Federal IDR process as specified by the Secretary.

(B) *Manner*. The initiating party must provide written notice of IDR initiation to the other party. The initiating party may satisfy this requirement by furnishing the notice of IDR initiation to the other party electronically (such as by email) if the following two conditions are satisfied—

(*1*) The initiating party has a good faith belief that the electronic method is readily accessible by the other party; and

(*2*) The notice is provided in paper form free of charge upon request.

(C) *Notice to the Secretary*. The initiating party must also furnish the notice of IDR initiation to the Secretary by submitting the notice through the Federal IDR portal. The initiation date of the Federal IDR process will be the date of receipt by the Secretary.

(c) *Federal IDR process following initiation*—(1) *Selection of certified IDR entity*—(i) *In general*. The plan or the provider, facility, or provider of air ambulance services receiving the notice of IDR initiation under paragraph (b)(2) of this section may agree or object to the preferred certified IDR entity identified in the notice of IDR initiation. If the party in receipt of the notice of IDR initiation fails to object within 3 business days, the preferred certified IDR entity identified in the notice of IDR initiation will be selected and will be treated as jointly agreed to by the parties, provided that the certified IDR entity does not have a conflict of interest. If the party in receipt of the notice of IDR initiation objects, that party must notify the initiating party of the objection and propose an alternative certified IDR entity. The initiating party must then agree or object to the alternative certified IDR entity; if the initiating party fails to agree or object to the alternative certified IDR entity, the alternative certified IDR entity will be selected and will be treated as jointly agreed to by the parties. In order to select a preferred certified IDR entity, the plan and the provider, facility, or provider of air ambulance services, must jointly agree on a certified IDR entity not later than 3 business days after the initiation date of the Federal IDR process. If the plan and the provider, facility, or provider of air ambulance services fail to agree upon a certified IDR entity within that time, the Secretary shall select a certified IDR entity in accordance with paragraph (c)(1)(iv) of this section.

(ii) *Requirements for selected certified IDR entity*. The certified IDR entity selected must be an IDR entity certified under paragraph (e) of this section, that:

(A) Does not have a conflict of interest as defined in paragraph (a)(2) of this section;

(B) Ensures that assignment of personnel to a payment determination and decisions regarding hiring, compensation, termination, promotion, or other similar matters related to personnel assigned to the dispute are not made based upon the likelihood that the assigned personnel will support a particular party to the determination being disputed other than as outlined under paragraph (c)(4)(iii) of this section; and

(C) Ensures that any personnel assigned to a payment determination do not have any conflicts of interests as defined in paragraph (a)(2) of this section regarding any party to the dispute within the 1 year immediately preceding an assignment of dispute determination, similar to the requirements laid out in 18 U.S.C. 207(b).

(iii) *Notice of certified IDR entity selection*. Upon the selection of a certified IDR entity, in accordance with paragraph (c)(1)(i) of this section, the plan or the provider or emergency facility that submitted the notice of IDR initiation under paragraph (b)(2) of this section must notify the Secretary of the selection as soon as reasonably practicable, but no later than 1 business day after such selection, through the Federal IDR portal. In addition, if the

non-initiating party believes that the Federal IDR process is not applicable, the non-initiating party must also provide information regarding the Federal IDR process's inapplicability through the Federal IDR portal by the same date that the notice of certified IDR entity selection must be submitted.

(A) *Content.* If the parties have agreed on the selection of a certified IDR entity or the party in receipt of the notice of IDR initiation has not objected to the other party's selection, the notice of the certified IDR entity selection must include the following information:

(*1*) Name of the certified IDR entity;

(*2*) The certified IDR entity number; and

(*3*) Attestation by both parties, or by the initiating party if the non-initiating party fails to object to the selection of the certified IDR entity, that the selected certified IDR entity meets the requirements of paragraph (c)(1)(ii) of this section.

(B) [Reserved]

(iv) *Failure to select a certified IDR entity.* If the plan and the provider, facility, or provider of air ambulance services fail to select a certified IDR entity in accordance with paragraph (c)(1)(i) of this section, the initiating party must notify the Secretary of the failure no later than 1 business day after the date of such failure (or in other words, 4 business days after initiation of the Federal IDR process) by electronically submitting the notice as described in paragraph (c)(1)(iii) of this section but indicating that the parties have failed to select a certified IDR entity. In addition, if the non-initiating party believes that the Federal IDR process is not applicable, the non-initiating party must also provide information regarding the Federal IDR process's inapplicability through the Federal IDR portal by the same date that the notice of failure to select must be submitted. Upon notification of the failure of the parties to select a certified IDR entity, the Secretary will select a certified IDR entity that charges a fee within the allowed range of certified IDR entity fees through a random selection method not later than 6 business days after the date of initiation of the Federal IDR process and will notify the plan and the provider or facility of the selection. If there are insufficient certified IDR entities that charge a fee within the allowed range of certified IDR entity fees available to arbitrate the dispute, the Secretary, jointly with the Secretary of Health and Human Services and Secretary of Labor, will select a certified IDR entity that has received approval, as described in paragraph (e)(2)(vi)(B) of this section, to charge a fee outside of the allowed range of certified IDR entity fees.

(v) *Review by certified IDR entity.* After selection by the parties (including when the initiating party selects a certified IDR entity and the other party does not object), or by the Secretary under paragraph (c)(1)(iv) of this section, the certified IDR entity must review the selection and attest that it meets the requirements of paragraph (c)(1)(ii) of this section. If the certified IDR entity is unable to attest that it meets the requirements of paragraph (c)(1)(ii) within 3 business days of selection, the parties, upon notification, must select another certified IDR entity under paragraph (c)(1) of this section, treating the date of notification of the failure to attest to the requirements of (c)(1)(ii) of this section as the date of initiation of the Federal IDR process for purposes of the time periods in paragraphs (c)(1)(i) and (iv) of this section. Additionally, the certified IDR entity selected must review the information submitted in the notice of IDR initiation to determine whether the Federal IDR process applies. If the Federal IDR process does not apply, the certified IDR entity must notify the Secretary and the parties within 3 business days of making that determination.

(2) *Authority to continue negotiations*—(i) *In general.* If the parties to the Federal IDR process agree on an out-of-network rate for a qualified IDR item or service after providing the notice of IDR initiation to the Secretary consistent with paragraph (b)(2) of this section, but before the certified IDR entity has made its payment determination, the amount agreed to by the parties for the qualified IDR item or service will be treated as the out-of-network rate for the qualified IDR

item or service. To the extent the amount exceeds the initial payment amount (or initial denial of payment) and any cost sharing paid or required to be paid by the participant or beneficiary, payment must be made directly by the plan to the nonparticipating provider, facility, or nonparticipating provider of air ambulance services not later than 30 business days after the agreement is reached. In no instance may either party seek additional payment from the participant or beneficiary, including in instances in which the out-of-network rate exceeds the qualifying payment amount. The initiating party must send a notification to the Secretary and to the certified IDR entity (if selected) electronically through the Federal IDR portal, as soon as possible, but no later than 3 business days after the date of the agreement. The notification must include the out-of-network rate for the qualified IDR item or service and signatures from authorized signatories for both parties.

(ii) *Method of allocation of the certified IDR entity fee.* In the case of an agreement described in paragraph (c)(2)(i) of this section, the certified IDR entity is required to return half of each parties' certified IDR entity fee, unless directed otherwise by both parties. The administrative fee under paragraph (d)(2) of this section will not be returned to the parties.

(3) *Treatment of batched items and services*—(i) *In general.* Batched items and services may be submitted and considered jointly as part of one payment determination by a certified IDR entity only if the batched items and services meet the requirements of this paragraph (c)(3). Batched items and services submitted and considered jointly as part of one payment determination under this paragraph (c)(3)(i) are treated as a batched determination and subject to the fee for batched determinations under this section.

(A) The qualified IDR items and services are billed by the same provider or group of providers, the same facility, or the same provider of air ambulance services. Items and services are billed by the same provider or group of providers, the same facility, or the same provider of air ambulance services if the items or services are billed with the same National Provider Identifier or Tax Identification Number;

(B) Payment for the qualified IDR items and services would be made by the same plan;

(C) The qualified IDR items and services are the same or similar items and services. The qualified IDR items and services are considered to be the same or similar items or services if each is billed under the same service code, or a comparable code under a different procedural code system, such as Current Procedural Terminology (CPT) codes with modifiers, if applicable, Healthcare Common Procedure Coding System (HCPCS) with modifiers, if applicable, or Diagnosis-Related Group (DRG) codes with modifiers, if applicable; and

(D) All the qualified IDR items and services were furnished within the same 30-business-day period, or the same 90-calendar-day period under paragraph (c)(4)(vi)(B) of this section, as applicable.

(ii) *Treatment of bundled payment arrangements.* In the case of qualified IDR items and services billed by a provider, facility, or provider of air ambulance services as part of a bundled payment arrangement, or where a plan makes or denies an initial payment as a bundled payment, the qualified IDR items and services may be submitted as part of one payment determination. Bundled payment arrangements submitted under this paragraph (c)(3)(ii) are subject to the rules for batched determinations set forth in paragraph (c)(3)(i) of this section and the certified IDR entity fee for single determinations as set forth in paragraph (e)(2)(vii) of this section.

(4) *Payment determination for a qualified IDR item or service*—(i) *Submission of offers.* Not later than 10 business days after the selection of the certified IDR entity, the plan and the provider, facility, or provider of air ambulance services:

(A) Must each submit to the certified IDR entity:

(*1*) An offer of an out-of-network rate expressed as both a dollar amount and the corresponding percentage of the qualifying payment amount represented by that dollar amount;

(*2*) Information requested by the certified IDR entity relating to the offer.

(*3*) The following additional information, as applicable—

(*i*) For providers and facilities, information on the size of the provider's practice or of the facility (if applicable). Specifically, a group of providers must specify whether the providers' practice has fewer than 20 employees, 20 to 50 employees, 51 to 100 employees, 101 to 500 employees, or more than 500 employees. For facilities, the facility must specify whether the facility has 50 or fewer employees, 51 to 100 employees, 101 to 500 employees, or more than 500 employees;

(*ii*) For providers and facilities, information on the practice specialty or type, respectively (if applicable);

(*iii*) For plans, information on the coverage area of the plan, the relevant geographic region for purposes of the qualifying payment amount, whether the coverage is fully-insured or partially or fully self-insured; and

(*iv*) The qualifying payment amount for the applicable year for the same or similar item or service as the qualified IDR item or service.

(B) May each submit to the certified IDR entity any information relating to the offer that was submitted by either party, except that the information may not include information on factors described in paragraph (c)(4)(v) of this section.

(ii) *Payment determination and notification.* Not later than 30 business days after the selection of the certified IDR entity, the certified IDR entity must:

(A) Select as the out-of-network rate for the qualified IDR item or service one of the offers submitted under paragraph (c)(4)(i) of this section, taking into account the considerations specified in paragraph (c)(4)(iii) of this section (as applied to the information provided by the parties pursuant to paragraph (c)(4)(i) of this section). The certified IDR entity must select the offer closest to the qualifying payment amount unless the certified IDR entity determines that credible information submitted by either party under paragraph (c)(4)(i) clearly demonstrates that the qualifying payment amount is materially different from the appropriate out-of-network rate, or if the offers are equally distant from the qualifying payment amount but in opposing directions. In these cases, the certified IDR entity must select the offer as the out-of-network rate that the certified IDR entity determines best represents the value of the qualified IDR item or services, which could be either offer.

(B) Notify the plan and the provider or facility, as applicable, of the selection of the offer under paragraph (c)(4)(ii)(A) of this section, and provide the written decision required under (c)(4)(vi) of this section.

(iii) *Considerations in determination.* In determining which offer to select, the certified IDR entity must consider:

(A) The qualifying payment amount(s) for the applicable year for the same or similar item or service.

(B) Information requested by the certified IDR entity under paragraph (c)(4)(i)(A)(*2*) of this section relating to the offer, to the extent a party provides credible information.

(C) Additional information submitted by a party, provided the information is credible and relates to the circumstances described in paragraphs (c)(4)(iii)(C)(*1*) through (*5*) of this section, with respect to a qualified IDR item or service of a nonparticipating provider, facility, or group health plan that is the subject of a payment determination. This information must also clearly demonstrate that the qualifying payment amount is materially different from the appropriate out-of-network rate.

(*1*) The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished the qualified IDR item or service (such as those endorsed by the consensus-based entity authorized in section 1890 of the Social Security Act).

(*2*) The market share held by the provider or facility or that of the plan in the geographic region in which the qualified IDR item or service was provided.

(*3*) The acuity of the participant, or beneficiary, receiving the qualified IDR item or service, or the complexity of furnishing the qualified IDR item or service to the participant or beneficiary.

(*4*) The teaching status, case mix, and scope of services of the facility that furnished the qualified IDR item or service, if applicable.

(*5*) Demonstration of good faith efforts (or lack thereof) made by the provider or facility or the plan to enter into network agreements with each other, and, if applicable, contracted rates between the provider or facility, as applicable, and the plan during the previous 4 plan years.

(D) Additional information submitted by a party, provided the information is credible and relates to the offer submitted by either party and does not include information on factors described in paragraph (c)(4)(v) of this section.

(iv) *Examples*. The rules of paragraph (c)(4)(iii) of this section are illustrated by the following examples:

(A) *Example 1—(1) Facts*. A nonparticipating provider and a group health plan are parties to a payment determination in the Federal IDR process. The nonparticipating provider submits an offer and additional written information asserting that the provider has made good faith efforts to enter into network agreements with the plan. The nonparticipating provider fails to provide any documentation of these efforts, such as correspondence or records of conversations with representatives of the plan.

(*2*) *Conclusion*. In this *Example 1*, the nonparticipating provider has submitted additional information. However, this information is not credible, as the nonparticipating provider has failed to provide any documentation in support of the provider's assertions of good faith efforts to enter into network agreements with the plan. Therefore, the certified IDR entity cannot consider the information.

(B) *Example 2—(1) Facts*. A nonparticipating provider and a group health plan are parties to a payment determination in the Federal IDR process. The nonparticipating provider submits credible information relating to the provider's level of training, experience, and quality and outcome measurements from 2019. The provider also submits credible information that clearly demonstrates that the provider's level of training and expertise was necessary for providing the service that is the subject of the payment determination to the particular patient. Further, the provider submits credible information that clearly demonstrates that the qualifying payment amount generally presumes the service would be delivered by a provider with a lower level of training, experience, and quality and outcome measurements. This information, taken together, demonstrates that the qualifying payment amount is not an appropriate payment amount, and the provider submits an offer that is higher than the qualifying payment amount and commensurate with the provider's level of training, experience, and quality and outcome measurements with respect to the service provided. The plan submits the qualifying payment amount as its offer with no additional information.

(*2*) *Conclusion*. In this *Example 2*, the nonparticipating provider has submitted information that is credible. Moreover, the credible information clearly demonstrates that the qualifying payment amount does not adequately take into account the provider's level of training, experience, and quality and outcome measurements with respect to the service provided, and that the appropriate out-of-network rate should therefore be higher than the qualifying payment amount. Accordingly, the certified IDR entity must select the provider's offer, as that offer best represents the value of the service that is the subject of the payment determination.

(C) *Example 3—(1) Facts*. A nonparticipating provider and a group health plan are parties to a payment determination in the Federal IDR process. The nonparticipating provider submits credible information to the certified IDR entity relating to the acuity of the patient that received the service, and the complexity of furnishing the service to the patient, by providing details of the service at issue and the training required to furnish the complex service. The provider contends that this information demonstrates that the qualifying payment amount is not an appropriate payment amount, and the provider submits an offer that is higher than the qualifying payment amount and equal to what the provider believes

is commensurate with the acuity of the patient and the complexity of the service that is the subject of the payment determination. However, the evidence submitted by the provider does not clearly demonstrate that the qualifying payment amount fails to encompass the acuity and complexity of the service. The plan submits the qualifying payment amount as its offer, along with credible information that demonstrates how the qualifying payment amount was calculated for this particular service, taking into consideration the acuity of the patient and the complexity of the service.

(*2*) *Conclusion*. The information submitted by the provider to the certified IDR entity is credible with respect to the acuity of the patient and complexity of the service. However, in this example, the provider has not clearly demonstrated that the qualifying payment amount is materially different from the appropriate out-of-network rate, based on the acuity of the patient and the complexity of the service that is the subject of the payment determination. Accordingly, the certified IDR entity must select the offer closest to the qualifying payment amount, which is the plan's offer.

(D) *Example 4*—(*1*) *Facts*. A nonparticipating provider and a group health plan are parties to a payment determination in the Federal IDR process. The plan submits credible information demonstrating that the patent for the item that is the subject of the payment determination has expired, including written documentation that demonstrates how much the cost of the item was at the time the provider rendered service and how the qualifying payment amount exceeds that cost. The plan submits an offer that is lower than the qualifying payment amount and commensurate with the cost of the item at the time service was rendered. The nonparticipating provider submits the qualifying payment amount as its offer and also submits credible information demonstrating the provider's level of training, experience, and quality and outcome measurements from 2019, but the provider does not explain how this additional information is relevant to the cost of the item.

(*2*) *Conclusion*. In this *Example 4*, both the nonparticipating provider and plan submitted information that is credible and that may be considered by the certified IDR entity. However, only the plan provided credible information that was relevant to the service that is the subject of the payment determination. Moreover, the plan has clearly demonstrated that the qualifying payment amount does not adequately take into account the complexity of the item furnished—in this case that the item is no longer patent protected. While the provider submitted credible information, the provider failed to show how the information was relevant to the item that is the subject of the payment determination. Accordingly, the certified IDR entity must select the offer that best represents the value of the item, which is the plan's offer in this example.

(v) *Prohibition on consideration of certain factors*. In determining which offer to select, the certified IDR entity must not consider:

(A) Usual and customary charges (including payment or reimbursement rates expressed as a proportion of usual and customary charges);

(B) The amount that would have been billed by the provider or facility with respect to the qualified IDR item or service had the provisions of 45 CFR 149.410 and 149.420 (as applicable) not applied; or

(C) The payment or reimbursement rate for items and services furnished by the provider or facility payable by a public payor, including under the Medicare program under title XVIII of the Social Security Act; the Medicaid program under title XIX of the Social Security Act; the Children's Health Insurance Program under title XXI of the Social Security Act; the TRICARE program under chapter 55 of title 10, United States Code; chapter 17 of title 38, United States Code; or demonstration projects under section 1115 of the Social Security Act.

(vi) *Written decision*. (A) The certified IDR entity must explain its determination in a written decision submitted to the parties and the Secretary, in a form and manner specified by the Secretary;

(B) If the certified IDR entity does not choose the offer closest to the qualifying payment amount, the certified IDR entity's written decision must include an explanation of the credible information that the certified IDR entity determined demonstrated that the qualifying payment amount was materially different from the appropriate out-of-network rate, based on the considerations allowed under paragraphs (c)(4)(iii)(B) through (D) of this section, with respect to the qualified IDR item or service.

(vii) *Effects of determination*—(A) *Binding*. A determination made by a certified IDR entity under paragraph (c)(4)(ii) of this section:

(*1*) Is binding upon the parties, in the absence of fraud or evidence of intentional misrepresentation of material facts presented to the certified IDR entity regarding the claim; and

(*2*) Is not subject to judicial review, except in a case described in any of paragraphs (1) through (4) of section 10(a) of title 9, United States Code.

(B) *Suspension of certain subsequent IDR requests*. In the case of a determination made by a certified IDR entity under paragraph (c)(4)(ii) of this section, the party that submitted the initial notification under paragraph (b)(2) of this section may not submit a subsequent notification involving the same other party with respect to a claim for the same or similar item or service that was the subject of the initial notification during the 90-calendar-day period following the determination.

(C) *Subsequent submission of requests permitted*. If the end of the open negotiation period specified in paragraph (b)(1) of this section occurs during the 90-calendar-day suspension period regarding claims for the same or similar item or service that were the subject of the initial notice of IDR determination as described in paragraph (c)(4)(vi) of this section, either party may initiate the Federal IDR process for those claims by submitting a notification as specified in paragraph (b)(2) of this section during the 30-business-day period beginning on the day after the last day of the 90-calendar-day suspension period.

(viii) *Recordkeeping requirements*. The certified IDR entity must maintain records of all claims and notices associated with the Federal IDR process with respect to any determination for 6 years. The certified IDR entity must make these records available for examination by the plan, provider, facility, provider of air ambulance services, or a State or Federal oversight agency upon request, except to the extent the disclosure would violate either State or Federal privacy law.

(ix) *Payment*. If applicable, the amount of the offer selected by the certified IDR entity (less the sum of the initial payment and any cost sharing paid or owed by the participant or beneficiary) must be paid directly to the provider, facility, or provider of air ambulance services not later than 30 calendar days after the determination by the certified IDR entity. If the offer selected by the certified IDR entity is less than the sum of the initial payment and any cost sharing paid by the participant or beneficiary, the provider, facility, or provider of air ambulance services will be liable to the plan for the difference. The provider, facility, or provider of air ambulance services must pay the difference directly to the plan not later than 30 calendar days after the determination by the certified IDR entity.

(d) *Costs of IDR process*—(1) *Certified IDR entity fee*. (i) With respect to the Federal IDR process described in paragraph (c) of this section, the party whose offer submitted to the certified IDR entity under paragraph (c)(4)(ii)(A) of this section is not selected is responsible for the payment to the certified IDR entity of the predetermined fee charged by the certified IDR entity.

(ii) Each party to a determination for which a certified IDR entity is selected under paragraph (c)(1) of this section must pay the predetermined certified IDR entity fee charged by the certified IDR entity to the certified IDR entity at the time the parties submit their offers under (c)(4)(i) of this section. The certified IDR entity fee paid by the prevailing party whose offer is selected by the certified IDR entity will be returned to that party within 30 business days following the date of the certified IDR entity's determination.

(2) *Administrative fee.* (i) Each party to a determination for which a certified IDR entity is selected under paragraph (c)(1) of this section must, at the time the certified IDR entity is selected under paragraph (c)(1), pay to the certified IDR entity a non-refundable administrative fee due to the Secretary for participating in the Federal IDR process described in this section.

(ii) The administrative fee amount will be established in guidance published annually by the Secretary in a manner such that the total fees paid for a year are estimated to be equal to the projected amount of expenditures by the Departments of the Treasury, Labor, and Health and Human Services for the year in carrying out the Federal IDR process.

(e) *Certification of IDR entity*—(1) *In general.* In order to be selected under paragraph (c)(1) of this section—

(i) An IDR entity must meet the standards described in this paragraph (e) and be certified by the Secretary, jointly with the Secretaries of Health and Human Services and Labor, as set forth in this paragraph (e) and guidance promulgated by the Secretary. Once certified, the IDR entity will be provided with a certified IDR entity number.

(ii) An IDR entity must provide written documentation to the Secretary regarding general company information (such as contact information, Taxpayer Identification Number, and website), as well as the applicable service area in which the IDR entity intends to conduct payment determinations under the Federal IDR process. IDR entities may choose to submit their application for all States or self-limit to a particular subset of States.

(iii) An IDR entity that the Secretary, jointly with the Secretary of Labor and the Secretary of Health and Human Services, certifies must enter into an agreement as a condition of certification. The agreement shall include specified provisions encompassed by this section, including, but not limited to, the requirements applicable to certified IDR entities when making payment determinations, as well as the requirements regarding certification and revocation (such as specifications for wind-down activities and reallocation of certified IDR entity fees, where warranted).

(2) *Requirements.* An IDR entity must provide written documentation to the Secretary through the Federal IDR portal that demonstrates that the IDR entity satisfies the following standards to be a certified IDR entity under this paragraph (e):

(i) Possess (directly or through contracts or other arrangements) sufficient arbitration and claims administration of health care services, managed care, billing and coding, medical and legal expertise to make the payment determinations described in paragraph (c) of this section within the time prescribed in paragraph (c)(4)(ii) of this section.

(ii) Employ (directly or through contracts or other arrangements) a sufficient number of personnel to make the determinations described in paragraph (c) of this section within the time prescribed by (c)(4)(ii) of this section. To satisfy this standard, the written documentation must include a description of the IDR entity's organizational structure and capabilities, including an organizational chart and the credentials, responsibilities, and number of personnel employed to make determinations described in paragraph (c) of this section.

(iii) Maintain a current accreditation from a nationally recognized and relevant accrediting organization, such as URAC, or ensure that it otherwise possesses the requisite training to conduct payment determinations (for example, providing documentation that personnel employed by the IDR entity have completed arbitration training by the American Arbitration Association, the American Health Law Association, or a similar organization);

(iv) Have a process to ensure that no conflict of interest, as defined in paragraph (a)(2) of this section, exists between the parties and the personnel the certified IDR entity assigns to a payment determination to avoid violating paragraph (c)(1)(ii) of this section, including policies and procedures for conducting ongoing audits for conflicts of interest, to ensure that should any conflicts of interest arise, the certified IDR entity has procedures in place to inform the Secretary, jointly with the

Secretary of Health and Human Services and the Secretary of Labor, of the conflict of interest and to mitigate the risk by reassigning the dispute to other personnel in the event that any personnel previously assigned have a conflict of interest.

(v) Have a process to maintain the confidentiality of IIHI obtained in the course of conducting determinations. A certified IDR entity's responsibility to comply with these confidentiality requirements shall survive revocation of the IDR entity's certification for any reason, and IDR entities must comply with the record retention and disposal requirements described in this section. Under this process, once certified, the certified IDR entity must comply with the following requirements:

(A) *Privacy*. The certified IDR entity may create, collect, handle, disclose, transmit, access, maintain, store, and/or use IIHI, only to perform:

(*1*) The certified IDR entity's required duties described in this section; and

(*2*) Functions related to carrying out additional obligations as may be required under applicable Federal or State laws or regulations.

(B) *Security*. (*1*) The certified IDR entity must ensure the confidentiality of all IIHI it creates, obtains, maintains, stores, and transmits;

(*2*) The certified IDR entity must protect against any reasonably anticipated threats or hazards to the security of this information;

(*3*) The certified IDR entity must ensure that IIHI is securely destroyed or disposed of in an appropriate and reasonable manner 6 years from either the date of its creation or the first date on which the certified IDR entity had access to it, whichever is earlier;

(*4*) The certified IDR entity must implement policies and procedures to prevent, detect, contain, and correct security violations in the event of a breach of IIHI;

(C) *Breach notification*. The certified IDR entity must, following the discovery of a breach of unsecured IIHI, notify of the breach the provider, facility, or provider of air ambulance services; the plan; the Secretary, jointly with the Secretary of Health and Human Services and the Secretary of Labor; and each individual whose unsecured IIHI has been, or is reasonably believed to have been, subject to the breach, to the extent possible.

(*1*) *Breaches treated as discovered*. For purposes of this paragraph (e)(2)(v)(C), a breach shall be treated as discovered by a certified IDR entity as of the first day on which the breach is known to the certified IDR entity or, by exercising reasonable diligence, would have been known to the certified IDR entity. A certified IDR entity shall be deemed to have knowledge of a breach if the breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the breach, who is an employee, officer, or other agent of the certified IDR entity;

(*2*) *Timing of notification*. A certified IDR entity must provide the notification required by this paragraph (e)(2)(v)(C) without unreasonable delay and in no case later than 60 calendar days after discovery of a breach.

(*3*) *Content of notification*. The notification required by this paragraph (e)(2)(v)(C) must include, to the extent possible:

(*i*) The identification of each individual whose unsecured IIHI has been, or is reasonably believed by the certified IDR entity to have been, subject to the breach;

(*ii*) A brief description of what happened, including the date of the breach and the date of the discovery of the breach, to the extent known;

(*iii*) A description of the types of unsecured IIHI that were involved in the breach (for example whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);

(*iv*) A brief description of what the certified IDR entity involved is doing to investigate the breach, to mitigate harm to the affected parties, and to protect against any further breaches; and

(*v*) Contact procedures for individuals to ask questions or learn additional information, which must include a toll-free telephone number, email address, website, or postal address.

(*4*) *Method for providing notification*. A certified IDR entity must submit the

notification required by this paragraph (e)(2)(v)(C) in written form (in clear and understandable language) either on paper or electronically through the Federal IDR portal or electronic mail.

(D) *Application to contractor and subcontractors.* The certified IDR entity must ensure compliance with this paragraph (e)(2)(v) of this section by any contractor or subcontractor with access to IIHI performing any duties related to the Federal IDR process.

(vi) Meet appropriate indicators of fiscal integrity and stability by demonstrating that the certified IDR entity has a system of safeguards and controls in place to prevent and detect improper financial activities by its employees and agents to assure fiscal integrity and accountability for all certified IDR entity fees and administrative fees received, held, and disbursed and by submitting 3 years of financial statements or, if not available, other information to demonstrate fiscal stability of the IDR entity;

(vii) Provide a fixed fee for single determinations and a separate fixed fee for batched determinations within the upper and lower limits for each, as set forth in guidance issued by the Secretary. The certified IDR entity may not charge a fee that is not within the approved limits as set forth in guidance unless the certified IDR entity or IDR entity seeking certification receives written approval from the Secretary to charge a flat rate beyond the upper or lower limits approved by the Secretary for fees. The certified IDR entity or IDR entity seeking certification may update its fees and seek approval from the Secretary to charge a flat fee beyond the upper or lower limits for fees annually as provided in guidance. In order for the certified IDR entity to receive the Secretary's written approval to charge a flat fee beyond the upper or lower limits for fees as set forth in guidance, it must satisfy both conditions in paragraphs (e)(2)(vii)(A) and (B) of this section as follows:

(A) Submit, in writing, a proposal to the Secretary that includes:

(*1*) The alternative flat fee the certified IDR entity or IDR entity seeking certification believes is appropriate for the certified IDR entity or IDR entity seeking certification to charge;

(*2*) A description of the circumstances that require the alternative fee; and

(*3*) A description of how the alternative flat rate will be used to mitigate the effects of these circumstances; and

(B) Receive from the Secretary, jointly with the Secretary of Health and Human Services and the Secretary of Labor, written approval to charge the fee documented in the certified IDR entity's or the IDR entity seeking certification's written proposal.

(viii) Have a procedure in place to retain the certified IDR entity fees described in paragraph (d)(1) of this section paid by both parties in a trust or escrow account and to return the certified IDR entity fee paid by the prevailing party of an IDR payment determination, or half of each party's certified IDR entity fee in the case of an agreement described in paragraph (c)(2)(i) of this section, within 30 business days following the date of the determination;

(ix) Have a procedure in place to retain the administrative fees described in paragraph (d)(2) of this section and to remit the administrative fees to the Secretary in accordance with the timeframe and procedures set forth in guidance published by the Secretary;

(x) Discharge its responsibilities in accordance with paragraph (c) of this section, including not making any determination with respect to which the certified IDR entity would not be eligible for selection pursuant to paragraph (c)(1) of this section; and

(xi) Collect the information required to be reported to the Secretary under paragraph (f) of this section and report the information on a timely basis in the form and manner provided in guidance published by the Secretary.

(3) *Conflict-of-interest standards.* In addition to the general standards set forth in paragraph (e)(2)(iv) of this section, an IDR entity must provide written documentation that the IDR entity satisfies the standards to be a certified IDR entity under this paragraph (e)(3).

(i) The IDR entity must provide an attestation indicating that it does not have a conflict of interest as defined in paragraph (a)(2) of this section;

(ii) The IDR entity must have procedures in place to ensure that personnel assigned to a determination do not have any conflicts of interest regarding any party to the dispute within the 1 year immediately preceding an assignment of dispute determination, similar to the requirements laid out in 18 U.S.C. 207(b). In order to satisfy this requirement, if certified, the IDR entity must ensure that any personnel assigned to a determination do not have any conflicts of interest as defined in paragraph (a)(2) of this section.

(iii) Following certification under this paragraph (e), if a certified IDR entity acquires control of, becomes controlled by, or comes under common control with any entity described in paragraph (e)(3)(i) of this section, the certified IDR entity must notify the Secretary in writing no later than 3 business days after the acquisition or exercise of control and shall be subject to revocation of certification under paragraph (e)(6)(ii) of this section.

(4) *Period of certification.* Subject to paragraphs (e)(5) and (6) of this section, each certification (including a recertification) of a certified IDR entity under the process described in paragraph (e)(1) of this section will be effective for a 5-year period.

(5) *Petition for denial or revocation*—(i) *In general.* An individual, provider, facility, provider of air ambulance services, plan, or issuer may petition for a denial of a certification for an IDR entity or a revocation of a certification for a certified IDR entity for failure to meet a requirement of this section using the standard form and manner set forth in guidance issued by the Secretary. The petition for denial of a certification must be submitted within the timeframe set forth in guidance issued by the Secretary.

(ii) *Content of petition.* The individual, provider, facility, provider of air ambulance services, plan, or issuer seeking denial or revocation of certification must submit a written petition using the standard form issued by the Secretary including the following information:

(A) The identity of the IDR entity seeking certification or certified IDR entity that is the subject of the petition;

(B) The reason(s) for the petition;

(C) Whether the petition seeks denial or revocation of a certification;

(D) Documentation to support the reasons outlined in the petition; and

(E) Other information as may be required by the Secretary.

(iii) *Process.* (A) The Secretary, jointly with the Secretary of Health and Human Services and the Secretary of Labor, will acknowledge receipt of the petition within 10 business days of receipt of the petition.

(B) If the Secretary finds that the petition adequately shows a failure of the IDR entity seeking certification or the certified IDR entity to follow the requirements of this paragraph (e), the Secretary, jointly with the Secretary of Health and Human Services and the Secretary of Labor, will notify the IDR entity seeking certification or the certified IDR entity by providing a de-identified copy of the petition. Following the notification, the IDR entity seeking certification or certified IDR entity will have 10 business days to provide a response. After the time period for providing the response has passed, the Secretary, jointly with the Secretary of Health and Human Services and the Secretary of Labor, will review the response (if any), determine whether a denial or revocation of a certification is warranted, and issue a notice of the decision to the IDR entity or certified IDR entity and to the petitioner. This decision will be subject to the appeal requirements of paragraph (e)(6)(v) of this section.

(C) Effect on certification under petition. Regarding a petition for revocation of a certified IDR entity's certification, if the Secretary, jointly with the Secretary of Health and Human Services and the Secretary of Labor, finds that the petition adequately shows a failure to comply with the requirements of this paragraph (e), following the Secretary's notification of the failure to the certified IDR entity under paragraph (e)(5)(iii)(B) of this section, the certified IDR entity may continue to work on previously assigned determinations but may not accept new determinations until the Secretary issues a notice of the decision to the certified IDR entity finding that a

revocation of certification is not warranted.

(6) *Denial of IDR entity certification or revocation of certified IDR entity certification*—(i) *Denial of IDR entity certification*. The Secretary, jointly with the Secretary of Health and Human Services and the Secretary of Labor, may deny the certification of an IDR entity under paragraph (e)(1) of this section if, during the process of certification, including as a result of a petition described in paragraph (e)(5) of this section, the Secretary determines the following:

(A) The IDR entity fails to meet the applicable standards set forth under this paragraph (e);

(B) The IDR entity has committed or participated in fraudulent or abusive activities, including, during the certification process, submitting fraudulent data, or submitting information or data the IDR entity knows to be false to the Secretary, the Secretary of Health and Human Services, or the Secretary of Labor;

(C) The IDR entity has failed to comply with requests for information from the Secretary, the Secretary of Health and Human Services, or the Secretary of Labor as part of the certification process;

(D) In conducting payment determinations, including those outside the Federal IDR process, the IDR entity has failed to meet the standards that applied to those determinations or reviews, including standards of independence and impartiality; or

(E) The IDR entity is otherwise not fit or qualified to make determinations under the Federal IDR process.

(ii) *Revocation of certification of a certified IDR entity*. The Secretary, jointly with the Secretary of Health and Human Services and the Secretary of Labor, may revoke the certification of a certified IDR entity under paragraph (e)(1) of this section if, as a result of an audit, a petition described in paragraph (e)(5) of this section, or otherwise, the Secretary determines the following:

(A) The certified IDR entity has a pattern or practice of noncompliance with any requirements of this paragraph (e);

(B) The certified IDR entity is operating in a manner that hinders the efficient and effective administration of the Federal IDR process;

(C) The certified IDR entity no longer meets the applicable standards for certification set forth under this paragraph (e);

(D) The certified IDR entity has committed or participated in fraudulent or abusive activities, including submission of false or fraudulent data to the Secretary, the Secretary of Health and Human Services, or the Secretary of Labor;

(E) The certified IDR entity lacks the financial viability to provide arbitration under the Federal IDR process;

(F) The certified IDR entity has failed to comply with requests from the Secretary, the Secretary of Health and Human Services, or the Secretary of Labor made as part of an audit, including failing to submit all records of the certified IDR entity that pertain to its activities within the Federal IDR process; or

(G) The certified IDR entity is otherwise no longer fit or qualified to make determinations.

(iii) *Notice of denial or revocation*. The Secretary, jointly with the Secretary of Health and Human Services and the Secretary of Labor, will issue a written notice of denial to the IDR entity or revocation to the certified IDR entity within 10 business days of the Secretary's decision, including the effective date of denial or revocation, the reason(s) for denial or revocation, and the opportunity to request appeal of the denial or revocation.

(iv) *Request for appeal of denial or revocation*. To request an appeal, the IDR entity or certified IDR entity must submit a request for appeal to the Secretary within 30 business days of the date of the notice under paragraph (e)(6)(iii) of this section of denial or revocation and in the manner prescribed by the instructions to the notice. During this time period, the Secretary, jointly with the Secretary of Health and Human Services and the Secretary of Labor, will not issue a notice of final denial or revocation and a certified IDR entity may continue to

work on previously assigned determinations but may not accept new determinations. If the IDR entity or certified IDR entity does not timely submit a request for appeal of the denial or revocation, the Secretary, jointly with the Secretary of Health and Human Services and the Secretary of Labor, will issue a notice of final denial or revocation to the IDR entity or certified IDR entity (if applicable) and the petitioner.

(v) *Denial or final revocation*. Upon notice of denial or final revocation, the IDR entity shall not be considered a certified IDR entity and therefore shall not be eligible to accept payment determinations under the Federal IDR process. Moreover, after a notice of final revocation, the IDR entity may not re-apply to be a certified IDR entity until on or after the 181st day after the date of the notice of denial or final revocation.

(f) *Reporting of information relating to the Federal IDR process*—(1) *Reporting of information*. Within 30 business days of the close of each month, for qualified IDR items and services furnished on or after January 1, 2022, each certified IDR entity must, in a form and manner specified by the Secretary, report:

(i) The number of notices of IDR initiation submitted under paragraph (b)(2) of this section to the certified IDR entity during the immediately preceding month;

(ii) The size of the provider practices and the size of the facilities submitting notices of IDR initiation under paragraph (b)(2) of this section during the immediately preceding month, as required to be provided to the certified IDR entity under paragraph (c)(4)(i)(A)(*2*) of this section;

(iii) The number of such notices of IDR initiation with respect to which a determination was made under paragraph (c)(4)(ii) of this section;

(iv) The number of times during the month that the out-of-network rate determined (or agreed to) under this section has exceeded the qualifying payment amount, specified by qualified IDR items and services;

(v) With respect to each notice of IDR initiation under paragraph (b)(2) of this section for which such a determination was made, the following information:

(A) A description of the qualified IDR items and services included with respect to the notification, including the relevant billing and service codes;

(B) The relevant geographic region for purposes of the qualifying payment amount for the qualified IDR items and services with respect to which the notification was provided;

(C) The amount of the offer submitted under paragraph (c)(4)(i) of this section by the plan and by the provider or facility (as applicable) expressed as a dollar amount and as a percentage of the qualifying payment amount;

(D) Whether the offer selected by the certified IDR entity under paragraph (c)(4) of this section was the offer submitted by the plan or by the provider or facility (as applicable);

(E) The amount of the selected offer expressed as a dollar amount and as a percentage of the qualifying payment amount;

(F) The rationale for the certified IDR entity's decision, including the extent to which the decision relied on the criteria in paragraph (c)(4)(iv) of this section;

(G) The practice specialty or type of each provider or facility, respectively, involved in furnishing each qualified IDR item or service;

(H) The identity for each plan, and provider or facility, with respect to the notification. Specifically, each certified IDR entity must provide each party's name and address, as applicable; and

(I) For each determination, the number of business days elapsed between selection of the certified IDR entity and the determination of the out-of-network rate by the certified IDR entity.

(vi) The total amount of certified IDR entity fees paid to the certified IDR entity under paragraph (d)(1) of this section during the month.

(2) [Reserved]

(g) *Extension of time periods for extenuating circumstances*—(1) *General*. The time periods specified in this section (other than the time for payment, if applicable, under paragraph (c)(4)(ix) of

this section) may be extended in extenuating circumstances at the Secretary's discretion if:

(i) An extension is necessary to address delays due to matters beyond the control of the parties or for good cause; and

(ii) The parties attest that prompt action will be taken to ensure that the determination under this section is made as soon as administratively practicable under the circumstances.

(2) *Process to request an extension*. The parties may request an extension by submitting a request for extension due to extenuating circumstances through the Federal IDR portal if the extension is necessary to address delays due to matters beyond the control of the parties or for good cause.

(h) *Applicability date*. The provisions of this section are applicable with respect to plan years beginning on or after January 1, 2022, except that the provisions regarding IDR entity certification at paragraphs (a) and (e) of this section are applicable beginning on October 7, 2021.

[T.D. 9955, 86 FR 56100, Oct. 7, 2021]

§54.9817–1T Preventing surprise medical bills for air ambulance services (temporary).

(a) *In general*. If a group health plan provides or covers any benefits for air ambulance services, the plan must cover such services from a nonparticipating provider of air ambulance services in accordance with paragraph (b) of this section.

(b) *Coverage requirements*. A plan described in paragraph (a) of this section must provide coverage of air ambulance services in the following manner—

(1) The cost-sharing requirements with respect to the services must be the same requirements that would apply if the services were provided by a participating provider of air ambulance services.

(2) The cost-sharing requirement must be calculated as if the total amount that would have been charged for the services by a participating provider of air ambulance services were equal to the lesser of the qualifying payment amount (as determined in accordance with §54.9816–6T) or the billed amount for the services.

(3) The cost-sharing amounts must be counted towards any in-network deductible and in-network out-of-pocket maximums (including the annual limitation on cost sharing under section 2707(b) of the Public Health Service Act) (as applicable) applied under the plan (and the in-network deductible and out-of-pocket maximums must be applied) in the same manner as if the cost-sharing payments were made with respect to services furnished by a participating provider of air ambulance services.

(4) The plan must—

(i) Not later than 30 calendar days after the bill for the services is transmitted by the provider of air ambulance services, determine whether the services are covered under the plan and, if the services are covered, send to the provider an initial payment or a notice of denial of payment. For purposes of this paragraph (b)(4)(i), the 30-calendar-day period begins on the date the plan receives the information necessary to decide a claim for payment for the services.

(ii) Pay a total plan payment directly to the nonparticipating provider furnishing such air ambulance services that is equal to the amount by which the out-of-network rate for the services exceeds the cost-sharing amount for the services (as determined in accordance with paragraphs (b)(1) and (2) of this section), less any initial payment amount made under paragraph (b)(4)(i) of this section. The total plan payment must be made in accordance with the timing requirement described in section 9817(b)(6), or in cases where the out-of-network rate is determined under a specified State law or All-Payer Model Agreement, such other timeframe as specified by the State law or All-Payer Model Agreement.

(c) *Applicability date*. The provisions of this section are applicable with respect to plan years beginning on or after January 1, 2022.

[T.D. 9951, 86 FR 36950, July 13, 2021]

§ 54.9817–2T Independent dispute resolution process for air ambulance services (temporary).

(a) *Definitions.* Unless otherwise stated, the definitions in § 54.9816–3T apply.

(b) *Determination of out-of-network rates to be paid by group health plans; independent dispute resolution process*—(1) *In general.* Except as provided in paragraphs (b)(2) and (3) of this section, in determining the out-of-network rate to be paid by group health plans for out-of-network air ambulance services, plans must comply with the requirements of § 54.9816–8T, except that references in § 54.9816–8T to the additional circumstances in § 54.9816–8T(c)(4)(iii)(C) shall be understood to refer to § 54.9817–2T(b)(2).

(2) *Additional information.* Additional information submitted by a party, provided the information is credible, relates to the circumstances described in paragraphs (b)(2)(i) through (vi) of this section, with respect to a qualified IDR service of a nonparticipating provider of air ambulance services or group health plan that is the subject of a payment determination. This information must also clearly demonstrate that the qualifying payment amount is materially different from the appropriate out-of-network rate.

(i) The quality and outcomes measurements of the provider that furnished the services.

(ii) The acuity of the condition of the participant or beneficiary receiving the service, or the complexity of furnishing the service to the participant or beneficiary.

(iii) The training, experience, and quality of the medical personnel that furnished the air ambulance services.

(iv) Ambulance vehicle type, including the clinical capability level of the vehicle.

(v) Population density of the point of pick-up (as defined in 42 CFR 414.605) for the air ambulance (such as urban, suburban, rural, or frontier).

(vi) Demonstrations of good faith efforts (or lack thereof) made by the nonparticipating provider of air ambulance services or the plan to enter into network agreements with each other and, if applicable, contracted rates between the provider of air ambulance services and the plan during the previous 4 plan years.

(3) *Reporting of information relating to the IDR process.* In applying the requirements of § 54.9816–8T(f), within 30 business days of the close of each month, for services furnished on or after January 1, 2022, the information the certified IDR entity must report, in a form and manner specified by the Secretary, with respect to the Federal IDR process involving air ambulance services is:

(i) The number of notices of IDR initiation submitted under the Federal IDR process to the certified IDR entity that pertain to air ambulance services during the immediately preceding month;

(ii) The number of such notices of IDR initiation with respect to which a final determination was made under § 54.9816–8T(c)(4)(ii) (as applied by paragraph (b)(1) of this section);

(iii) The number of times the payment amount determined (or agreed to) under this subsection has exceeded the qualifying payment amount, specified by services;

(iv) With respect to each notice of IDR initiation under § 54.9816–8T(b)(2) (as applied by paragraph (b)(1) of this section) for which a determination was made, the following information:

(A) A description of each air ambulance service included in such notification, including the relevant billing and service codes;

(B) The point of pick-up (as defined in 42 CFR 414.605) for the services included in such notification;

(C) The amount of the offers submitted under § 54.9816–8T(c)(4)(i) (as applied by paragraph (b)(1) of this section) by the group health plan and by the nonparticipating provider of air ambulance services, expressed as a dollar amount and as a percentage of the qualifying payment amount;

(D) Whether the offer selected by the certified IDR entity under § 54.9816–8T(c)(4)(ii) (as applied by paragraph (b)(1) of this section) to be the payment amount applied was the offer submitted by the plan or by the provider of air ambulance services;

(E) The amount of the selected offer expressed as a dollar amount and as a

percentage of the qualifying payment amount;

(F) The rationale for the certified IDR entity's decision, including the extent to which the decision relied on the criteria in paragraph (b)(2) of this section;

(G) Air ambulance vehicle type, including the clinical capability level of such vehicle (to the extent this information has been provided to the certified IDR entity);

(H) The identity for each plan and provider of air ambulance services, with respect to the notification. Specifically, each certified IDR entity must provide each party's name and address, as applicable; and

(I) For each determination, the number of business days elapsed between selection of the certified IDR entity and the selection of the payment amount by the certified IDR entity.

(v) The total amount of certified IDR entity fees paid to the certified IDR entity under paragraph § 54.9816–8T(d)(1) (as applied by paragraph (b)(1) of this section) during the month for determinations involving air ambulance services.

(c) *Applicability date.* The provisions of this section are applicable with respect to plan years beginning on or after January 1, 2022.

[T.D. 9955, 86 FR 56109, Oct. 7, 2021]

§ 54.9822–1T Choice of health care professional (temporary).

(a) *Choice of health care professional*—(1) *Designation of primary care provider*—(i) *In general.* If a group health plan, requires or provides for designation by a participant or beneficiary of a participating primary care provider, then the plan must permit each participant or beneficiary to designate any participating primary care provider who is available to accept the participant or beneficiary. In such a case, the plan must comply with the rules of paragraph (a)(4) of this section by informing each participant of the terms of the plan regarding designation of a primary care provider.

(ii) *Construction.* Nothing in paragraph (a)(1)(i) of this section is to be construed to prohibit the application of reasonable and appropriate geographic limitations with respect to the selection of primary care providers, in accordance with the terms of the plan, the underlying provider contracts, and applicable State law.

(iii) *Example.* The rules of this paragraph (a)(1) are illustrated by the following example:

(A) *Facts.* A group health plan requires individuals covered under the plan to designate a primary care provider. The plan permits each individual to designate any primary care provider participating in the plan's network who is available to accept the individual as the individual's primary care provider. If an individual has not designated a primary care provider, the plan designates one until the individual has made a designation. 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.

(B) *Conclusion.* In this *Example,* the plan has satisfied the requirements of this paragraph (a).

(2) *Designation of pediatrician as primary care provider*—(i) *In general.* If a group health plan requires or provides for the designation of a participating primary care provider for a child by a participant or beneficiary, the plan must permit the participant or beneficiary to designate a physician (allopathic or osteopathic) who specializes in pediatrics (including pediatric subspecialties, based on the scope of that provider's license under applicable State law) as the child's primary care provider if the provider participates in the network of the plan and is available to accept the child. In such a case, the plan must comply with the rules of paragraph (a)(4) of this section by informing each participant of the terms of the plan 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 with respect to coverage of pediatric care.

(iii) *Examples.* The rules of this paragraph (a)(2) are illustrated by the following examples:

(A) *Example 1—(1) Facts.* A group health plan's HMO designates for each

participant a physician who specializes in internal medicine to serve as the primary care provider for the participant and any beneficiaries. Participant *A* requests that Pediatrician *B* be designated as the primary care provider for *A*'s child. *B* is a participating provider in the HMO's network and is available to accept the child.

(*2*) *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).

(B) *Example 2*—(*1*) *Facts*. Same facts as *Example 1* (paragraph (a)(2)(iii)(A) of this section), except that *A* takes *A*'s child to *B* for treatment of the child's severe shellfish allergies. *B* wishes to refer *A*'s child to an allergist for treatment. The HMO, however, does not provide coverage for treatment of food allergies, nor does it have an allergist participating in its network, and it therefore refuses to authorize the referral.

(*2*) *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 described in paragraph (a)(3)(ii) of this section, may not require authorization or referral by the plan, 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 must comply with the rules of paragraph (a)(4) of this section by informing each participant that the plan may not require authorization or referral for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology. The plan may require such a professional to agree to otherwise adhere to the plan'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. 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 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 is described in this paragraph (a)(3) if the plan—

(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 with respect to coverage of obstetrical or gynecological care; or

(B) Preclude the group health plan involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan of treatment decisions.

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

(A) *Example 1*—(*1*) *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.

(*2*) *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.

(B) *Example 2*—(*1*) *Facts*. Same facts as *Example 1* (paragraph (a)(3)(iv)(A) of this section) except that *A* seeks gynecological services from *C*, an out-of-network provider.

(*2*) *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.

(C) *Example 3*—(*1*) *Facts*. Same facts as *Example 1* (paragraph (a)(3)(iv)(A) of this section) except that the group health plan only requires *B* to inform *A*'s designated primary care physician of treatment decisions.

(*2*) *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 the designated primary care physician to be notified of treatment decisions does not violate this paragraph (a)(3).

(D) *Example 4*—(*1*) *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.

(*2*) *Conclusion*. In this *Example 4*, the plan requirement for prior authorization before providing benefits for uterine fibroid embolization does not violate the requirements of this paragraph (a)(3) because, though the prior authorization requirement applies to obstetrical services, it does not restrict access to any providers specializing in obstetrics or gynecology.

(4) *Notice of right to designate a primary care provider*—(i) *In general*. If a group health plan requires the designation by a participant or beneficiary of a primary care provider, the plan must provide a notice informing each participant of the terms of the plan 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*. In the case of a group health plan, the notice described in paragraph (a)(4)(i) of this section must be included whenever the plan provides a participant with a summary plan description or other similar description of benefits under the plan.

(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 that require or allow for the designation of primary care providers by participants or beneficiaries, insert:

> [Name of group health plan] 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 designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan] 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] at [insert contact information].

(B) For plans 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 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 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] at [insert contact information].

(b) *Applicability date*. The provisions of this section are applicable with respect to plan years beginning on or after January 1, 2022.

[T.D. 9951, 86 FR 36950, July 13, 2021]

§ 54.9825–1T Basis and scope (temporary).

(a) *Basis*. This section and §§ 54.9825–2T through 54.9825–6T implement subchapter B of chapter 100 of the Internal Revenue Code of 1986.

(b) *Scope*. This part establishes standards for group health plans with respect to surprise medical bills, transparency in health care coverage, and additional patient protections.

[T.D. 9958, 86 FR 66696, Nov. 23, 2021]

§ 54.9825–2T Applicability (temporary).

(a) *In general*. The requirements in §§ 54.9825–4T through 54.9825–6T apply to group health plans (including grandfathered health plans as defined in § 54.9815–1251), except as specified in paragraph (b) of this section.

(b) *Exceptions*. The requirements in §§ 54.9825–4T through 54.9825–6T do not apply to the following:

(1) Excepted benefits as described in § 54.9831–1(c).

(2) Short-term, limited-duration insurance as defined in § 54.9801–2.

(3) Health reimbursement arrangements or other account-based group health plans as described in § 54.9815–2711(d).

[T.D. 9958, 86 FR 66696, Nov. 23, 2021]

§ 54.9825–3T Definitions (temporary).

The definitions in § 54.9816–3T apply to §§ 54.9825–4T through 54.9825–6T unless otherwise specified. In addition, for purposes of §§ 54.9825–4T through 54.9825–6T, the following definitions apply:

Brand prescription drug means a drug for which an application is approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(c)), or under section 351 of the PHS Act (42 U.S.C. 262), and that is generally marketed under a proprietary, trademark-protected name. The term ''brand prescription drug'' includes a drug with Emergency Use Authorization issued pursuant to section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb–3), and that is generally marketed under a proprietary, trademark-protected name. The term ''brand prescription drug'' includes drugs that the U.S. Food and Drug Administration determines to be interchangeable biosimilar products under sections 351(i)(3) and 351(k)(4) of the PHS Act (42 U.S.C. 262).

Dosage unit means the smallest form in which a pharmaceutical product is administered or dispensed, such as a pill, tablet, capsule, ampule, or measurement of grams or milliliters.

Federal Employees Health Benefits (FEHB) line of business refers to all health benefit plans that are offered to eligible enrollees pursuant to a contract between the Office of Personnel Management and Federal Employees Health Benefits (FEHB) Program carriers. Such plans are Federal governmental plans offered pursuant to 5 U.S.C. chapter 89.

Life-years means the total number of months of coverage for participants and beneficiaries, as applicable, divided by 12.

Market segment means one of the following: The individual market (excluding the student market), the student market, the fully-insured small group market, the fully-insured large group market (excluding the FEHB line of business), self-funded plans offered by small employers, self-funded plans offered by large employers, and the FEHB line of business.

Premium amount means, with respect to individual health insurance coverage and fully-insured group health plans, earned premium as that term is defined in 45 CFR 158.130, excluding the adjustments specified in 45 CFR 158.130(b)(5). Premium amount means,

with respect to self-funded group health plans and other arrangements that do not rely exclusively or primarily on payments of premiums as defined in 45 CFR 158.130, the premium equivalent amount representing the total cost of providing and maintaining coverage, including claims costs, administrative costs, and stop-loss premiums, as applicable.

Prescription drug (drug) means a set of pharmaceutical products that have been assigned a National Drug Code (NDC) by the Food and Drug Administration and are grouped by name and ingredient in the manner specified by the Secretary, jointly with the Secretary of Labor and the Secretary of Health and Human Services.

Prescription drug rebates, fees, and other remuneration means all remuneration received by or on behalf of a plan or issuer, its administrator or service provider, including remuneration received by and on behalf of entities providing pharmacy benefit management services to the plan or issuer, with respect to prescription drugs prescribed to participants and beneficiaries in the plan or coverage, as applicable, regardless of the source of the remuneration (for example, pharmaceutical manufacturer, wholesaler, retail pharmacy, or vendor). Prescription drug rebates, fees, and other remuneration also include, for example, discounts, chargebacks or rebates, cash discounts, free goods contingent on a purchase agreement, up-front payments, coupons, goods in kind, free or reduced-price services, grants, or other price concessions or similar benefits. Prescription drug rebates, fees, and other remuneration include bona fide service fees. Bona fide service fees mean fees paid by a drug manufacturer to an entity providing pharmacy benefit management services to the plan or issuer that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement, and that are not passed on in whole or in part to a client or customer of the entity, whether or not the entity takes title to the drug.

Reference year means the calendar year immediately preceding the calendar year in which data submissions under this section are required.

Reporting entity means an entity that submits some or all of the information required under §§ 54.9825–4T through 54.9825–6T with respect to a plan or issuer, and that may be different from the plan or issuer that is subject to the requirements of §§ 54.9825–4T through 54.9825–6T.

Student market has the meaning given in 45 CFR 158.103.

Therapeutic class means a group of pharmaceutical products that have similar mechanisms of action or treat the same types of conditions, grouped in the manner specified by the Secretary, jointly with the Secretary of Labor and the Secretary of Health and Human Services, in guidance. The Secretary may require plans and issuers to classify drugs according to a commonly available public or commercial therapeutic classification system, a therapeutic classification system provided by the Secretary of Health and Human Services, or a combination thereof.

Total annual spending means incurred claims, as that term is defined in 45 CFR 158.140, excluding the adjustments specified in 45 CFR 158.140(b)(1)(i), (b)(2)(iv), and (b)(4), and including cost sharing. With respect to prescription drugs, total annual spending is net of prescription drug rebates, fees, and other remuneration.

[T.D. 9958, 86 FR 66696, Nov. 23, 2021]

§ 54.9825–4T Reporting requirements related to prescription drug and health care spending (temporary).

(a) *General requirement.* A group health plan or a health insurance issuer offering group health insurance coverage must submit an annual report to the Secretary, the Secretary of Health and Human Services, and the Secretary of Labor, on prescription drug and health care spending, premiums, and enrollment under the plan or coverage.

(b) *Timing and form of report.* The report for the 2020 reference year must be submitted to the Secretary by December 27, 2021. Beginning with the 2021 reference year, the report for each reference year is due by June 1 of the year

following the reference year. The report must be submitted in the form and manner prescribed by the Secretary, jointly with the Secretary of Health and Human Services and the Secretary of Labor.

(c) *Transfer of business.* Issuers that acquire a line or block of business from another issuer during a reference year are responsible for submitting the information and report required by this section for the acquired business for that reference year, including for the part of the reference year that was prior to the acquisition.

(d) *Reporting entities and special rules to prevent unnecessary duplication*—(1) *Special rule for insured group health plans.* To the extent coverage under a group health plan consists of group health insurance coverage, the plan may satisfy the requirements of paragraph (a) of this section if the plan requires the health insurance issuer offering the coverage to report the information required by this section in compliance with this subpart pursuant to a written agreement. Accordingly, if a health insurance issuer and a group health plan sponsor enter into a written agreement under which the issuer agrees to provide the information required under paragraph (a) of this section in compliance with this section, and the issuer fails to do so, then the issuer, but not the plan, violates the reporting requirements of paragraph (a) of this section with respect to the relevant information.

(2) *Other contractual arrangements.* A group health plan or health insurance issuer offering group health insurance coverage may satisfy the requirements under paragraph (a) of this section by entering into a written agreement under which one or more other parties (such as health insurance issuers, pharmacy benefit managers, third-party administrators, or other third parties) report some or all of the information required under paragraph (a) of this section in compliance with this section. Notwithstanding the preceding sentence, if a group health plan or health insurance issuer chooses to enter into such an agreement and the party with which it contracts fails to provide the information in accordance with paragraph (a) of this section, the plan or issuer violates the reporting requirements of paragraph (a) of this section.

(e) *Applicability date.* The provisions of this section are applicable beginning December 27, 2021.

[T.D. 9958, 86 FR 66696, Nov. 23, 2021]

§ 54.9825–5T Aggregate reporting (temporary).

(a) *General requirement.* A group health plan or a health insurance issuer offering group health insurance coverage must submit, or arrange to be submitted, the information required in § 54.9825–6T(b) separately for each State in which group health coverage or group health insurance coverage was provided in connection with the group health plan or by the health insurance issuer. The report must include the experience of all plans and policies in the State during the reference year covered by the report, and must include the experience separately for each market segment as defined in § 54.9825–3T.

(b) *Aggregation by reporting entity*—(1) *In general.* If a reporting entity submits data on behalf of more than one group health plan in a State and market segment, the reporting entity may aggregate the data required in § 54.9825–6T(b) for the group health plans for each market segment in the State.

(2) *Multiple reporting entities.* (i) If multiple reporting entities submit the required data related to one or more plans or issuers in a State and market segment, the data submitted by each of these reporting entities must not be aggregated at a less granular level than the aggregation level used by the reporting entity that submits the data on total annual spending on health care services, as required by § 54.9825–6T(b)(4), on behalf of these plans or issuers.

(ii) The Secretary, jointly with the Secretary of Health and Human Services and the Secretary of Labor, may specify in guidance alternative or additional aggregation methods for data submitted by multiple reporting entities, to ensure a balance between compliance burdens and a data aggregation level that facilitates the development of the biannual public report required under section 9825(b) of the Code.

(3) *Group health insurance coverage with dual contracts.* If a group health

plan involves health insurance coverage obtained from two affiliated issuers, one providing in-network coverage only and the second providing out-of-network coverage only, the plan's out-of-network experience may be treated as if it were all related to the contract provided by the in-network issuer.

(c) *Aggregation by State.* (1) Experience with respect to each fully-insured policy must be included on the report for the State where the contract was issued, except as specified in paragraphs (c)(3) and (4) of this section.

(2) Experience with respect to each self-funded group health plan must be included on the report for the State where the plan sponsor has its principal place of business.

(3) For individual market business sold through an association, experience must be attributed to the issue State of the certificate of coverage.

(4) For health coverage provided to plans through a group trust or multiple employer welfare arrangement, the experience must be included in the report for the State where the employer (if the plan is sponsored at the individual employer level) or the association (if the association qualifies as an employer under ERISA section 3(5)) has its principal place of business or the state where the association is incorporated, in the case of an association with no principal place of business.

(d) *Applicability date.* The provisions of this section are applicable beginning December 27, 2021.

[T.D. 9958, 86 FR 66696, Nov. 23, 2021]

§ 54.9825–6T Required information (temporary).

(a) *Information for each plan or coverage.* The report required under § 54.9825–4T must include the following information for each plan or coverage, at the plan or coverage level:

(1) The identifying information for plans, issuers, plan sponsors, and any other reporting entities.

(2) The beginning and end dates of the plan year that ended on or before the last day of the reference year.

(3) The number of participants and beneficiaries, as applicable, covered on the last day of the reference year.

(4) Each State in which the plan or coverage is offered.

(b) *Information for each state and market segment.* The report required under § 54.9825–4T must include the following information with respect to plans or coverage for each State and market segment for the reference year, unless otherwise specified:

(1) The 50 brand prescription drugs most frequently dispensed by pharmacies, and for each such drug, the data elements listed in paragraph (b)(5) of this section. The most frequently dispensed drugs must be determined according to total number of paid claims for prescriptions filled during the reference year for each drug.

(2) The 50 most costly prescription drugs and for each such drug, the data elements listed in paragraph (b)(5) of this section. The most costly drugs must be determined according to total annual spending on each drug.

(3) The 50 prescription drugs with the greatest increase in expenditures between the year immediately preceding the reference year and the reference year, and for each such drug: The data elements listed in paragraph (b)(5) of this section for the year immediately preceding the reference year, and the data elements listed in paragraph (b)(5) of this section for the reference year. The drugs with the greatest increase in expenditures must be determined based on the increase in total annual spending from the year immediately preceding the reference year to the reference year. A drug must be approved for marketing or issued an Emergency Use Authorization by the Food and Drug Administration for the entirety of the year immediately preceding the reference year and for the entirety of the reference year to be included in the data submission as one of the drugs with the greatest increase in expenditures.

(4) Total annual spending on health care services by the plan or coverage and by participants and beneficiaries, as applicable, broken down by the type of costs, including—

(i) Hospital costs;

(ii) Health care provider and clinical service costs, for primary care and specialty care separately;

(iii) Costs for prescription drugs, separately for drugs covered by the plan's or issuer's pharmacy benefit and drugs covered by the plan's or issuer's hospital or medical benefit; and

(iv) Other medical costs, including wellness services.

(5) Prescription drug spending and utilization, including—

(i) Total annual spending by the plan or coverage;

(ii) Total annual spending by the participants and beneficiaries, as applicable, enrolled in the plan or coverage, as applicable;

(iii) The number of participants and beneficiaries, as applicable, with a paid prescription drug claim;

(iv) Total dosage units dispensed; and

(v) The number of paid claims.

(6) Premium amounts, including—

(i) Average monthly premium amount paid by employers and other plan sponsors on behalf of participants and beneficiaries, as applicable;

(ii) Average monthly premium amount paid by participants and beneficiaries, as applicable; and

(iii) Total annual premium amount and the total number of life-years.

(7) Prescription drug rebates, fees, and other remuneration, including—

(i) Total prescription drug rebates, fees, and other remuneration, and the difference between total amounts that the plan or issuer pays the entity providing pharmacy benefit management services to the plan or issuer and total amounts that such entity pays to pharmacies.

(ii) Prescription drug rebates, fees, and other remuneration, excluding bona fide service fees, broken down by the amounts passed through to the plan or issuer, the amounts passed through to participants and beneficiaries, as applicable, and the amounts retained by the entity providing pharmacy benefit management services to the plan or issuer; and the data elements listed in paragraph (b)(5) of this section—

(A) For each therapeutic class; and

(B) For each of the 25 prescription drugs with the greatest amount of total prescription drug rebates and other price concessions for the reference year.

(8) The method used to allocate prescription drug rebates, fees, and other remuneration, if applicable.

(9) The impact of prescription drug rebates, fees, and other remuneration on premium and cost sharing amounts.

(c) *Applicability date.* The provisions of this section are applicable beginning December 27, 2021.

[T.D. 9958, 86 FR 66696, Nov. 23, 2021]

§ 54.9831–1 Special rules relating to group health plans.

(a) *Group health plan*—(1) *Defined.* A group health plan means a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.

(2) *Determination of number of plans.* [Reserved]

(b) *General exception for certain small group health plans.* (1) Subject to paragraph (b)(2) of this section, the requirements of §§ 54.9801–1 through 54.9801–6, 54.9802–1, 54.9802–2, 54.9811–1, 54.9812–1, 54.9815–1251 through 54.9815–2719A, and 54.9833–1 do not apply to any group health plan for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees.

(2) The exception of paragraph (b)(1) of this section does not apply with respect to the following requirements:

(i) Section 54.9802–1(b), as such paragraph applies with respect to genetic information as a health factor.

(ii) Section 54.9802–1(c), as such paragraph applies with respect to genetic information as a health factor.

(iii) Section 54.9802–1(e), as such paragraph applies with respect to genetic information as a health factor.

(iv) Section 54.9802–3T(b).

(v) Section 54.9802–3T(c).

(vi) Section 54.9802–3T(d).

(vii) Section 54.9802–3T(e).

(c) *Excepted benefits*—(1) *In general.* The requirements of §§ 54.9801–1 through 54.9801–6, 54.9802–1, 54.9802–2, 54.9811–1, 54.9812–1, 54.9815–1251 through 54.9815–2719A, and 54.9833–1 do not apply to any group health plan in relation to

its provision of the benefits described in paragraph (c)(2), (3), (4), or (5) of this section (or any combination of these benefits).

(2) *Benefits excepted in all circumstances*. The following benefits are excepted in all circumstances—

(i) Coverage only for accident (including accidental death and dismemberment);

(ii) Disability income coverage;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Coverage issued as a supplement to liability insurance;

(v) Workers' compensation or similar coverage;

(vi) Automobile medical payment insurance;

(vii) Credit-only insurance (for example, mortgage insurance);

(viii) Coverage for on-site medical clinics; and

(ix) Travel insurance, within the meaning of § 54.9801–2.

(3) *Limited excepted benefits*—(i) *In general*. Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan as described in paragraph (c)(3)(ii) of this section. In addition, benefits provided under a health flexible spending arrangement (health FSA) are excepted benefits if they satisfy the requirements of paragraph (c)(3)(v) of this section; benefits provided under an employee assistance program are excepted benefits if they satisfy the requirements of paragraph (c)(3)(vi) of this section; benefits provided under limited wraparound coverage are excepted benefits if they satisfy the requirements of paragraph (c)(3)(vii) of this section; and benefits provided under a health reimbursement arrangement or other account-based group health plan, other than a health FSA, are excepted benefits if they satisfy the requirements of paragraph (c)(3)(viii) 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)(ii)(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), or provided under a qualified long-term care insurance contract, as defined in section 7702B(b); or

(C) Based on cognitive impairment or a loss of functional capacity that is expected to be chronic.

(v) *Health flexible spending arrangements*. Benefits provided under a health flexible spending arrangement (as defined in section 106(c)(2)) are excepted for a class of participants only if they satisfy the following two requirements—

(A) Other group health plan coverage, not limited to excepted benefits, is made available for the year to the class of participants by reason of their employment; and

(B) The arrangement is structured so that the maximum benefit payable to any participant in the class for a year cannot exceed two times the participant's salary reduction election under the arrangement for the year (or, if greater, cannot exceed $500 plus the amount of the participant's salary reduction election). For this purpose, any amount that an employee can elect to receive as taxable income but elects to apply to the health flexible spending

arrangement is considered a salary reduction election (regardless of whether the amount is characterized as salary or as a credit under the arrangement).

(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:

(*1*) 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 Plan 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 29 CFR 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 § 54.9801–2) 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). 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 primary plan and under the limited wraparound coverage includes both employer and employee contributions towards the 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 9815) and 29 CFR 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 § 54.9801–2), consistent with the requirements of section 9802 and section 2705 of the PHS Act (incorporated by reference into section 9815).

(*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 9815) or fails to be excludible from income for any individual due to the application of section 105(h) (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.

(*1*) *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*).

(*i*) 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), if such provisions were applicable; provides minimum value (as defined in section 36B(c)(2)(C)(ii)); and is reasonably expected to be affordable (applying the safe harbor rules for determining affordability set forth in § 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 this paragraph (c)(3)(vii)(D)(*1*)(*i*) is considered satisfied.

(*ii*) Eligibility for the limited wraparound coverage is limited to employees who are reasonably determined at the time of enrollment to not be full-time employees (and their dependents, as defined in § 54.9801–2), or who are retirees (and their dependents, as defined in § 54.9801–2). 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 this paragraph (c)(3)(vii)(D)(*2*). For this purpose, the term ''full-time employee'' means a ''full-time employee'' as defined in § 54.4980H–1(a)(21) who is not in a limited non-assessment period for certain employees (as defined in § 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), 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)(*2*)(*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)) and was affordable (applying the safe harbor rules for determining affordability set forth in § 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)(*2*)(*iii*) 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).

(viii) *Health reimbursement arrangements (HRAs) and other account-based group health plans.* Benefits provided under an HRA or other account-based group health plan, other than a health FSA, are excepted if they satisfy all of the requirements of this paragraph

(c)(3)(viii). See paragraph (c)(3)(v) of this section for the circumstances in which benefits provided under a health FSA are excepted benefits. For purposes of this paragraph (c)(3)(viii), the term ''HRA or other account-based group health plan'' has the same meaning as ''account-based group health plan'' set forth in § 54.9815–2711(d)(6)(i) of this part, except that the term does not include health FSAs. For ease of reference, an HRA or other account-based group health plan that satisfies the requirements of this paragraph (c)(3)(viii) is referred to as an excepted benefit HRA.

(A) *Otherwise not an integral part of the plan*. Other group health plan coverage that is not limited to excepted benefits and that is not an HRA or other account-based group health plan must be made available by the same plan sponsor for the plan year to the participant.

(B) *Benefits are limited in amount*—(*1*) *Limit on annual amounts made available*. The amounts newly made available for each plan year under the HRA or other account-based group health plan do not exceed $1,800. In the case of any plan year beginning after December 31, 2020, the dollar amount in the preceding sentence shall be increased by an amount equal to such dollar amount multiplied by the cost-of-living adjustment. The cost of living adjustment is the percentage (if any) by which the C–CPI–U for the preceding calendar year exceeds the C–CPI–U for calendar year 2019. The term ''C–CPI–U'' means the Chained Consumer Price Index for All Urban Consumers as published by the Bureau of Labor Statistics of the Department of Labor. The C–CPI–U for any calendar year is the average of the C–CPI–U as of the close of the 12-month period ending on March 31 of such calendar year. The values of the C–CPI–U used for any calendar year shall be the latest values so published as of the date on which the Bureau publishes the initial value of the C–CPI–U for the month of March for the preceding calendar year. Any such increase that is not a multiple of $50 shall be rounded down to the next lowest multiple of $50. The Department of the Treasury and the Internal Revenue Service will publish the adjusted amount for plan years beginning in any calendar year no later than June 1 of the preceding calendar year.

(*2*) *Carryover amounts*. If the terms of the HRA or other account-based group health plan allow unused amounts to be made available to participants and dependents in later plan years, such carryover amounts are disregarded for purposes of determining whether benefits are limited in amount.

(*3*) *Multiple HRAs or other account-based group health plans*. If the plan sponsor provides more than one HRA or other account-based group health plan to the participant for the same time period, the amounts made available under all such plans are aggregated to determine whether the benefits are limited in amount, except that HRAs or other account-based group health plans that reimburse only excepted benefits are not included in determining whether the benefits are limited in amount.

(C) *Prohibition on reimbursement of certain health insurance premiums*. The HRA or other account-based group health plan must not reimburse premiums for individual health insurance coverage, group health plan coverage (other than COBRA continuation coverage or other continuation coverage), or Medicare Part A, B, C, or D, except that the HRA or other account-based group health plan may reimburse premiums for such coverage that consists solely of excepted benefits. See also, paragraph (c)(3)(viii)(F) of this section.

(D) *Uniform availability*. The HRA or other account-based group health plan is made available under the same terms to all similarly situated individuals, as defined in § 54.9802–1(d) of this part, regardless of any health factor (as described in § 54.9802–1(a)).

(E) *Notice requirement*. *See* 29 CFR 2520.102–3(j)(2) and (3) and 29 CFR 2520.104b–2(a) for rules regarding the time, manner, and content for summary plan descriptions (including a description of conditions pertaining to eligibility to receive benefits; annual or lifetime caps or other limits on benefits under the plan; and a description or summary of the benefits) applicable to plans subject to Tile I of the Employee Retirement Income Security Act of 1974, as amended.

(F) *Special rule.* The HRA or other account-based group health plan must not reimburse premiums for short-term, limited-duration insurance (as defined in § 54.9801–2 of this part) if the conditions of this paragraph (c)(3)(viii)(F) are satisfied.

(*1*) The HRA or other account-based group health plan is offered by a small employer (as defined in PHS Act section 2791(e)(4)).

(*2*) The other group health plan coverage offered by the employer pursuant to paragraph (c)(3)(viii)(A) of this section is either fully-insured or partially-insured.

(*3*) The Secretary of Health and Human Services (HHS) makes a finding, in consultation with the Secretaries of Labor and the Treasury, that the reimbursement of premiums for short-term, limited-duration insurance by excepted benefit HRAs has caused significant harm to the small group market in the state that is the principal place of business of the small employer.

(*4*) The finding by the Secretary of HHS is made after submission of a written recommendation by the applicable state authority of such state, in a form and manner specified by HHS. The written recommendation must include evidence that the reimbursement of premiums for short-term, limited-duration insurance by excepted benefit HRAs established by insured or partially-insured small employers in the state has caused significant harm to the state's small group market, including with respect to premiums.

(*5*) The restriction shall be imposed or discontinued by publication by the Secretary of HHS of a notice in the FEDERAL REGISTER and shall apply only prospectively and with a reasonable time for plan sponsors to comply.

(4) *Noncoordinated benefits*—(i) *Excepted benefits that are not coordinated.* Coverage for only a specified disease or illness (for example, cancer-only policies) or hospital indemnity or other fixed indemnity insurance is excepted only if it meets each of the conditions specified in paragraph (c)(4)(ii) of this section. To be hospital indemnity or other fixed indemnity insurance, the insurance must pay a fixed dollar amount per day (or per other period) of hospitalization or illness (for example, $100/day) regardless of the amount of expenses incurred.

(ii) *Conditions.* Benefits are described in paragraph (c)(4)(i) of this section only if—

(A) The benefits are provided under a separate policy, certificate, or contract of insurance;

(B) There is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and

(C) The benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor.

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

Example. (i) *Facts.* An employer sponsors a group health plan that provides coverage through an insurance policy. The policy provides benefits only for hospital stays at a fixed percentage of hospital expenses up to a maximum of $100 a day.

(ii) *Conclusion.* In this *Example,* even though the benefits under the policy satisfy the conditions in paragraph (c)(4)(ii) of this section, because the policy pays a percentage of expenses incurred rather than a fixed dollar amount, the benefits under the policy are not excepted benefits under this paragraph (c)(4). This is the result even if, in practice, the policy pays the maximum of $100 for every day of hospitalization.

(5) *Supplemental benefits.* (i) The following benefits are excepted only if they are provided under a separate policy, certificate, or contract of insurance—

(A) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act; also known as Medigap or MedSupp insurance);

(B) Coverage supplemental to the coverage provided under Chapter 55, title 10 of the United States Code (also known as TRICARE supplemental programs); and

(C) *Similar supplemental coverage provided to coverage under a group health plan.* To be similar supplemental coverage, the coverage must be specifically designed to fill gaps in the primary coverage. The preceding sentence is satisfied if the coverage is designed

to fill gaps in cost sharing in the primary coverage, such as coinsurance or deductibles, or the coverage is designed to provide benefits for items and services not covered by the primary coverage and that are not essential health benefits (as defined under section 1302(b) of the Patient Protection and Affordable Care Act) in the State where the coverage is issued, or the coverage is designed to both fill such gaps in cost sharing under, and cover such benefits not covered by, the primary coverage. Similar supplemental coverage does not include coverage that becomes secondary or supplemental only under a coordination-of-benefits provision.

(ii) The rules of this paragraph (c)(5) are illustrated by the following example:

Example. (i) *Facts.* An employer sponsors a group health plan that provides coverage for both active employees and retirees. The coverage for retirees supplements benefits provided by Medicare, but does not meet the requirements for a supplemental policy under section 1882(g)(1) of the Social Security Act.

(ii) *Conclusion.* In this *Example,* the coverage provided to retirees does not meet the definition of supplemental excepted benefits under this paragraph (c)(5) because the coverage is not Medicare supplemental insurance as defined under section 1882(g)(1) of the Social Security Act, is not a TRICARE supplemental program, and is not supplemental to coverage provided under a group health plan.

(d) *Treatment of partnerships.* For purposes of this part:

(1) *Treatment as a group health plan.* (*See* 29 CFR 2590.732(d)(1) and 45 CFR 146.145(d)(1), under which a plan providing medical care, maintained by a partnership, and usually not treated as an employee welfare benefit plan under ERISA is treated as a group health plan for purposes of Part 7 of Subtitle B of title I of ERISA and title XXVII of the PHS Act.)

(2) *Employment relationship.* In the case of a group health plan, the term *employer* also includes the partnership in relation to any bona fide partner. In addition, the term *employee* also includes any bona fide partner. Whether or not an individual is a bona fide partner is determined based on all the relevant facts and circumstances, including whether the individual performs services on behalf of the partnership.

(3) *Participants of group health plans.* In the case of a group health plan, the term *participant* also includes any individual described in paragraph (d)(3)(i) or (ii) of this section if the individual is, or may become, eligible to receive a benefit under the plan or the individual's beneficiaries may be eligible to receive any such benefit.

(i) In connection with a group health plan maintained by a partnership, the individual is a partner in relation to the partnership.

(ii) In connection with a group health plan maintained by a self-employed individual (under which one or more employees are participants), the individual is the self-employed individual.

(e) *Determining the average number of employees.* [Reserved]

[T.D. 9166, 69 FR 78746, Dec. 30, 2004; 70 FR 21146, Apr. 25, 2005, as amended by T.D. 9299, 71 FR 75057, Dec. 13, 2006; T.D. 9427, 73 FR 62422, Oct. 20, 2008; T.D. 9464, 74 FR 51678, Oct. 7, 2009; T.D. 9656, 79 FR 10308, Feb. 24, 2014; T.D. 9697, 79 FR 59135, Oct. 1, 2014; T.D. 9714, 80 FR 14004, Mar. 18, 2015; T.D. 9791, 81 FR 75324, Oct. 31, 2016; T.D. 9867, 84 FR 28999, June 20, 2019]

§ 54.9833–1 Applicability dates.

Sections 54.9801–1 through 54.9801–6, 54.9831–1, and this section are applicable for plan years beginning on or after July 1, 2005. Notwithstanding the previous sentence, the definition of ''short-term, limited-duration insurance'' in § 54.9801–2 applies October 2, 2018.

[T.D. 9166, 69 FR 78746, Dec. 30, 2004, as amended by T.D. 9791, 81 FR 75325, Oct. 31, 2016; T.D. 9837, 83 FR 38242, Aug. 3, 2018]

PART 55—EXCISE TAX ON REAL ESTATE INVESTMENT TRUSTS AND REGULATED INVESTMENT COMPANIES

Subpart A—Excise Tax on Real Estate Investment Trusts

Sec.
55.4981–1 [Reserved]
55.4981–2 Imposition of excise tax with respect to certain undistributed income of real estate investment trusts; calendar years beginning after December 31, 1986.

Subpart B—Excise Tax on Regulated Investment Companies

55.4982–1 Imposition of excise tax on undistributed income of regulated investment companies.

Subpart C—Procedure and Administration

55.6001–1 Notice or regulations requiring records, statements, and special returns.
55.6011–1 General requirement of return, statement, or list.
55.6060–1 Reporting requirements for tax return preparers.
55.6061–1 Signing of returns and other documents.
55.6065–1 Verification of returns.
55.6071–1 Time for filing returns.
55.6081–1 Automatic extension of time for filing a return due under Chapter 44.
55.6091–1 Place for filing Chapter 44 tax returns.
55.6091–2 Exceptional cases.
55.6107–1 Tax return preparer must furnish copy of return or claim for refund to taxpayer and must retain a copy or record.
55.6109–1 Tax return preparers furnishing identifying numbers for returns or claims for refund.
55.6151–1 Time and place for paying of tax shown on returns.
55.6161–1 Extension of time for paying tax or deficiency.
55.6165–1 Bonds where time to pay tax or deficiency has been extended.
55.6694–1 Section 6694 penalties applicable to tax return preparer.
55.6694–2 Penalties for understatement due to an unreasonable position.
55.6694–3 Penalty for understatement due to willful, reckless, or intentional conduct.
55.6694–4 Extension of period of collection when tax return preparer pays 15 percent of a penalty for understatement of taxpayer's liability and certain other procedural matters.
55.6695–1 Other assessable penalties with respect to the preparation of tax returns or claims for refund for other persons.
55.6696–1 Claims for credit or refund by tax return preparers.
55.7701–1 Tax return preparer.

AUTHORITY: 26 U.S.C. 6001, 6011, 6071, 6091, and 7805.

Section 55.6011–1 also issued under 26 U.S.C. 6011(a);

Section 55.6060–1 also issued under 26 U.S.C. 6060(a);

Section 55.6071–1 also issued under 26 U.S.C. 6071(a);

Section 55.6081–1 also issued under 26 U.S.C. 6081(a);

Section 55.6091–1 also issued under 26 U.S.C. 6091(a);

Section 55.6109–1 also issued under 26 U.S.C. 6109(a);

Section 55.6109–2 also issued under 26 U.S.C. 6109(a);

Section 55.6151–1 also issued under 26 U.S.C. 6151;

Section 55.6695–1 also issued under 26 U.S.C. 6695(b).

SOURCE: T.D. 7767, 46 FR 11282, Feb. 6, 1981; 46 FR 15263, Mar. 5, 1981, unless otherwise noted.

Subpart A—Excise Tax on Real Estate Investment Trusts

§ 55.4981–1 [Reserved]

§ 55.4981–2 Imposition of excise tax with respect to certain undistributed income of real estate investment trusts; calendar years beginning after December 31, 1986.

Section 4981, as amended by the Tax Reform Act of 1986, imposes an excise tax on a real estate investment trust in the amount of four percent of the excess, if any, of the required distribution for a calendar year over the distributed amount for such calendar year. Section 4981, as so amended, applies only to calendar years that begin after December 31, 1986.

[T.D. 8180, 53 FR 6148, Mar. 1, 1988, as amended by T.D. 9849, 84 FR 9239, Mar. 14, 2019]

Subpart B—Excise Tax on Regulated Investment Companies

§ 55.4982–1 Imposition of excise tax on undistributed income of regulated investment companies.

Section 4982 imposes an excise tax on a regulated investment company in the amount of four percent of the excess, if any, of the required distribution for a calendar year over the distributed amount for such calendar year. Section 4982 applies only to calendar years beginning after December 31, 1986.

[T.D. 8180, 53 FR 6148, Mar. 1, 1988]

Subpart C—Procedure and Administration

SOURCE: T.D. 7767, 46 FR 11282, Feb. 6, 1981; 46 FR 15263, Mar. 5, 1981, unless otherwise noted. Redesignated by T.D. 8180, 53 FR 6148, Mar. 1, 1988.

§ 55.6001–1 Notice or regulations requiring records, statements, and special returns.

(a) *In general.* Any person subject to tax under Chapter 44 of the Code shall keep such complete and detailed records as are sufficient to enable the district director to determine accurately the amount of liability under Chapter 44.

(b) *Notice by district director requiring returns, statements, or the keeping of records.* The district director may require any person, by notice served upon him, to make such returns, render such statements, or keep such specific records as will enable the district director to determine whether or not such person is liable for tax under Chapter 44.

(c) *Retention of records.* The records required by this section shall be kept at all times available for inspection by authorized internal revenue officers or employees, and shall be retained so long as the contents thereof may become material in the administration of any internal revenue law.

§ 55.6011–1 General requirement of return, statement, or list.

Every person liable for tax under Chapter 44 shall file an annual return with respect to the tax on the form prescribed by the Internal Revenue Service for such purpose and shall include therein the information required by the form and the instructions issued with respect thereto. For calendar years beginning after December 31, 1986, the return, which must be made on a calendar year basis, shall be filed by a real estate investment trust on Form 8612 and by a regulated investment company on Form 8613.

[T.D. 8180, 53 FR 6148, Mar. 1, 1988]

§ 55.6060–1 Reporting requirements for tax return preparers.

(a) *In general.* A person that employs one or more tax return preparers to prepare a return or claim for refund under chapter 44 of subtitle D of the Internal Revenue Code, other than for the person, at any time during a return period, shall satisfy the record keeping and inspection requirements in the manner stated in § 1.6060–1 of this chapter.

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

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

§ 55.6061–1 Signing of returns and other documents.

Any return required to be made by a real estate investment trust or a regulated investment company with respect to the tax imposed by Chapter 44 shall be signed by a person authorized by section 6062 of the Code to sign the income tax return of the real estate investment trust or the regulated investment company. Any statement or other document required to be made with respect to the tax imposed by Chapter 44 shall be signed by the person required or duly authorized to sign in accordance with the regulations, forms, or instructions prescribed with respect to such statement or document. An individual's signature on a return, statement, or other document made by or for the real estate investment trust or the regulated investment company shall be prima facie evidence that the individual is authorized to sign the return, statement, or other document.

[T.D. 8180, 53 FR 6148, Mar. 1, 1988]

§ 55.6065–1 Verification of returns.

If a return, statement, or other document made under the provisions of Chapter 44 or Subtitle F or the Code or the regulations thereunder with respect to any tax imposed by Chapter 44 of the Code, or the form and instructions issued with respect to such return, statement, or other document, requires that it shall contain or be verified by a written declaration that it is made under the penalties of perjury, it must be so verified by the person or persons required to sign such return, statement, or other document. In addition, any other statement or document submitted under any provision of Chapter 44 or Subtitle F of the Code or regulations thereunder with respect to any tax imposed by Chapter 44 of the Code may be required to contain or be verified by a written declaration that it is made under the penalties of perjury.

§ 55.6071–1 Time for filing returns.

(a) *Returns for calendar years beginning after December 31, 1986.* A return required by § 55.6011–1 for any calendar year beginning after December 31, 1986, shall be filed on or before March 15 of the following calendar year. See § 55.6081–1 for rules relating to extensions of time for filing a return required by § 55.6011–1.

(b) *Returns for excise tax under section 4981 as in effect before amendment by the Tax Reform Act of 1986.* A return required by § 55.6011–1 for any excise tax under section 4981, as in effect before amendment by the Tax Reform Act of 1986, shall be filed at the time (including any extension of time granted or allowed under section 6081) that the real estate investment trust is required to file its income tax return under section 6012 for the taxable year for which the tax under section 4981, as in effect before amendment by the Tax Reform Act of 1986, is imposed.

[T.D. 8180, 53 FR 6148, Mar. 1, 1988]

§ 55.6081–1 Automatic extension of time for filing a return due under Chapter 44.

(a) *In general.* A Real Estate Investment Trust (REIT) required to file a return on Form 8612, ''Return of Excise Tax on Undistributed Income of Real Estate Investment Trusts,'' or a Regulated Investment Company (RIC) required to file a return on Form 8613, ''Return of Excise Tax on Undistributed Income of Regulated Investment Companies,'' will be allowed an automatic 6-month extension of time to file the return after the date prescribed for filing the return if the REIT or RIC files an application under this section in accordance with paragraph (b) of this section.

(b) *Requirements.* To satisfy this paragraph (b), a REIT or RIC must—

(1) Submit a complete application on Form 7004, ''Application for Automatic Extension of Time to File Certain Business Income Tax, Information, and Other Returns,'' or in any other manner prescribed by the Commissioner;

(2) File the application on or before the date prescribed for filing the return with the Internal Revenue Service office designated in the application's instructions; and

(3) Remit the amount of the properly estimated unpaid tax liability on or before the date prescribed for payment.

(c) *No extension of time for the payment of tax.* An automatic extension of time for filing a return granted under paragraph (a) of this section will not extend the time for payment of any tax due on such return.

(d) *Termination of automatic extension.* The Commissioner may terminate an automatic extension at any time by mailing to the REIT or RIC a notice of termination at least 10 days prior to the termination date designated in such notice. The Commissioner must mail the notice of termination to the address shown on the Form 7004 or to the REIT or RIC's last known address. For further guidance regarding the definition of last known address, see § 301.6212–2 of this chapter.

(e) *Penalties.* See section 6651 for failure to file or failure to pay the amount shown as tax on the return.

(f) *Effective/applicable dates.* This section is applicable for applications for an automatic extension of time to file a return due under chapter 44, filed after July 1, 2008.

[T.D. 9407, 73 FR 37369, July 1, 2008]

§ 55.6091–1 Place for filing Chapter 44 tax returns.

Except as provided in § 55.6091–2 (relating to exceptional cases):

(a) *In general.* Chapter 44 tax returns shall be filed with any person assigned the responsibility to receive returns in the local Internal Revenue Service office serving the principal place of business or principal office or agency of the real estate investment trust or regulated investment company.

(b) *Returns filed with service centers or by hand carrying.* Notwithstanding paragraph (a) of this section, unless a return is filed by hand carrying, whenever instructions applicable to Chapter 44 tax returns provide that the returns be filed with a service center, the returns must be so filed in accordance with the instructions. Returns which are filed by hand carrying shall be filed with any person assigned the responsibility to receive hand-carried returns in the local Internal Revenue Service

office in accordance with paragraph (a) of this section.

[T.D. 7767, 46 FR 11282, Feb. 6, 1981; 46 FR 15263, Mar. 5, 1981. Redesignated and amended by T.D. 8180, 53 FR 6148, Mar. 1, 1988; T.D. 9156, 69 FR 55746, Sept. 16, 2004]

§ 55.6091–2 Exceptional cases.

Notwithstanding the provisions of § 55.6091–1, the Commissioner may permit the filing of any Chapter 44 tax return in any local Internal Revenue Service office.

[T.D. 7767, 46 FR 11282, Feb. 6, 1981; 46 FR 15263, Mar. 5, 1981. Redesignated by T.D. 8180, 53 FR 6148, Mar. 1, 1988, as amended by T.D. 9156, 69 FR 55746, Sept. 16, 2004]

§ 55.6107–1 Tax return preparer must furnish copy of return or claim for refund to taxpayer and must retain a copy or record.

(a) *In general.* A person who is a signing tax return preparer of any return or claim for refund of tax under Chapter 44 of subtitle D of the Internal Revenue Code shall furnish a completed copy of the return or claim for refund to the taxpayer, and retain a completed copy or record in the manner stated in § 1.6107–1 of this chapter.

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

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

§ 55.6109–1 Tax return preparers furnishing identifying numbers for returns or claims for refund.

(a) *In general.* Each tax return or claim for refund of tax under chapter 44 of Subtitle D prepared by one or more signing tax return preparers must include the identifying number of the preparer required by § 1.6695–1(b) of this chapter to sign the return or claim for refund in the manner stated in § 1.6109–2 of this chapter.

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

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

§ 55.6151–1 Time and place for paying of tax shown on returns.

The tax shown on any return which is imposed by Chapter 44 shall, without notice or assessment and demand, be paid to the internal revenue officer with whom the return is filed at the time and place for filing such return (determined without regard to any extension of time for filing the return). For provisions relating to the time and place for filing such return, see §§ 55.6071–1 and 55.6091–1. For provisions relating to the extension of time for paying the tax see § 55.6161–1.

[T.D. 8180, 53 FR 6148, Mar. 1, 1988]

§ 55.6161–1 Extension of time for paying tax or deficiency.

(a) *In general*—(1) *Tax shown or required to be shown on return.* A reasonable extension of the time for payment of the amount of any tax imposed by Chapter 44 and shown or required to be shown on any return, may be granted by the district directors at the request of the taxpayer. The period of such extension shall not be in excess of 6 months from the date fixed for payment of such tax.

(2) *Deficiency.* The time for payment of any amount determined as a deficiency in respect of tax imposed by Chapter 44 may, at the request of the taxpayer, be extended by the internal revenue officer to whom the tax is required to be paid. The extension may be for a period not to exceed 18 months from the date fixed for payment of the deficiency, as shown on the notice and demand. In exceptional cases, a further extension for a period not in excess of 12 months may be granted. No extension of time for payment of a deficiency shall be granted if the deficiency is due to negligence, to intentional disregard of rules and regulations, or to fraud with intent to evade tax.

(3) *Extension of time for filing distinguished.* The granting of an extension of time for filing a return does not operate to extend the time for the payment of the tax or any part thereof unless so specified in the extension.

(b) *Certain rules relating to extension of time for paying income tax to apply.* The provisions of § 1.6161–1 (b), and (c), and

(d) of this chapter (relating to a requirement for undue hardship, the application for extension, and payment pursuant to an extension) shall apply to extensions of time for payment of the tax imposed by Chapter 44.

§ 55.6165–1 Bonds where time to pay tax or deficiency has been extended.

If an extension of time for payment of tax or deficiency is granted under section 6161, the district director or the director of the service center may, if he deems it necessary, require a bond for the payment of the amount in respect of which the extension is granted in accordance with the terms of the extension. However, the bond shall not exceed double the amount with respect to which the extension is granted. For provisions relating to form of bonds, see the regulations under section 7101 contained in part 301 of this chapter (Regulations on Procedure and Administration).

§ 55.6694–1 Section 6694 penalties applicable to tax return preparer.

(a) *In general.* For general definitions regarding section 6694 penalties applicable to preparers of tax returns or claims for refund of tax under chapter 44 of Subtitle D see § 1.6694–1 of this chapter.

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

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

§ 55.6694–2 Penalties for understatement due to an unreasonable position.

(a) *In general.* A person who is a tax return preparer of any return or claim for refund of excise tax under chapter 44 of subtitle D of the Internal Revenue Code (Code) shall be subject to penalties under section 6694(a) of the Code in the manner stated in § 1.6694–2 of this chapter.

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

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

§ 55.6694–3 Penalty for understatement due to willful, reckless, or intentional conduct.

(a) *In general.* A person who is a tax return preparer of any return or claim for refund of tax under chapter 44 of subtitle D of the Internal Revenue Code (Code) shall be subject to penalties under section 6694(b) of the Code in the manner stated in § 1.6694–3 of this chapter.

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

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

§ 55.6694–4 Extension of period of collection when tax return preparer pays 15 percent of a penalty for understatement of taxpayer's liability and certain other procedural matters.

(a) *In general.* For rules relating to the extension of period of collection when a tax return preparer who prepared a return or claim for refund for excise tax under chapter 44 of subtitle D of the Internal Revenue Code pays 15 percent of a penalty for understatement of taxpayer's liability and procedural matters relating to the investigation, assessment and collection of the penalties under section 6694(a) and (b), the rules under § 1.6694–4 of this chapter will apply.

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

[T.D. 9436, 73 FR 78460, Dec. 22, 2008]

§ 55.6695–1 Other assessable penalties with respect to the preparation of tax returns or claims for refund for other persons.

(a) *In general.* A person who is a tax return preparer of any return or claim for refund of tax under chapter 44 of subtitle D of the Internal Revenue Code (Code) shall be subject to penalties for failure to furnish a copy to the taxpayer under section 6695(a) of the Code, failure to sign the return under section 6695(b) of the Code, failure to furnish an identification number under section 6695(c) of the Code, failure to retain a copy or list under section 6695(d) of the Code, failure to file

a correct information return under section 6695(e) of the Code, and negotiation of a check under section 6695(f) of the Code, in the manner stated in § 1.6695–1 of this chapter.

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

[T.D. 9436, 73 FR 78460, Dec. 22, 2008]

§ 55.6696–1 Claims for credit or refund by tax return preparers.

(a) *In general.* For rules for claims for credit or refund by a tax return preparer who prepared a return or claim for refund for tax under chapter 44 of subtitle D of the Internal Revenue Code, the rules under § 1.6696–1 of this chapter will apply.

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

[T.D. 9436, 73 FR 78460, Dec. 22, 2008]

§ 55.7701–1 Tax return preparer.

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

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

[T.D. 9436, 73 FR 78460, Dec. 22, 2008]

PART 56—PUBLIC CHARITY EXCISE TAXES

Sec.

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56.6695–1 Other assessable penalties with respect to the preparation of tax returns or claims for refund for other persons.
56.6696–1 Claims for credit or refund by tax return preparers.
56.7701–1 Tax return preparer.

AUTHORITY: 26 U.S.C. 7805.

Section 56.4911–7 also issued under 26 U.S.C. 4911(f)(3);

Section 56.6060–1 also issued under 26 U.S.C. 6060(a);

Section 56.6109–1 also issued under 26 U.S.C. 6109(a);

Section 56.6109–2 also issued under 26 U.S.C. 6109(a);

Section 56.6695–1 also issued under 26 U.S.C. 6695(b).

SOURCE: T.D. 8308, 55 FR 35598, Aug. 31, 1990, unless otherwise noted.

§ 56.4911–0 Outline of regulations under section 4911.

Immediately following is an outline of the regulations under section 4911 of the Internal Revenue Code relating to an excise tax on electing public charities' excess lobbying expenditures.

§ 56.4911–0 Outline of regulations under section 4911.

§ 56.4911–1 Tax on excess lobbying expenditures.

(a) In general.
(b) Excess lobbying expenditures.
(c) Nontaxable amounts.
(1) Lobbying nontaxable amount.
(2) Grass roots nontaxable amount.

(d) Examples.

§ 56.4911–2 Lobbying expenditures, direct lobbying communications, and grass roots lobbying communications.

(a) Lobbying expenditures.
(1) In general.
(2) Overview of § 56.4911 and the definitions of ''direct lobbying communication'' and ''grass roots lobbying communication''.
(b) Influencing legislation: direct and grass roots lobbying communications defined.
(1) Direct lobbying communication.
(2) Grass roots lobbying communication.
(3) Exceptions to the definition of influencing legislation.
(4) Examples.
(5) Special rule for certain mass media advertisements.
(c) Exceptions to the definitions of direct lobbying communication and grass roots lobbying communication.
(1) Nonpartisan analysis, study, or research exception.
(2) Examinations and discussions of broad social, economic, and similar problems.
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(4) Communications pertaining to ''self-defense'' by the organization.
(d) Definitions.
(1) Legislation.
(2) Action.
(3) Legislative body.
(4) Administrative bodies.

§ 56.4911–3 Expenditures for direct and/or grass roots lobbying communications.

(a) Definition of term ''expenditures for''.
(1) In general.
(2) Allocation of mixed purpose expenditures.
(3) Allocation of mixed lobbying.
(b) Examples.
(c) Certain transfers treated as lobbying expenditures.
(1) Transfer earmarked for grass roots purposes.
(2) Transfer earmarked for direct and grass roots lobbying.
(3) Certain transfers to noncharities that lobby.

§ 56.4911–4 Exempt purpose expenditures.

(a) Application.
(b) Included expenditures.
(c) Excluded expenditures.
(d) Certain transfers treated as exempt purpose expenditures.
(e) Transfers not exempt purpose expenditures.
(f) Definitions.
(g) Example.

§ 56.4911–5 Communications with members.

(a) In general.
(b) Communications (directed only to members) that are not lobbying communications.
(c) Communications (directed only to members) that are direct lobbying communications.
(d) Communications (directed only to members) that are grass roots lobbying communications.
(e) Written communications directed to members and nonmembers.
(1) In general.
(2) Direct lobbying directly encouraged.
(3) Grass roots expenditure if grass roots lobbying directly encouraged.
(4) No direct encouragement of direct lobbying or of grass roots lobbying.
(f) Definitions and special rules.
(1) Member; general rule.
(2) Member; special rule.
(3) Member; affiliated group of organizations.
(4) Member; limited affiliated group of organizations.
(5) Subscriber.
(6) Directly encourages.
(7) Percentages of total distribution.
(8) Reasonable allocation rule.

§ 56.4911–6 Records of lobbying and grass roots expenditures.

(a) Records of lobbying expenditures.
(b) Records of grass roots expenditures.

§ 56.4911–7 Affiliated group of organizations.

(a) Affiliation between two organizations.
(1) In general.
(2) Organizations not described in section 501(c)(3).
(3) Action on legislative issues.
(b) Interlocking governing boards.
(1) In general.
(2) Majority or quorum.
(3) Votes required under governing instrument or local law.
(4) Representatives constituting less than 15% of governing board.
(5) Representatives.
(c) Governing instrument.
(d) Three or more organizations affiliated.
(1) Two controlled organizations affiliated.
(2) Chain rule.
(e) Affiliated group of organizations.
(1) Defined.
(2) Multiple membership.
(3) Taxable year of affiliated group.
(4) Electing member organization.
(5) Election of member's year as group's taxable year.
(f) Examples.

§ 56.4911–8 Excess lobbying expenditures of affiliated group.

(a) Application.
(b) Affiliated group treated as one organization.

(c) Tax imposed on excess lobbying expenditures of affiliated group.
(d) Liability for tax.
(1) Electing organizations.
(2) Tax based on excess lobbying expenditures.
(3) Tax based on excess grass roots expenditures.
(4) Tax based on exempt purpose expenditures.
(5) Taxable year for which liable.
(6) Organization a member of more than one affiliated group.
(e) Former member organizations.

§ 56.4911–9 Application of section 501(h) to affiliated groups of organizations.

(a) Scope.
(b) Determination required.
(c) Member organizations that are not electing organizations.
(d) Filing of information relating to affiliated group of organizations.
(1) Scope.
(2) In general.
(3) Additional information required.
(4) Information required of electing member organization.
(e) Example.
(f) Cross reference.

§ 56.4911–10 Members of a limited affiliated group of organizations.

(a) Scope.
(b) Members of limited affiliated group.
(c) Controlling and controlled organizations.
(d) Expenditures of controlling organization.
(1) Scope.
(2) Expenditures for direct lobbying.
(3) Grass roots expenditures.
(4) Exempt purpose expenditures.
(e) Expenditures of controlled member.
(f) Reports of members of limited affiliated groups.
(1) Controlling member organization's additional information on annual return.
(2) Reports of controlling members to other members.
(3) Reports of controlled member organizations.
(g) National legislative issues.
(h) Examples.

§ 56.6001–1 Notice or regulations requiring records, statements, and special returns.

(a) In general.
(b) Cross references.

§ 56.6011–1 General requirement of return, statement, or list.

§ 56.4911–1 Tax on excess lobbying expenditures.

(a) *In general.* Section 4911(a) imposes an excise tax of 25 percent on the excess lobbying expenditures (as defined in paragraph (b) of this section) for a taxable year of an organization for which the expenditure test election under section 501(h) is in effect (an ''electing public charity''). An electing public charity's annual limit on expenditures for influencing legislation (*i.e.*, the amount of lobbying expenditures on which no tax is due) is the lobbying nontaxable amount or, on expenditures for influencing legislation through grass roots lobbying, the grass roots nontaxable amount (see paragraph (c) of this section). For rules concerning the application of the excise tax imposed by section 4911(a) to the members of an affiliated group of organizations (as defined in § 56.4911–7(e)), see § 56.4911–8.

(b) *Excess lobbying expenditures.* For any taxable year for which the expenditure test election under section 501(h) is in effect, the amount of an electing public charity's excess lobbying expenditures is the greater of—

(1) The amount by which the organization's lobbying expenditures (within the meaning of § 56.4911–2(a)) exceed the organization's lobbying nontaxable amount, or

(2) The amount by which the organization's grass roots expenditures (within the meaning of §§ 56.4911–2(a)) exceed the organization's grass roots nontaxable amount.

(c) *Nontaxable amounts*—(1) *Lobbying nontaxable amount.* Under section 4911(c)(2), the lobbying nontaxable amount for any taxable year for which the expenditure test election is in effect is the lesser of—

(i) $1,000,000, or

(ii) To the extent of the electing public charity's exempt purpose expenditures (within the meaning of § 56.4911–4) for that year, the sum of 20 percent of the first $500,000 of such expenditures, plus 15 percent of the second $500,000 of such expenditures, plus 10 percent of the third $500,000 of such expenditures,

plus 5 percent of the remainder of such expenditures.

(2) *Grass roots nontaxable amount.* Under section 4911(c)(4), an electing public charity's grass roots nontaxable amount for any taxable year is 25 percent of its lobbying nontaxable amount for that year.

(d) *Examples.* The provisions of this section are illustrated by the examples in § 1.501(h)–3.

§ 56.4911–2 Lobbying expenditures, direct lobbying communications, and grass roots lobbying communications.

(a) *Lobbying expenditures*—(1) *In general.* An electing public charity's lobbying expenditures for a year are the sum of its expenditures during that year for direct lobbying communications (''direct lobbying expenditures'') plus its expenditures during that year for grass roots lobbying communications (''grass roots expenditures'').

(2) *Overview of § 56.4911–2 and the definitions of ''direct lobbying communication'' and ''grass roots lobbying communication''.* Paragraph (b)(1) of this section defines the term ''direct lobbying communication.'' Paragraph (b)(2) of this section provides the general definition of the term ''grass roots lobbying communication.'' (But also see paragraph (b)(5) of this section (special rebuttable presumption regarding certain paid mass media communications) and § 56.4911–5 (special, more lenient, definitions for certain communications from an electing public charity to its bona fide members)). Paragraph (b)(3) of this section lists and cross-references various exceptions to the definitions set forth in paragraphs (b) (1) and (2) (the text of the exceptions, along with relevant definitions and examples, is generally set forth in paragraph (c)). Paragraph (b)(4) of this section contains numerous examples illustrating the application of paragraphs (b) (1), (2) and (3). As mentioned above, paragraph (b)(5) of this section sets forth the special rebuttable presumption regarding a limited number of paid mass media communications about highly publicized legislation. Paragraph (d) of this section contains definitions of (and examples illustrating) various terms used in this section.

(b) *Influencing legislation: direct and grass roots lobbying communications defined*—(1) *Direct lobbying communication*—(i) *Definition.* A direct lobbying communication is any attempt to influence any legislation through communication with:

(A) Any member or employee of a legislative body; or

(B) Any government official or employee (other than a member or employee of a legislative body) who may participate in the formulation of the legislation, but only if the principal purpose of the communication is to influence legislation.

(ii) *Required elements.* A communication with a legislator or government official will be treated as a direct lobbying communication under this § 56.4911–2(b)(1) if, but only if, the communication:

(A) Refers to specific legislation (see paragraph (d)(1) of this section for a definition of the term ''specific legislation''); and

(B) Reflects a view on such legislation.

(iii) *Special rule for referenda, ballot initiatives or similar procedures.* Solely for purposes of this section 4911, where a communication refers to and reflects a view on a measure that is the subject of a referendum, ballot initiative or similar procedure, the general public in the State or locality where the vote will take place constitutes the legislative body, and individual members of the general public area, for purposes of this paragraph (b)(1), legislators. Accordingly, if such a communication is made to one or more members of the general public in that state or locality, the communication is a direct lobbying communication (unless it is nonpartisan analysis, study or research (see paragraph (c)(1) of this section).

(2) *Grass roots lobbying communication*—(i) *Definition.* A grass roots lobbying communication is any attempt to influence any legislation through an attempt to affect the opinions of the general public or any segment thereof.

(ii) *Required elements.* A communication will be treated as a grass roots lobbying communication under this

§56.4911–2(b)(2)(ii) if, but only if, the communication:

(A) Refers to specific legislation (see paragraph (d)(1) of this section for a definition of the term ''specific legislation'');

(B) Reflects a view on such legislation; and

(C) Encourages the recipient of the communication to take action with respect to such legislation (see paragraph (b)(2)(iii) of this section for the definition of encouraging the recipient to take action.

For special, more lenient rules regarding an organization's communications directed only or primarily to bona fide members of the organization, see §56.4911–5. For special rules regarding certain paid mass media advertisements about highly publicized legislation, see paragraph (b)(5) of this section. For special rules regarding lobbying on referenda, ballot initiatives and similar procedures, see paragraph (b)(1)(iii) of this section).

(iii) *Definition of encouraging recipient to take action*. For purposes of this section, encouraging a recipient to take action with respect to legislation means that the communication:

(A) States that the recipient should contact a legislator or an employee of a legislative body, or should contact any other government official or employee who may participate in the formulation of legislation (but only if the principal purpose of urging contact with the government official or employee is to influence legislation);

(B) States the address, telephone number, or similar information of a legislator or an employee of a legislative body;

(C) Provides a petition, tear-off postcard or similar material for the recipient to communicate with a legislator or an employee of a legislative body, or with any other government official or employee who may participate in the formulation of legislation (but only if the principal purpose of so facilitating contact with the government official or employee is to influence legislation); or

(D) Specifically identifies one or more legislators who will vote on the legislation as: opposing the communication's view with respect to the legislation; being undecided with respect to the legislation; being the recipient's representative in the legislature; or being a member of the legislative committee or subcommittee that will consider the legislation. Encouraging the recipient to take action under this paragraph (b)(2)(iii)(D) does not include naming the main sponsor(s) of the legislation for purposes of identifying the legislation.

(iv) *Definition of directly encouraging recipient to take action*. Communications described in one or more of paragraphs (b)(2)(iii) (A) through (C) of this section not only ''encourage,'' but also ''directly encourage'' the recipient to take action with respect to legislation. Communications described in paragraph (b)(2)(iii)(D) of this section, however, do not directly encourage the recipient to take action with respect to legislation. Thus, a communication would encourage the recipient to take action with respect to legislation, but not directly encourage such action, if the communication does no more than identify one or more legislators who will vote on the legislation as: opposing the communication's view with respect to the legislation; being undecided with respect to the legislation; being the recipient's representative in the legislature; or being a member of the legislative committee or subcommittee that will consider the legislation. Communications that encourage the recipient to take action with respect to legislation but that do not directly encourage the recipient to take action with respect to legislation may be within the exception for nonpartisan analysis, study or research (se paragraph (c)(1) of this section) and thus not be grass roots lobbying communications.

(v) *Subsequent lobbying use of nonlobbying communications or research materials*—(A) *Limited effect of application*. Even though certain communications or research materials are initially not grass roots lobbying communications under the general definition set forth in paragraph (b)(2)(ii) of this section, subsequent use of the communications or research materials for grass roots lobbying may cause them to be treated as grass roots lobbying communications. This paragraph (b)(2)(v) does not

cause any communications or research materials to be considered direct lobbying communications.

(B) *Limited scope of application*. Under this paragraph (b)(2)(v), only ''advocacy communications or research materials'' are potentially treated as grass roots lobbying communications. Communications or research materials that are not ''advocacy communications or research materials'' are not treated as grass roots lobbying communications under this paragraph (b)(2)(v). ''Advocacy communications or research materials'' are any communications or materials that both refer to and reflect a view on specific legislation but that do not, in their initial format, contain a direct encouragement for recipients to take action with respect to legislation.

(C) *Subsequent use in lobbying*. Where advocacy communications or research materials are subsequently accompanied by a direct encouragement for recipients to take action with respect to legislation, the advocacy communications or research materials themselves are treated as grass roots lobbying communications unless the organization's primary purpose in undertaking or preparing the advocacy communications or research materials was not for use in lobbying. In such a case, all expenses of preparing and distributing the advocacy communications or research materials will be treated as grass roots expenditures.

(D) *Time limit on application of subsequent use rule*. The characterization of expenditures as grass roots lobbying expenditures under paragraph (b)(2)(v)(C) shall apply only to expenditures paid less than six months before the first use of the advocacy communications or research materials with a direct encouragement to action.

(E) *Safe harbor in determining ''primary purpose''*. The primary purpose of the organization in undertaking or preparing advocacy communications or research materials will not be considered to be for use in lobbying if, prior to or contemporaneously with the use of the advocacy communications or research materials with the direct encouragement to action, the organization makes a substantial nonlobbying distribution of the advocacy communications or research materials (without the direct encouragement to action). Whether a distribution is substantial will be determined by reference to all of the facts and circumstances, including the normal distribution pattern of similar nonpartisan analyses, studies or research by that and similar organizations.

(F) *Special rule for partisan analysis, study or research*. In the case of advocacy communications or research materials that are not nonpartisan analysis, study or research, the nonlobbying distribution thereof will not be considered ''substantial'' unless that distribution is at least as extensive as the lobbying distribution thereof.

(G) *Factors considered in determining primary purpose*. Where the nonlobbying distribution of advocacy communications or research materials is not substantial, all of the facts and circumstances must be weighed to determine whether the organization's primary purpose in preparing the advocacy communications or research materials was for use in lobbying. While not the only factor, the extent of the organization's nonlobbying distribution of the advocacy communications or research materials is particularly relevant, especially when compared to the extent of their distribution with the direct encouragement to action. Another particularly relevant factor is whether the lobbying use of the advocacy communications or research materials is by the organization that prepared the document, a related organization, or an unrelated organization. Where the subsequent lobbying distribution is made by an unrelated organization, clear and convincing evidence (which must include evidence demonstrating cooperation or collusion between the two organizations) will be required to establish that the primary purpose for preparing the communication for use in lobbying.

(H) *Examples*. The provisions of this paragraph (b)(2)(v) are illustrated by the following examples:

Example 1. Assume a nonlobbying ''report'' (that is not nonpartisan analysis, study or research) is prepared by an organization, but distributed to only 50 people. The report, in that format, refers to and reflects a view on

specific legislation but does not contain a direct encouragement for the recipients to take action with respect to legislation. Two months later, the organization sends the report to 10,000 people along with a letter urging recipients to write their Senators about the legislation discussed in the report. Because the report's nonlobbying distribution is not as extensive as its lobbying distribution, the report's nonlobbying distribution is not substantial for purposes of this paragraph (b)(2)(v). Accordingly, the organization's primary purpose in preparing the report must be determined by weighing all of the facts and circumstances. In light of the relatively minimal nonlobbying distribution and the fact that the lobbying distribution is by the preparing organization rather than by an unrelated organization, and in the absence of evidence to the contrary, both the report and the letter are grass roots lobbying communications. Assume that all costs of preparing the report were paid within the six months preceding the mailing of the letter. Accordingly, all of the organization's expenditures for preparing and mailing the two documents are grass roots lobbying expenditures.

Example 2. Assume the same facts as in Example (1), except that the costs of the report are paid over the two month period of January and February. Between January 1 and 31, the organization pays $1,000 for the report. In February, the organization pays $500 for the report. Further assume that the report is first used with a direct encouragement to action on August 1. Six months prior to August 1 is February 1. Accordingly, no costs paid for the report before February 1 are treated as grass roots lobbying expenditures under the subsequent use rule. Under these facts, the subsequent use rule treats only the $500 paid for the report in February as grass roots lobbying expenditures.

(3) *Exceptions to the definition of influencing legislation.* In many cases, a communication is not a direct or grass roots lobbying communication under paragraph (b)(1) or (b)(2) of this section if it falls within one of the exceptions listed in paragraph (c) of this section. See paragraph (c)(1), Nonpartisan analysis, study or research; paragraph (c)(2), Examinations and discussions of broad social, economic and similar problems; paragraph (c)(3), Requests for technical advice; and paragraph (c)(4), Communications pertaining to self-defense by the organization. In addition, see § 56.4911–5, which provides special rules regarding the treatment of certain lobbying communications directed in whole or in part to members of an electing public charity.

(4) *Examples.* This paragraph (b)(4) provides examples to illustrate the rules set forth in the section regarding direct and grass roots lobbying. The expenditure test election under section 501(h) is assumed to be in effect for all organizations discussed in the examples in this paragraph (b)(4). In addition, it is assumed that the special rules of § 56.4911–5, regarding certain of a public charity's communications with its members, do not apply to any of the examples in this paragraph (b)(4).

(i) *Direct lobbying.* The provisions of this section regarding direct lobbying communications are illustrated by the following examples:

Example 1. Organization P's employee, X, is assigned to approach members of Congress to gain their support for a pending bill. X drafts and P prints a position letter on the bill. P distributes the letter to members of Congress. Additionally, X personally contacts several members of Congress or their staffs to seek support for P's position on the bill. The letter and the personal contacts are direct lobbying communications.

Example 2. Organization M's president writes a letter to the Congresswoman representing the district in which M is headquartered, requesting that the Congresswoman write an administrative agency regarding proposed regulations recently published by that agency. M's president also requests that the Congresswoman's letter to the agency state the Congresswoman's support of M's application for a particular type of permit granted by the agency. The letter written by M's president is not a direct lobbying communication.

Example 3. Organization Z prepares a paper on a particular state's environmental problems. The paper does not reflect a view on any specific pending legislation or on any specific legislative proposal that Z either supports or opposes. Z's representatives give the paper to a state legislator. Z's paper is not a direct lobbying communication.

Example 4. State X enacts a statute that requires the licensing of all day care providers. Agency B in State X is charged with preparing rules to implement the bill enacted by State X. One week after enactment of the bill, organization C sends a letter to Agency B providing detailed proposed rules that organization C suggests to Agency B as the appropriate standards to follow in implementing the statute on licensing of day care providers. Organization C's letter to Agency B is not a lobbying communication.

Example 5. Organization B researches, prepares and prints a code of standards of minimum safety requirements in an area of common electrical wiring. Organization B sells the code of standards booklet to the public and its is widely used by professional in the installation of electrical wiring. A number of states have codified all, or part, of the code of standards as mandatory safety standards. On occasion, B lobbies state legislators for passage of the code of standards for safety reasons. Because the primary purpose of preparing the code of standards was the promotion of public safety and the standards were specifically used in a profession for that purpose, separate from any legislative requirement, the research, preparation, printing and public distribution of the code of standards is not an expenditure for a direct (or grass roots) lobbying communication. Costs, such as transportation, photocopying, and other similar expenses, incurred in lobbying state legislators for passage of the code of standards into law are expenditures for direct lobbying communications.

Example 6. On the organization's own initiative, representatives of Organization F present written testimony to a Congressional committee. The news media report on the testimony of Organization F, detailing F's opposition to a pending bill. The testimony is a direct lobbying communication but is not a grass roots lobbying communication.

Example 7. Organization R's monthly newsletter contains an editorial column that refers to and reflects a view on specific pending bills. R sends the newsletter to 10,000 nonmember subscribers. Senator Doe is among the subscribers. The editorial column in the newsletter copy sent to Senator Doe is not a direct lobbying communication because the newsletter is sent to Senator Doe in her capacity as a subscriber rather than her capacity as a legislator. (NOTE, though, that the editorial column may be a grass roots lobbying communication if it encourages recipients to take action with respect to the pending bills it refers to and on which it reflects a view).

Example 8. Assume the same facts as in Example (7), except that one of Senator Doe's staff members sees Senator Doe's copy of the editorial and writes to R requesting additional information. R responds with a letter that refers to and reflects a view on specific legislation. R's letter is a direct lobbying communication unless it is within one of the exceptions set forth in paragraph (c) of this section (such as the exception for nonpartisan analysis, study or research). (R's letter is not within the scope of the exception for responses to written requests from a legislative body or committee for technical advice (see paragraph (c)(3) of this section) because the letter is not in response to a written request from a legislative body or committee).

(ii) *Grass roots lobbying.* The provisions of this section regarding grass roots lobbying communications are illustrated in paragraph (b)(4)(ii)(A) of this section by examples of communications that are not grass roots lobbying communications and in paragraph (b)(4)(ii)(B) by examples of communications that are grass roots lobbying communications. The provisions of this section are further illustrated in paragraph (b)(4)(ii)(C), with particular regard to the exception for nonpartisan analysis, study, or research:

(A) *Communications that are not grass roots lobbying communications.*

Example 1. Organization L places in its newsletter an article that asserts that lack of new capital is hurting State W's economy. The article recommends that State W residents either invest more in local businesses or increase their savings so that funds will be available to others interested in making investments. The article is an attempt to influence opinions with respect to a general problem that might receive legislative attention and is distributed in a manner so as to reach and influence many individuals. However, the article does not refer to specific legislation that is pending in a legislative body, nor does the article refer to a specific legislative proposal the organization either supports or opposes. The article is not a grass roots lobbying communication.

Example 2. Assume the same facts as Example (1), except that the article refers to a bill pending in State W's legislature that is intended to provide tax incentives for private savings. The article praises the pending bill and recommends that it be enacted. However, the article does not encourage readers to take action with respect to the legislation. The article is not a grass roots lobbying communication.

Example 3. Organization B sends a letter to all persons on its mailing list. The letter includes an update on numerous environmental issues with a discussion of general concerns regarding pollution, proposed federal regulations affecting the area, and several pending legislative proposals. The letter endorses two pending bills and opposes another pending bill, but does not name any legislator involved (other than the sponsor of one bill, for purposes of identifying the bill), nor does it otherwise encourage the reader to take action with respect to the legislation. The letter is not a grass roots lobbying communication.

Example 4. A pamphlet distributed by organization Z discusses the dangers of drugs and

encourages the public to send their legislators a coupon, printed with the statement ''I support a drug-free America.'' The term ''drug-free America'' is not widely identified with any of the many specific pending legislative proposals regarding drug issues. The pamphlet does not refer to any of the numerous pending legislative proposals, nor does the organization support or oppose a specific legislative proposal. The pamphlet is not a grass roots lobbying communication.

Example 5. A pamphlet distributed by organization B encourages readers to join an organization and ''get involved in the fight against drugs.'' The text states, in the course of a discussion of several current drug issues, that organization B supports a specific bill before Congress that would establish an expanded drug control program. The pamphlet does not encourage readers to communicate with legislators about the bill (such as by including the names of undecided or opposed legislators). The pamphlet is not a grass roots lobbying communication.

Example 6. Organization E, an environmental organization, routinely summarizes in each edition of its newsletter the new environment-related bills that have been introduced in Congress since the last edition of the newsletter. The newsletter identifies each bill by a bill number and the name of the legislation's sponsor. The newsletter also reports on the status of previously introduced environment-related bills. The summaries and status reports do not encourage recipients of the newsletter to take action with respect to legislation, as described in paragraphs (b)(2)(iii) (A) through (D) of this section. Although the summaries and status reports refer to specific legislation and often reflect a view on such legislation, they do not encourage the newsletter recipients to take action with respect to such legislation. The summaries and status reports are not grass roots lobbying communications.

Example 7. Organization B prints in its newsletter a report on pending legislation that B supports, the Family Equity bill. The report refers to and reflects a view on the Family Equity bill, but does not directly encourage recipients to take action. Nor does the report specifically identify any legislator as opposing the communication's view on the legislation, as being undecided, or as being a member of the legislative committee or subcommittee that will consider the legislation. However, the report does state the following:

Rep. Doe (D-Ky.) and Rep. Roe (R-Ma.), both ardent supporters of the Family Equity bill, spoke at B's annual convention last week. Both encouraged B's efforts to get the Family Equity bill enacted and stated that they thought the bill could be enacted even over a presidential veto. B's legislative affairs liaison questioned others, who seemed to agree with that assessment. For example, Sen. Roe (I-Ca.) said that he thinks the bill will pass with such a large majority, ''the President won't even consider vetoing it.''

Assume the newsletter, and thus the report, is sent to individuals throughout the U.S., including some recipients in Kentucky, Massachusetts and California. Because the report is distributed nationally, the mere fact that the report identifies several legislators by party and state as part of its discussion does not mean the report specifically identifies the named legislators as the Kentucky, Massachusetts and California recipients' representatives in the legislature for purposes of paragraph (b)(2)(iii) of this section. The report is not a grass roots lobbying communication.

(B) *Communications that are grass roots lobbying communications.*

Example 1. A pamphlet distributed by organization Y states that the ''President's plan for a drug-free America,'' which will establish a drug control program, should be passed. The pamphlet encourages readers to ''write or call your senators and representatives and tell them to vote for the President's plan.'' No legislative proposal formally bears the name ''President's plan for a drug-free America,'' but that and similar terms have been widely used in connection with specific legislation pending in Congress that was initially proposed by the President. Thus, the pamphlet refers to specific legislation, reflects a view on the legislation, and encourages readers to take action with respect to the legislation. The pamphlet is a grass roots lobbying communication.

Example 2. Assume the same facts as in Example (1), except that the pamphlet does not encourage the public to write or call representatives, but does list the members of the committee that will consider the bill. The pamphlet is a grass roots lobbying communication.

Example 3. Assume the same facts as in Example (1), except that the pamphlet encourages readers to ''write the President to urge him to make the bill a top legislative priority'' rather than encouraging readers to communicate with members of Congress. The pamphlet is a grass roots lobbying communication.

Example 4. Organization B, a nonmembership organization, includes in one of three sections of its newsletter an endorsement of two pending bills and opposition to another pending bill and also identifies several legislators as undecided on the three bills. The section of the newsletter devoted to the three pending bills is a grass roots lobbying communication.

Example 5. Organization D, a nonmembership organization, sends a letter to all persons on its mailing list. The letter includes an extensive discussion concluding that a significant increase in spending for the Air

Force is essential in order to provide an adequate defense of the nation. Prior to a concluding fundraising request, the letter encourages readers to write their Congressional representatives urging increased appropriations to build the B–1 bomber. The letter is a grass roots lobbying communication.

Example 6. The President nominates X for a position in the President's cabinet. Organization Y disagrees with the views of X and does not believe X has the necessary administrative capabilities to effectively run a cabinet-level department. Accordingly, Y sends a general mailing requesting recipients to write to four Senators on the Senate Committee that will consider the nomination. The mailing is a grass roots lobbying communication.

Example 7. Organization F mails letters requesting that each recipient contribute money to or join F. In addition, the letters express F's opposition to a pending bill that is to be voted upon by the U.S. House of Representatives. Although the letters are form letters sent as a mass mailing, each letter is individualized to report to the recipient the name of the recipient's congressional representative. The letters are grass roots lobbying communications.

Example 8. Organization C sends a mailing that opposes a specific legislative proposal and includes a postcard addressed to the President for the recipient to sign stating opposition to the proposal. The letter requests that the recipient send to C a contribution as well as the postcard opposing the proposal. C states in the letter that it will deliver all the postcards to the White House. The letter is a grass roots lobbying communication.

(C) *Additional examples*.

Example 1. The newsletter of an organization concerned with drug issues is circulated primarily to individuals who are not members of the organization. A story in the newsletter reports on the prospects for passage of a specifically identified bill, stating that the organization supports the bill. The newsletter story identifies certain legislators as undecided, but does not state that readers should contact the undecided legislators. The story does not provide a full and fair exposition sufficient to qualify as nonpartisan analysis, study or research. The newsletter story is a grass roots lobbying communication.

Example 2. Assume the same facts as in Example (1), except that the newsletter story provides a full and fair exposition sufficient to qualify as nonpartisan analysis, study or research. The newsletter story is *not* a grass roots lobbying communication because it is within the exception for nonpartisan analysis, study or research (since it does not *directly* encourage recipients to take action).

Example 3. Assume the same facts as in Example (2), except that the newsletter story explicitly asks readers to contact the undecided legislators. Because the newsletter story directly encourages readers to take action with respect to the legislation, the newsletter story is not within the exception for nonpartisan analysis, study or research. Accordingly, the newsletter story is a grass roots lobbying communication.

Example 4. Assume the same facts as in Example (1), except that the story does not identify any undecided legislators. The story is not a grass roots lobbying communication.

Example 5. X organization places an advertisement that specifically identifies and opposes a bill that X asserts would harm the farm economy. The advertisement is not a mass media communication described in paragraph (b)(5)(ii) of this section and does not directly encourage readers to take action with respect to the bill. However, the advertisement does state that Senator Y favors the legislation. Because the advertisement refers to and reflects a view on specific legislation, and also encourages the readers to take action with respect to the legislation by specifically identifying a legislator who opposes X's views on the legislation, the advertisement is a grass roots lobbying communication.

Example 6. Assume the same facts as in Example (5), except that instead of identifying Senator Y as favoring the legislation, the advertisement identifies the ''junior Senator from State Z'' as favoring the legislation. The advertisement is a grass roots lobbying communication.

Example 7. Assume the same facts as in Example (5), except that instead of identifying Senator Y as favoring the legislation, the advertisement states: ''Even though this bill will have a devastating effect upon the farm economy, most of the Senators from the Farm Belt states are inexplicably in favor of the bill.'' The advertisement does not specifically identify one or more legislators as opposing the advertisement's view on the bill in question. Accordingly, the advertisement is not a grass roots lobbying communication because it does not encourage readers to take action with respect to the legislation.

Example 8. Organization V trains volunteers to go door-to-door to seek signatures for petitions to be sent to legislators in favor of a specific bill. The volunteers are wholly unreimbursed for their time and expenses. The volunteers' costs (to the extent any are incurred) are not lobbying or exempt purpose expenditures made by V (but the volunteers may not deduct their out-of-pocket expenditures (see section 170(f)(6)). When V asks the volunteers to contact others and urge them to sign the petitions, V encourages those volunteers to take action in favor of the specific bill. Accordingly, V's costs of soliciting the volunteers' help and its costs of training the

volunteers are grass roots expenditures. In addition, the costs of preparing, copying, distributing, etc. the petitions (and any other materials on the same specific subject used in the door-to-door signature gathering effort), are grass roots expenditures.

(5) *Special rule for certain mass media advertisements*—(i) *In general*. A mass media advertisement that is not a grass roots lobbying communication under the three-part grass roots lobbying definition contained in paragraph (b)(2) of this section may be a grass roots lobbying communication by virtue of paragraph (b)(5)(ii) of this section. The special rule in paragraph (b)(5)(ii) generally applies only to a limited type of paid advertisements that appear in the mass media.

(ii) *Presumption regarding certain paid mass media advertisements about highly publicized legislation*. If within two weeks before a vote by a legislative body, or a committee (but not a subcommittee) thereof, on a highly publicized piece of legislation, an organization's paid advertisement appears in the mass media, the paid advertisement will be presumed to be a grass roots lobbying communication, but only if the paid advertisement both reflects a view on the general subject of such legislation and either: refers to the highly publicized legislation; or encourages the public to communicate with legislators on the general subject of such legislation. An organization can rebut this presumption by demonstrating that the paid advertisement is a type of communication regularly made by the organization in the mass media without regard to the timing of legislation (that is, a customary course of business exception) or that the timing of the paid advertisement was unrelated to the upcoming legislative action. Notwithstanding the fact that an organization successfully rebuts the presumption, a mass media communication described in this paragraph (b)(5)(ii) is a grass roots lobbying communication if the communication would be a grass roots lobbying communication under the rules contained in paragraph (b)(2) of this section.

(iii) *Definitions*—(A) *Mass media*. For purposes of this paragraph (b)(5), the term ''mass media'' means television, radio, billboards and general circulation newspapers and magazines. General circulation newspapers and magazines do not include newspapers or magazines published by an organization for which the expenditure test election under section 501(h) is in effect, except where both: The total circulation of the newspaper or magazine is greater than 100,000; and fewer than one-half of the recipients are members of the organization (as defined in § 56.4911–5(f)).

(B) *Paid advertisement*. For purposes of this paragraph (b)(5), where an electing public charity is itself a mass media publisher or broadcaster, all portions of that organization's mass media publications or broadcasts are treated as paid advertisements in the mass media, except those specific portions that are advertisements paid for by another person. The term ''mass media'' is defined in paragraph (b)(5)(iii)(A).

(C) *Highly publicized*. For purposes of this paragraph (b)(5), ''highly publicized'' means frequent coverage on television and radio, and in general circulation newspapers, during the two weeks preceding the vote by the legislative body or committee. In the case of state or local legislation, ''highly publicized'' means frequent coverage in the mass media that serve the State or local jurisdiction in question. Even where legislation receives frequent coverage, it is ''highly publicized'' only if the pendency of the legislation or the legislation's general terms, purpose, or effect are known to a significant segment of the general public (as opposed to the particular interest groups directly affected) in the area in which the paid mass media advertisement appears.

(iv) *Examples*. The special rule of this paragraph (b)(5) is illustrated by the following examples. The expenditure test election under section 501(h) is assumed to be in effect for all organizations discussed in the examples in this paragraph (b)(5)(iv):

Example 1. Organization X places a television advertisement advocating one of the President's major foreign policy initiatives, as outlined by the President in a series of speeches and as drafted into proposed legislation. The initiative is popularly known as ''the President's World Peace Plan,'' and is voted upon by the Senate four days after X's

advertisement. The advertisement concludes: ''SUPPORT THE PRESIDENT'S WORLD PEACE PLAN!'' The President's plan and position are highly publicized during the two weeks before the Senate vote, as evidenced by: coverage of the plan on several nightly television network news program; more than one article about the plan on the front page of a majority of the country's ten largest daily general circulation newspapers; and an editorial about the plan in four of the country's ten largest daily general circulation newspapers. Although the advertisement does not encourage readers to contact legislators or other government officials, the advertisement does refer to specific legislation and reflect a view on the general subject of the legislation. The communication is presumed to be a grass roots lobbying communication.

Example 2. Assume the same facts as in Example (1), except that the advertisement appears three weeks before the Senate's vote on the plan. Because the advertisement appears more than two weeks before the legislative vote, the advertisement is *not* within the scope of the special rule for mass media communications on highly publicized legislation. Accordingly, the advertisement is a grass roots lobbying communication only if it is described in the general definition contained in paragraph (b)(2) of this section. Because the advertisement does not encourage recipients to take action with respect to the legislation in question, the advertisement is not a grass roots lobbying communication.

Example 3. Organization Y places a newspaper advertisement advocating increased government funding for certain public works projects the President has proposed and that are being considered by a legislative committee. The advertisement explains the President's proposals and concludes: ''SUPPORT FUNDING FOR THESE VITAL PROJECTS!'' The advertisement does not encourage readers to contact legislators or other government officials nor does it name any undecided legislators, but it does name the legislation being considered by the committee. The President's proposed funding of public works, however, is not highly publicized during the two weeks before the vote: there has been little coverage of the issue on nightly television network news programs, only one front-page article on the issue in the country's ten largest daily general circulation newspapers, and only one editorial about the issue in the country's ten largest daily general circulation newspapers. Two days after the advertisement appears, the committee votes to approve funding of the projects. Although the advertisement appears less than two weeks before the legislative vote, the advertisement is *not* within the scope of the special rule for mass media communications on highly publicized legislation because the issue of funding for public works projects is not highly publicized. Thus, the advertisement is a grass roots lobbying communication only if it is described in the general definition contained in paragraph (b)(2) of this section. Because the advertisement does not encourage recipients to take action with respect to the legislation in question, the advertisement is not a grass roots lobbying communication.

Example 4. Organization P places numerous advertisements in the mass media about a bill being considered by the State Assembly. The bill is highly publicized, as evidenced by numerous front-page articles, editorials and letters to the editor published in the state's general circulation daily newspapers, as well as frequent coverage of the bill by the television and radio stations serving the state. The advertisements run over a three week period and, in addition to showing pictures of a family being robbed at gunpoint, say: ''The State Assembly is considering a bill to make gun ownership illegal. This outrageous legislation would violate your constitutional rights and the rights of other law-abiding citizens. If this legislation is passed, you and your family will be criminals if you want to exercise your right to protect yourselves.'' The advertisements refer to and reflect a view on a specific bill but do not encourage recipients to take action. Sixteen days after the last advertisement runs, a State Assembly committee votes to defeat the legislation. None of the advertisements is a grass roots lobbying communication.

Example 5. Assume the same facts as in Example (4), except that it is publicly announced prior to the advertising campaign that the committee vote is scheduled for five days after the last advertisement runs. Because of public pressure resulting from the advertising campaign, the bill is withdrawn and no vote is ever taken. None of the advertisements is a grass roots lobbying communication.

(c) *Exceptions to the definitions of direct lobbying communication and grass roots lobbying communication*—(1) *Nonpartisan analysis, study, or research exception*—(i) *In general.* Engaging in nonpartisan analysis, study, or research and making available to the general public or a segment or members thereof or to governmental bodies, officials, or employees the results of such work constitute neither a direct lobbying communication under § 56.4911–2(b)(1) nor a grass roots lobbying communication under § 56.4911–2(b)(2).

(ii) *Nonpartisan analysis, study, or research.* For purposes of this section,

''nonpartisan analysis, study, or research'' means an independent and objective exposition of a particular subject matter, including any activity that is ''educational'' within the meaning of §1.501(c)(3)–1(d)(3). Thus, ''nonpartisan analysis, study, or research'' may advocate a particular position or viewpoint so long as there is a sufficiently full and fair exposition of the pertinent facts to enable the public or an individual to form an independent opinion or conclusion. The mere presentation of unsupported opinion, however, does not qualify as ''nonpartisan analysis, study, or research''.

(iii) *Presentation as part of a series.* Normally, whether a publication or broadcast qualifies as ''nonpartisan analysis, study, or research'' will be determined on a presentation-by-presentation basis. However, if a publication or broadcast is one of a series prepared or supported by an electing organization and the series as a whole meets the standards of paragraph (c)(1)(ii) of this section, then any individual publication or broadcast within the series is not a direct or grass roots lobbying communication even though such individual broadcast or publication does not, by itself, meet the standards of paragraph (c)(1)(ii) of this section. Whether a broadcast or publication is considered part of a series will ordinarily depend upon all the facts and circumstances of each particular situation. However, with respect to broadcast activities, all broadcasts within any period of six consecutive months will ordinarily be eligible to be considered as part of a series. If an electing organization times or channels a part of a series which is described in this paragraph (c)(1)(iii) in a manner designed to influence the general public or the action of a legislative body with respect to a specific legislative proposal, the expenses of preparing and distributing such part of the analysis, study, or research will be expenditures for a direct or grass roots lobbying communications, as the case may be.

(iv) *Making available results of nonpartisan analysis, study, or research.* An organization may choose any suitable means, including oral or written presentations, to distribute the results of its nonpartisan analysis, study, or research, with or without charge. Such means include distribution of reprints of speeches, articles and reports; presentation of information through conferences, meetings and discussions; and dissemination to the news media, including radio, television and newspapers, and to other public forums. For purposes of this paragraph (c)(1)(iv), such communications may not be limited to, or be directed toward, persons who are interested solely in one side of a particular issue.

(v) *Subsequent lobbying use of certain analysis, study or research.* Even though certain analysis, study or research is initially within the exception for nonpartisan analysis, study or research, subsequent use of that analysis, study or research for grass roots lobbying may cause that analysis, study or research to be treated as a grass roots lobbying communication that is not within the exception for nonpartisan analysis, study or research. This paragraph (c)(1)(v) does not cause any analysis, study or research to be considered a direct lobbying communication. For rules regarding when analysis, study or research is treated as a grass roots lobbying communication that is not within the scope of the exception for nonpartisan analysis, study or research, see paragraph (b)(2)(v) of this section.

(vi) *Directly encouraging action by recipients of a communication.* A communication that reflects a view on specific legislation is not within the nonpartisan analysis, study, or research exception of this paragraph (c)(1) if the communication directly encourages the recipient to take action with respect to such legislation. For purposes of this section, a communication directly encourages the recipient to take action with respect to legislation if the communication is described in one or more of paragraphs (b)(2)(iii) (A) through (C) of this section. As described in paragraph (b)(2)(iv) of this section, a communication would encourage the recipient to take action with respect to legislation, but not directly encourage such action, if the communication does no more than specifically identify one or more legislators who will vote on the legislation as: opposing the communication's view with respect to the legislation; being

undecided with respect to the legislation; being the recipient's representative in the legislature; or being a member of the legislative committee or subcommittee that will consider the legislation.

(vii) *Examples*. The provisions of this paragraph (c)(1) may be illustrated by the following examples:

Example 1. Organization M establishes a research project to collect information for the purpose of showing the dangers of the use of pesticides in raising crops. The information collected includes data with respect to proposed legislation, pending before several State legislatures, which would ban the use of pesticides. The project takes favorable positions on such legislation without producing a sufficiently full and fair exposition of the pertinent facts to enable the public or an individual to form an independent opinion or conclusion on the pros and cons of the use of pesticides. This project is not within the exception for nonpartisan analysis, study, or research because it is designed to present information merely on one side of the legislative controversy.

Example 2. Organization N establishes a research project to collect information concerning the dangers of the use of pesticides in raising crops for the ostensible purpose of examining and reporting information as to the pros and cons of the use of pesticides in raising crops. The information is collected and distributed in the form of a published report which analyzes the effects and costs of the use and nonuse of various pesticides under various conditions on humans, animals and crops. The report also presents the advantages, disadvantages, and economic cost of allowing the continued use of pesticides unabated, of controlling the use of pesticides, and of developing alternatives to pesticides. Even if the report sets forth conclusions that the disadvantages as a result of using pesticides are greater than the advantages of using pesticides and that prompt legislative regulation of the use of pesticides is needed, the project is within the exception for nonpartisan analysis, study, or research since it is designed to present information on both sides of the legislative controversy and presents a sufficiently full and fair exposition of the pertinent facts to enable the public or an individual to form an independent opinion or conclusion.

Example 3. Organization O establishes a research project to collect information on the presence or absence of disease in humans from eating food grown with pesticides and the presence or absence of disease in humans from eating food not grown with pesticides. As part of the research project, O hires a consultant who prepares a ''fact sheet'' which calls for the curtailment of the use of pesticides and which addresses itself to the merits of several specific legislative proposals to curtail the use of pesticides in raising crops which are currently pending before State Legislatures. The ''fact sheet'' presents reports of experimental evidence tending to support its conclusions but omits any reference to reports of experimental evidence tending to dispute its conclusions. O distributes ten thousand copies to citizens' groups. Expenditures by O in connection with this work of the consultant are not within the exception for nonpartisan analysis, study, or research.

Example 4. P publishes a bi-monthly newsletter to collect and report all published materials, ongoing research, and new developments with regard to the use of pesticides in raising crops. The newsletter also includes notices of proposed pesticide legislation with impartial summaries of the provisions and debates on such legislation. The newsletter does not encourage recipients to take action with respect to such legislation, but is designed to present information on both sides of the legislative controversy and does present such information fully and fairly. It is within the exception for nonpartisan analysis, study, or research.

Example 5. X is satisfied that A, a member of the faculty of Y University, is exceptionally well qualified to undertake a project involving a comprehensive study of the effects of pesticides on crop yields. Consequently, X makes a grant to A to underwrite the cost of the study and of the preparation of a book on the effect of pesticides on crop yields. X does not take any position on the issues or control the content of A's output. A produces a book which concludes that the use of pesticides often has a favorable effect on crop yields, and on that basis argues against pending bills which would ban the use of pesticides. A's book contains a sufficiently full and fair exposition of the pertinent facts, including known or potential disadvantages of the use of pesticides, to enable the public or an individual to form an independent opinion or conclusion as to whether pesticides should be banned as provided in the pending bills. The book does not directly encourage readers to take action with respect to the pending bills. Consequently, the book is within the exception for nonpartisan analysis, study, or research.

Example 6. Assume the same facts as Example (2), except that, instead of issuing a report, X presents within a period of 6 consecutive months a two-program television series relating to the pesticide issue. The first program contains information, arguments, and conclusions favoring legislation to restrict the use of pesticides. The second program contains information, arguments, and conclusions opposing legislation to restrict the use of pesticides. The programs are broadcast within 6 months of each other during

commensurate periods of prime time. X's programs are within the exception for nonpartisan analysis, study, or research. Although neither program individually could be regarded as nonpartisan, the series of two programs constitutes a balanced presentation.

Example 7. Assume the same facts as in Example (6), except that X arranged for televising the program favoring legislation to restrict the use of pesticides at 8:00 on a Thursday evening and for televising the program opposing such legislation at 7:00 on a Sunday morning. X's presentation is not within the exception for nonpartisan analysis, study, or research, since X disseminated its information in a manner prejudicial to one side of the legislative controversy.

Example 8. Organization Z researches, writes, prints and distributes a study on the use and effects of pesticide X. A bill is pending in the U.S. Senate to ban the use of pesticide X. Z's study leads to the conclusion that pesticide X is extremely harmful and that the bill pending in the U.S. Senate is an appropriate and much needed remedy to solve the problems caused by pesticide X. The study contains a sufficiently full and fair exposition of the pertinent facts, including known or potential advantages of the use of pesticide X, to enable the public or an individual to form an independent opinion or conclusion as to whether pesticides should be banned as provided in the pending bills. In its analysis of the pending bill, the study names certain undecided Senators on the Senate committee considering the bill. Although the study meets the three part test for determining whether a communication is a grass roots lobbying communication, the study is within the exception for nonpartisan analysis, study or research, because it does not directly encourage recipients of the communication to urge a legislator to oppose the bill.

Example 9. Assume the same facts as in Example (8), except that, after stating support for the pending bill, the study concludes: ''You should write to the undecided committee members to support this crucial bill.'' The study is not within the exception for nonpartisan analysis, study or research because it directly encourages the recipients to urge a legislator to support a specific piece of legislation.

Example 10. Organization X plans to conduct a lobbying campaign with respect to illegal drug use in the United States. It incurs $5,000 in expenses to conduct research and prepare an extensive report primarily for use in the lobbying campaign. Although the detailed report discusses specific pending legislation and reaches the conclusion that the legislation would reduce illegal drug use, the report contains a sufficiently full and fair exposition of the pertinent facts to enable the public or an individual to form an independent conclusion regarding the effect of the legislation. The report does not encourage readers to contact legislators regarding the legislation. Accordingly, the report does not, in and of itself, constitute a lobbying communication.

Copies of the report are available to the public at X's office, but X does not actively distribute the report or otherwise seek to make the contents of the report available to the general public. Whether or not X's distribution is sufficient to meet the requirement in §56.4911–2(c)(1)(iv) that a nonpartisan communication be made available, X's distribution is not substantial (for purposes of §56.4911–2(b)(2)(v)(E)) in light of all of the facts and circumstances, including the normal distribution pattern of similar nonpartisan reports. X then mails copies of the report, along with a letter, to 10,000 individuals on X's mailing list. In the letter, X requests that individuals contact legislators urging passage of the legislation discussed in the report. Because X's research and report were primarily undertaken by X for lobbying purposes and X did not make a substantial distribution of the report (without an accompanying lobbying message) prior to or contemporaneously with the use of the report in lobbying, the report is a grass roots lobbying communication that is not within the exception for nonpartisan analysis, study or research.

Example 11. Assume the same facts as in Example (10), except that before using the report in the lobbying campaign, X sends the research and report (without an accompanying lobbying message) to universities and newspapers. At the same time, X also advertises the availability of the report in its newsletter. This distribution is similar in scope to the normal distribution pattern of similar nonpartisan reports. In light of all of the facts and circumstances, X's distribution of the report is substantial. Because of X's substantial distribution of the report, X's primary purpose will be considered to be other than for use in lobbying and the report will not be considered a grass roots lobbying communication. Accordingly, only the expenditures for copying and mailing the report to the 10,000 individuals on X's mailing list, as well as for preparing and mailing the letter, are expenditures for grass roots lobbying communications.

Example 12. Organization M pays for a bumper sticker that reads: ''STOP ABORTION: Vote NO on Prop. X!'' M also pays for a 30-second television advertisement and a billboard that similarly advocate opposition to Prop. X. In light of the limited scope of the communications, none of the communications is within the exception for nonpartisan analysis, study or research. First, none of the communications rises to the level of analysis, study or research. Second,

none of the communications is nonpartisan because none contains a sufficiently full and fair exposition of the pertinent facts to enable the public or an individual to form an independent opinion or conclusion. Thus, each communication is a direct lobbying communication.

(2) *Examinations and discussions of broad social, economic, and similar problems.* Examinations and discussions of broad social, economic, and similar problems are neither direct lobbying communications under § 56.4911–2(b)(1) nor grass roots lobbying communications under § 56.4911–2(b)(2) even if the problems are of the type with which government would be expected to deal ultimately. Thus, under §§ 56.4911–2(b)(1) and (2), lobbying communications do not include public discussion, or communications with members of legislative bodies or governmental employees, the general subject of which is also the subject of legislation before a legislative body, so long as such discussion does not address itself to the merits of a specific legislative proposal and so long as such discussion does not directly encourage recipients to take action with respect to legislation. For example, this paragraph (c)(2) excludes from grass roots lobbying under § 56.4911–2(b)(2) an organization's discussions of problems such as environmental pollution or population growth that are being considered by Congress and various State legislatures, but only where the discussions are not directly addressed to specific legislation being considered, and only where the discussions do not directly encourage recipients of the communication to contact a legislator, an employee of a legislative body, or a government official or employee who may participate in the formulation of legislation.

(3) *Requests for technical advice.* A communication is not a direct lobbying communication under § 56.4911–2(b)(1) if the communication is the providing of technical advice or assistance to a governmental body, a governmental committee, or a subdivision of either in response to a written request by the body, committee, or subdivision, as set forth in § 53.4945–2(d)(2).

(4) *Communications pertaining to ''self-defense'' by the organization.* A communication is not a direct lobbying communication under § 56.4911–2(b)(1) if either:

(i) The communication is an appearance before, or communication with, any legislative body with respect to a possible action by the body that might affect the existence of the electing public charity, its powers and duties, its tax-exempt status, or the deductibility of contributions to the organization, as set forth in § 53.4945–2(d)(3);

(ii) The communication is by a member of an affiliated group of organizations (within the meaning of § 56.4911–7(e)), and is an appearance before, or communication with, a legislative body with respect to a possible action by the body that might affect the existence of any other member of the group, its powers and duties, its tax-exempt status, or the deductibility of contributions to it;

(iii) The communication is by an electing public charity more than 75 percent of the members of which are other organizations that are described in section 501(c)(3), and is an appearance before, or communication with, any legislative body with respect to a possible action by the body which might affect the existence of one or more of the section 501(c)(3) member organizations, their powers, duties, or tax-exempt status, or the deductibility (under section 170) of contributions to one or more of the section 501(c)(3) member organizations, but only if the principal purpose of the appearance or communication is to defend the section 501(c)(3) member organizations (rather than the non-section 501(c)(3) member organizations); or

(iv) The communication is by an electing public charity that is a member of a limited affiliated group or organizations under § 56.4911–10, and is an appearance before, or communication with, the Congress of the United States with respect to a possible action by the Congress that might affect the existence of any member of the limited affiliated group, its powers and duties, tax-exempt status, or the deductibility of contributions to it.

(v) Under the self-defense exception of paragraphs (c)(4) (i) through (iv) of this section, a charity may communicate with an entire legislative body, with committees or subcommittees of

a legislative body, with individual legislators, with legislative staff members, or with representatives of the executive branch who are involved with the legislative process, so long as such communication is limited to the prescribed subjects. Similarly, under the self-defense exception, a charity may make expenditures in order to initiate legislation if such legislation concerns only matters which might affect the existence of the charity, its powers and duties, its tax-exempt status, or the deductibility of contributions to such charity. For examples illustrating the application and scope of the self-defense exception of this paragraph (c)(4), see § 53.4945–2(d)(3)(ii).

(d) *Definitions*. For purposes of section 4911 and the regulations thereunder—

(1) *Legislation*—(i) *In general*. ''Legislation'' includes action by the Congress, any state legislature, any local council, or similar legislative body, or by the public in a referendum, ballot initiative, constitutional amendment, or similar procedure. ''Legislation'' includes a proposed treaty required to be submitted by the President to the Senate for its advice and consent from the time the President's representative begins to negotiate its position with the prospective parties to the proposed treaty.

(ii) *Definition of specific legislation*. For purposes of paragraphs (b)(1) and (b)(2) of this section, ''specific legislation'' includes both legislation that has already been introduced in a legislative body and a specific legislative proposal that the organization either supports or opposes. In the case of a referendum, ballot initiative, constitutional amendment, or other measure that is placed on the ballot by petitions signed by a required number or percentage of voters, an item becomes ''specific legislation'' when the petition is first circulated among voters for signature.

(iii) *Examples*. The terms ''legislation'' and ''specific legislation'' are illustrated using the following examples:

Example 1. A nonmembership organization includes in its newsletter an article about problems with the use of pesticide X that states in part: ''Legislation that is pending in Congress would prohibit the use of this very dangerous pesticide. Fortunately, the legislation will probably be passed. Write your congressional representatives about this important issue.'' This is a grass roots lobbying communication that refers to and reflects a view on specific legislation and that encourages recipients to take action with respect to that legislation.

Example 2. An organization based in State A notes in its newsletter that State Z has passed a bill to accomplish a stated purpose and then says that State A should pass such a bill. The organization urges readers to write their legislators in favor of such a bill. No such bill has been introduced into the State A legislature. The organization has referred to and reflected a view on a specific legislative proposal and has also encouraged readers to take action thereon.

(2) *Action*. The term ''action'' in paragraph (d)(1)(i) of this section is limited to the introduction, amendment, enactment, defeat or repeal of Acts, bills, resolutions, or similar items.

(3) *Legislative body*. ''Legislative body'' does not include executive, judicial, or administrative bodies.

(4) *Administrative bodies*. ''Administrative bodies'' includes school boards, housing authorities, sewer and water districts, zoning boards, and other similar Federal, State, or local special purpose bodies, whether elective or appointive. Thus, for example, for purposes of section 4911, the term ''any attempt to influence any legislation'' does not include attempts to persuade an executive body or department to form, support the formation of, or to acquire property to be used for the formation or expansion of, a public park or equivalent preserves (such as public recreation areas, game, or forest preserves, and soil demonstration areas) established or to be established by act of Congress, by executive action in accordance with an act of Congress, or by a State, municipality or other governmental unit described in section 170(c)(1), as compared with attempts to persuade a legislative body, a member thereof, or other governmental official or employee, to promote the appropriation of funds for such an acquisition or other legislative authorization of such an acquisition. Therefore, for example, an organization would not be influencing legislation for purposes of section 4911, if it proposed to a Park Authority that it purchase a particular tract of land for a new park, even

though such an attempt would necessarily require the Park Authority eventually to seek appropriations to support a new park. However, in such a case, the organization would be influencing legislation, for purposes of section 4911, if it provided the Park Authority with a proposed budget to be submitted to a legislative body, unless such submission is described by one of the exceptions set forth in paragraph (c) of this section.

§ 56.4911–3 Expenditures for direct and/or grass roots lobbying communications.

(a) *Definition of term ''expenditures for''*—(1) *In general.* This § 56.4911–3 contains allocation rules regarding what portion of a lobbying communication's costs is a direct lobbying expenditure, what portion is a grass roots expenditure and what portion is, in certain cases, a nonlobbying expenditure. Except as otherwise indicated in this paragraph (a), all costs of preparing a direct or grass roots lobbying communication are included as expenditures for direct or grass roots lobbying. Expenditures for a direct or grass roots lobbying communication (''lobbying expenditures'') include amounts paid or incurred as current or deferred compensation for an employee's services attributable to the direct or grass roots lobbying communication, and the allocable portion of administrative, overhead, and other general expenditures attributable to the direct or grass roots lobbying communication. For example, except as otherwise provided in this paragraph (a), all expenditures for researching, drafting, reviewing, copying, publishing and mailing a direct or grass roots lobbying communication, as well as an allocable share of overhead expenses, are included as expenditures for direct or grass roots lobbying.

(2) *Allocation of mixed purpose expenditures*—(i) *Nonmembership communications.* Except as provided in paragraph (a)(2)(ii) of this section, lobbying expenditures for a communication that also has a bona fide nonlobbying purpose must include all costs attributable to those parts of the communication that are on the same specific subject as the lobbying message. All costs attributable to those parts of the communication that are not on the same specific subject as the lobbying message are not included as lobbying expenditures for allocation purposes. Whether or not a portion of a communication is on the same specific subject as the lobbying message will depend on the surrounding facts and circumstances. In general, a portion of a communication will be on the same specific subject as the lobbying message if that portion discusses an activity or specific issue that would be directly affected by the specific legislation that is the subject of the lobbying message. Moreover, discussion of the background or consequences of the specific legislation, or discussion of the background or consequences of an activity or specific issue affected by the specific legislation, is also considered to be on the same specific subject as the lobbying communication.

(ii) *Membership communications.* In the case of lobbying expenditures for a communication that also has a bona fide nonlobbying purpose and that is sent only or primarily to members, an electing public charity must make a reasonable allocation between the amount expended for the lobbying purpose and the amount expended for the nonlobbying purpose. An electing public charity that includes as a lobbying expenditure only the amount expended for the specific sentence or sentences that encourage the recipient to take action with respect to legislation has not made a reasonable allocation. For purposes of this paragraph, a communication is sent only or primarily to members if more than half of the recipients of the communication are members of the electing public charity making the communication within the meaning of § 56.4911–5. See § 56.4911–5 for separate rules on communications sent only or primarily to members. Nothing in this paragraph (a) shall change any allocation required by § 56.4911–5.

(3) *Allocation of mixed lobbying.* If a communication (to which § 56.4911–5 does not apply) is both a direct lobbying communication and a grass roots lobbying communication, the communication will be treated as a grass roots lobbying communication except to the extent that the electing public charity

demonstrates that the communication was made primarily for direct lobbying purposes, in which case a reasonable allocation shall be made between the direct and the grass roots lobbying purposes served by the communication.

(b) *Examples.* The provisions of paragraph (a) of this section are illustrated by the following examples. Except where otherwise explicitly stated, the expenditure test election under section 501(h) is assumed to be in effect for all organizations discussed in the examples in this paragraph (b). See § 56.4911–5 for special rules applying to the member communications described in some of the following examples.

Example 1. Organization R makes the services of E, one of its paid executives, available to S, an organization described in section 501(c)(4) of the Code. E works for several weeks to assist S in developing materials that urge voters to contact their congressional representatives to indicate their support for specific legislation. In performing this work, E uses office space and clerical assistance provided by R. R pays full salary and benefits to E during this period and receives no reimbursement from S for these payments or for the other facilities and assistance provided. All expenditures of R, including allocable office and overhead expenses, that are attributable to this assignment are grass roots expenditures because E was engaged in an attempt to influence legislation.

Example 2. An organization distributes primarily to nonmembers a pamphlet with two articles on unrelated subjects. The total cost of preparing, printing and mailing the pamphlet is $11,000, $1,000 for preparation and $10,000 for printing and mailing. The cost of preparing one article, a nonlobbying communication, is $600. The article is printed on three of the four pages in the pamphlet. The cost of preparing the second article, a grass-roots lobbying communication that addresses only one specific subject, is $400. This article is printed on one page of the four page pamphlet. In this situation, $400 of preparation costs and $2,500 (25% of $10,000) of printing and mailing costs are expenditures for a grass roots lobbying communication.

Example 3. Assume the same facts as in Example (2), except that the pamphlet is distributed only to members. In addition, assume the second article states that the recipient members should contact their congressional representatives. The organization allocates $400 of preparation costs and $2,500 of printing and mailing costs as expenditures for direct lobbying (see § 56.4911–5(c)). The allocation is reasonable for purposes of § 56.4911–3(a)(2)(ii).

Example 4. Organization J places a full-page advertisement in a newspaper. The advertisement urges passage of pending legislation to build three additional nuclear powered submarines, and states that readers should write their Congressional representatives in favor of the legislation. The advertisement also provides a general description of J's purposes and activities, invites readers to become members of J and asks readers to contribute money to J. Except for the cost of the portion of the advertisement describing J's purposes and activities and the portion specifically seeking members and contributions, the entire cost of the advertisement is an expenditure for a grass roots lobbying communication, because the entire advertisement, except for the lines specifically describing J and specifically seeking members and contributions, is on the same specific subject as the grass roots lobbying message.

Example 5. Assume the same facts as in Example (4), except that J places in the newspaper two separate half-page advertisements instead of one full-page advertisement. One of the two advertisements discusses the need for three additional nuclear powered submarines and urges readers to write their Congressional representatives in favor of the pending legislation to build the three submarines. The other advertisement contains only the membership and fundraising appeals, along with a general description of J's purposes and activities. The half-page advertisement urging readers to write to Congress is a grass roots lobbying communication and all of J's expenditures for producing and placing that advertisement are expenditures for a grass roots lobbying communication. J's expenditures for the other half-page advertisement are not expenditures for a grass roots or direct lobbying communication.

Example 6. Assume the same facts as in Example (4), except that the communication by J is in a letter mailed only to members of J, rather than in newspaper advertisement, and the invitation to become a member of J is an invitation to join a new membership category. In addition, assume that the communication states that the member recipients should ask nonmembers to write their Congressional representatives. J allocates one-half of the cost of the mailing as an expenditure for a grass roots lobbying communication (see § 56.4911–5(d)). Because the communication had both bona fide nonlobbying (e.g., membership solicitation and fundraising) purposes as well as lobbying purposes, J's allocation of one-half of the cost of the communication to grass roots lobbying and one-half to nonlobbying is reasonable for purposes of § 56.4911–3(a)(2)(ii).

Example 7. A particular monthly issue of organization X's newsletter, which is distributed mainly to nonmembers of X, has three articles of equal length. The first article is a grass roots lobbying communication, the

sole specific subject of which is pending legislation to help protect seals from being slaughtered in certain foreign countries. The second article discusses the rapid decline in the world's whale population, particularly because of the illegal hunting of whales by foreign countries. The third article deals with air pollution and the acid rain problem in North America. Because the first article is a grass roots lobbying communication, all of the costs allocable to that article (e.g., one-third of the newsletter's printing and mailing costs) are lobbying expenditures. The second article is not a lobbying communication and the pending legislation relating to seals addressed in the first article does not affect the illegal whale hunting activities. Because the second and third articles are not lobbying communications and are also not on the same specific subject as the first article, no portion of the costs attributable to those articles is a grass roots lobbying expenditure.

Example 8. Organization T, a nonmembership organization, prepares a three page document that is mailed to 3,000 persons on T's mailing list. The first two pages of the three page document, titled ''The Need for Child Care,'' support the need for additional child care programs, and include statistics on the number of children living in homes where both parents work or in homes with a single parent. The two pages also make note of the inadequacy of the number of day care providers to meet the needs of these parents. The third page of the document, titled ''H.R. 1,'' indicates T's support of H.R. 1, a bill pending in the U.S. House of Representatives. The document states that H.R. 1 will provide for $10,000,000 in additional subsidies to child care providers, primarily for those providers caring for lower income children. The third page of the document also notes that H.R. 1 includes new federal standards regulating the quality of child care providers. The document ends with T's request that recipients contact their congressional representative in support of H.R. 1. The entire three page document is on the same specific subject, and, therefore, all expenditures of preparing and distributing the three page document are grass roots lobbying expenditures.

Example 9. Assume the same facts as in Example (8), except that the document has a fourth page. The fourth page does not refer to the general need for child care or the specific need for additional child care providers. Instead, the fourth page advocates that a particular federal agency commence, under its existing statutory authority, licensing of day care providers in order to promote safe and effective child care. The cost of the fourth page is not a lobbying expenditure.

Example 10. Assume the same facts as in Example (8), except that T is a membership organization, 75 percent of the recipients of the three page document are members of T, and 25 percent of the recipients are nonmembers and are not subscribers within the meaning of § 56.4911–5(f)(5). Assume also that the document states that readers should write to Congress, but does not state that the readers should urge nonmembers to write to Congress. T treats the document as having a bona fide nonlobbying purpose, the purpose of educating its members about the need for child care. Accordingly, T allocates one-half of the cost of preparing and distributing the document as a lobbying expenditure (see § 56.4911–5(e)(2)(i)), of which 75 percent is a direct lobbying expenditure (see § 56.4911–5(e)(2)(iii)) and 25 percent is a grass roots lobbying expenditure (see § 56.4911–5(e)(2)(ii)). The remaining one-half is allocated as a nonlobbying expenditure. T's allocation is reasonable for purposes of § 56.4911–3(a)(2)(ii) and is correct for purposes of § 56.4911–5(e).

Example 11. Assume the same facts as in Example (10), except that T allocates one percent of the cost of preparing and distributing the document as a lobbying expenditure (for purposes of § 56.4911–5(e)(2)) and 99 percent as a nonlobbying expenditure. T's allocation is based upon the fact that out of 200 lines in the document, only two lines state that the recipient should contact legislators about the pending legislation. T's allocation is unreasonable for purposes of § 56.4911–3(a)(2)(ii).

Example 12. Organization F, a nonmembership organization, sends a one page letter to all persons on its mailing list. The only subject of the letter is the organization's opposition to a pending bill allowing private uses of certain national parks. The letter requests recipients to send letters opposing the bill to their congressional representatives. A second one page letter is sent in the same envelope. The second letter discusses the broad educational activities and publications of the organization in all areas of environmental protection and ends by requesting the recipient to make a financial contribution to organization F. Since the separate second letter is on a different subject from the lobbying letter, and the letters are of equal length, 50 percent of the mailing costs must be allocated as an expenditure for a grass roots lobbying communication.

Example 13. Assume the same facts as in Example (12), except that F is a membership organization and the letters in question are sent primarily (90 percent) to members. The other 10 percent of the recipients are nonmembers and are not subscribers within the meaning of § 56.4911–5(f)(5). Assume also that the first letter does not state that readers should urge nonmembers to write to legislators. F allocates one-half of the mailing costs as a lobbying expenditure, of which 90 percent is a direct lobbying expenditure and

10 percent is a grass roots lobbying expenditure (see § 56.4911–5(e)(2)). F's allocation is reasonable for purposes of § 56.4911–3(a)(2)(ii) and is correct for purposes of § 56.4911–5.

(c) *Certain transfers treated as lobbying expenditures*—(1) *Transfer earmarked for grass roots purposes*. A transfer is a grass roots expenditure to the extent that it is earmarked (as defined in § 56.4911–4(f)(4)) for grass roots lobbying purposes and is not described in § 56.4911–4(e).

(2) *Transfer earmarked for direct and grass roots lobbying*. A transfer that is earmarked for direct lobbying purposes or for direct lobbying and grass roots lobbying purposes is treated as a grass roots expenditure in full except to the extent the transferor demonstrates that all or part of the amounts transferred were expended for direct lobbying purposes, in which case that part of the amounts transferred is a direct lobbying expenditure by the transferor. This paragraph (c)(2) shall not apply to any expenditure described in § 56.4911–4(e).

(3) *Certain transfers to noncharities that lobby*—(i) *Limited application of paragraph (c)(3)*—(A) *In general*. This paragraph (c)(3) applies only to transfers for less than fair market value from an electing public charity to any noncharity that makes lobbying expenditures. A noncharity is any entity that is not described in section 501(c)(3). In order for this paragraph to apply, the electing public charity must transfer to a noncharity more in value than it receives in return. For example, this paragraph does not apply to an electing public charity's fair market value payment of rent to a landlord. However, this paragraph does apply where an electing public charity and a noncharity share office space and the electing public charity pays more than fair market value rent to the noncharity. Similarly, this paragraph applies where an electing public charity sells goods or services to a noncharity for less than fair market value. See paragraphs (c)(3)(i) (B), (C) and (D) of this section for exceptions where nonfair market value transfers are not covered by this paragraph (c)(3). See paragraph (c)(3)(i)(E) of this section to determine the amount of any non-fair market value transfer covered by this paragraph (c)(3). See paragraph (c)(3)(ii) of this section for the rules that apply to transfers governed by this paragraph (c)(3).

(B) *Exception for controlled grants*. Notwithstanding paragraph (c)(3)(i)(A) of this section, this paragraph (c)(3) does not apply where an electing public charity makes a grant to a noncharity that is a controlled grant (as defined in § 56.4911–4(f)(3)).

(C) *Exception for transfers that artificially inflate exempt purpose expenditures*. Notwithstanding paragraph (c)(3)(i)(A) of this section, this paragraph (c)(3) does not apply where an electing public charity makes a grant to a noncharity that is an expenditure described in § 56.4911–4(e) (relating to grants that artificially inflate exempt purpose expenditures).

(D) *Exception for substantially related activity*. Notwithstanding paragraph (c)(3)(i)(A) of this section, this paragraph (c)(3) does not apply where an electing public charity, in the course of an activity that is substantially related to the accomplishment of the electing public charity's exempt purposes, makes goods or services widely available for less than fair market value to individual members of the general public and those goods or services are actually purchased (or consumed for no charge) by a substantial number of wholly unrelated individual members of the general public for less than fair market value. For purposes of the preceding sentence, the term ''individual member of the general public'' does not include any person or entity directly or indirectly affiliated with the electing public charity in question. The following example illustrates this paragraph (c)(3)(i)(D):

Example. Organization P is an educational organization dedicated to preserving the environment. One of P's activities is educating the public about the benefits of installing cost-effective passive solar energy systems, thereby helping to preserve the environment. P charges for its extensive literature and advice, but the charges are less than the fair market value of the literature and advice. P makes its literature and advice widely available to individual members of the general public by advertising in various media and by pamphlets distributed in various areas. P annually provides its literature and advice for less than fair market value to 500 wholly

unrelated families, businesses, and tax-exempt organizations. Several of the businesses and tax-exempt organizations make lobbying expenditures within the meaning of section 4911. P's provision of its goods and services to these entities is not covered by this paragraph (c)(3) (and thus does not give rise to a lobbying expenditure by P under paragraph (c)(3)(ii)).

(E) *Determination of amount of transfer governed by paragraph (c)(3).* Where an electing public charity receives nothing of value in return for its transfer, the amount of the transfer governed by this paragraph (c)(3) is the greater of the fair market value or the cost of the goods or services transferred to the noncharity. Where the noncharity transfers something of value to the electing public charity in return for the charity's transfer, but that payment is less than the fair market value of the charity's transfer to the noncharity, the amount of the transfer governed by this paragraph (c)(3) is the excess of: first, the greater of the fair market value or cost of the goods or services transferred to the noncharity over, second, the value of the amount transferred to the charity. For example, if an electing public charity transfers $10,000 of goods and services to a noncharity that makes lobbying expenditures in return for payment by the noncharity of $2,000, the amount of the transfer governed by this paragraph (c)(3) is $8,000.

(ii) *Rules governing transfers to which paragraph (c)(3) applies.* A transfer to which this paragraph (c)(3) applies is treated in whole or in part as a grass roots and/or direct lobbying expenditure by the transferor in accordance with paragraphs (c)(3)(ii) (A), (B) and (C) of this section. In applying those paragraphs, the expenditures of the transferee will be determined as if the regulations under section 4911 applied to the transferee. This paragraph (c)(3) discusses only when certain transfers are lobbying expenditures by the transferor. This paragraph does not address other issues that may arise when an electing public charity makes a noncontrolled grant to a noncharity. Nothing in this paragraph (c)(3) shall be used to interpret issues relating to noncontrolled grants by charities to noncharities, such as whether the noncontrolled grant is consistent with the continued tax-exempt status of the electing public charity.

(A) *Transfers treated as grass roots expenditures.* The transfer is treated as a grass roots expenditure to the extent of the lesser of two amounts: The amount of the transfer and the amount of the transferee's grass roots expenditures.

(B) *Transfers treated as direct lobbying expenditures.* If the transfer is greater than the transferee's grass roots expenditures, the excess is treated as a direct lobbying expenditure, but only to the extent of the transferee's direct lobbying expenditures. (If, however, the transfer is less than the transferee's grass roots expenditures, none of the transfer is a direct lobbying expenditure.)

(C) *Transfers treated as nonlobbying.* If the transfer is greater than the sum of the transferee's grass roots and direct lobbying expenditures, the excess of the transfer over those lobbying expenses is not a lobbying expenditure.

(iii) *Example.* The following example illustrates the application of this paragraph (c)(3):

Example. Organization C, an electing public charity, shares employee E with N, a noncharity that makes lobbying expenditures. N's grass roots expenditures are $5,000 and its direct lobbying expenditures are $25,000. Each organization pays one-half of the $100,000 in direct and overhead costs associated with E. E devotes one-quarter of his time to C and three-quarters of his time to N. In substance, this arrangement is a transfer (for less than fair market value) from C to N in the amount of $25,000 (one-quarter of the $100,000 of direct and overhead costs associated with E's work). Accordingly, C is treated as having made a $5,000 grass roots expenditure (the lesser of N's grass roots expenditures ($5,000) or the amount of the transfer ($25,000)). C is also treated as having made a $20,000 direct lobbying expenditure (the lesser of N's direct lobbying expenditures ($25,000) or the remaining amount of the transfer ($20,000)).

§ 56.4911–4 Exempt purpose expenditures.

(a) *Application.* This section provides rules under section 4911(e) for determining an electing public charity's ''exempt purpose expenditures'' for a taxable year for purposes of section 4911(c)(2) and § 56.4911–1(c)(2). Those two sections generally define an electing

public charity's lobbying limit (lobbying nontaxable amount) as a sliding scale percentage of the organization's exempt purpose expenditures. In determining an electing public charity's exempt purpose expenditures, no expenditure shall be counted twice by an organization.

(b) *Included expenditures.* Amounts paid or incurred by an organization that are exempt purpose expenditures include—

(1) Amounts paid or incurred to accomplish a purpose enumerated in section 170(c)(2)(B), including (but not limited to) the amount of any transfer made by the organization (other than a transfer described in paragraph (e) of this section) to another organization to accomplish the transferor's exempt purposes, and including amounts expended by an organization out of transfers (other than a transfer described in paragraph (e) of this section) for which the organization is the transferee,

(2) Amounts paid or incurred as current or deferred compensation for an employee's services for a purpose enumerated in section 170(c)(2)(B),

(3) The allocable portion of administrative overhead, and other general expenditures attributable to the accomplishment of a purpose enumerated in section 170(c)(2)(B),

(4) Lobbying expenditures (as defined in §56.4911–2(a)) whether or not for a purpose enumerated in section 170(c)(2)(B),

(5) Amounts paid or incurred for activities described in §56.4911–2(c),

(6) Amounts paid or incurred for activities described in §56.4811–5 that are not lobbying expenditures,

(7) A reasonable allowance for exhaustion, wear and tear, obsolescence or amortization, of assets to the extent used for one or more of the purposes described in paragraphs (b)(1) through (6) of this section, computed on a straight-line basis (for this purpose, an allowance for depreciation will be treated as reasonable if based on a useful life that would satisfy section 321(k)(3)(A) as in effect on January 1, 1985), and

(8) Fundraising expenditures (but see section 4911(e)(1)(C) and paragraphs (c)(3) and (4) of this section.)

(c) *Excluded expenditures.* Notwithstanding paragraph (b) of this section, exempt purpose expenditures do not include—

(1) Amounts paid or incurred that are neither expenditures to accomplish a purpose enumerated in section 170(c)(2)(B), lobbying expenditures (as defined in §56.4911–2(a)), nor expenditures described in paragraph (b)(5), (6) or (8) of this section,

(2) The amounts of any transfer described in paragraph (e) of this section,

(3) Amounts paid to or incurred for a separate fundraising unit (as defined in paragraph (f)(2) of this section) of an organization or of an affiliated organization (see §56.4911–7(a)),

(4) Amounts paid to or incurred for any person not an employee, or any organization not an affiliated organization, if paid or incurred primarily for fundraising, but only if such person or organization engages in fundraising, fundraising counselling or the provision of similar advice or services,

(5) Amounts paid or incurred that are properly chargeable to a capital account, determined in accordance with the principles that apply under section 263 or, as applicable, section 263A, with respect to an unrelated trade or business,

(6) Amounts paid or incurred for a tax that is not imposed in connection with the organization's efforts to accomplish a purpose described in section 170(c)(2)(B), such as taxes imposed under sections 511(a)(1) and 4911(a), and

(7) Amounts paid or incurred for the production of income. For purposes of this section, amounts are paid or incurred for the production of income if they are paid or incurred for a purpose or activity that is not substantially related (aside from the need of the organization for income or funds or the use it makes of the profits derived) to the exercise or performance by the organization of its charitable, educational or other purpose or function constituting the basis for its exemption under section 501. For example, the costs of managing an endowment are amounts that are paid or incurred for the production of income and are thus not exempt purpose expenditures. Fundraising expenditures are not, for purposes of this section, amounts that are

paid or incurred for the production of income. Instead, the determination of whether fundraising costs are exempt purpose expenditures must be made with reference to section 4911(e)(1)(C) and paragraphs (b)(8), (c)(3) and (c)(4) of this section.

(d) *Certain transfers treated as exempt purpose expenditures*—(1) An organization's transfer will be treated as an exempt purpose expenditure under paragraph (b)(1) of this section if it is—

(i) Described in either paragraph (d)(2) or (d)(3) of this section, and

(ii) Not described in paragraph (e) of this section.

(2) A transfer is described in this paragraph (d)(2) if it is made to an organization described in section 501(c)(3) in furtherance of the transferor's exempt purposes and is not earmarked for any purpose other than a purpose described in section 170(c)(2)(B). Thus, a payment of dues by a local or state organization to, respectively, a state or national organization that is described in section 501(c)(3) is considered an exempt purpose expenditure of the transferor to the extent it is not otherwise earmarked.

(3) A transfer is described in this paragraph (d)(3) if it is a controlled grant (as defined in paragraph (f)(3) of this section), but only to the extent of the amounts that are paid or incurred by the transferee that would be exempt purpose expenditures if paid or incurred by the transferor.

(e) *Transfers not exempt purpose expenditures*—(1) An organization's transfer is described in this paragraph (e) if it is described in one of paragraphs (e)(2) through (e)(4).

(2) A transfer is described in this paragraph (e)(2) if it is made to a member of any affiliated group (as defined in § 56.4911–7(e)) of which the transferor is a member.

(3) A transfer is described in this paragraph (e)(3) if the Commissioner determines that the transfer artificially inflates the amount of the transferor's or transferee's exempt purpose expenditures. In general, the Commissioner will make that determination if a substantial purpose of a transfer is to inflate those exempt purpose expenditures. A transfer described in this paragraph will not be considered an exempt purpose expenditure of the transferor, but will be an exempt purpose expenditure of the transferee to the extent that the transferee expends the transfer in the active conduct of its charitable activities or attempts to influence legislation. Standards similar to those found in § 53.4942(b)–1(b) may be applied in determining whether the transferee has expended amounts in the ''active conduct'' of its charitable activities or attempts to influence legislation.

(4) A transfer is described in this paragraph (e)(4) if it is not a controlled grant and is made to an organization not described in section 501(c)(3) that does not attempt to influence legislation.

(f) *Definitions*—(1) For purposes of paragraph (c) of this section, ''fundraising'' includes—

(i) Soliciting dues or contributions from members of the organization, from persons whose dues are in arrears, or from the general public,

(ii) Soliciting grants from businesses or other organizations, including organizations described in section 501(c)(3), or

(iii) Soliciting grants from a governmental unit referred to in section 170(c)(1), or any agency or instrumentality thereof.

(2) For purposes of paragraph (c) of this section, a separate fundraising unit of any organization must consist of either two or more individuals a majority of whose time is spent on fundraising for the organization, or any separate accounting unit of the organization that is devoted to fundraising. For purposes of paragraph (c) of this section, amounts paid to or incurred for a separate fundraising unit include all amounts incurred for the creation, production, copying, and distribution of the fundraising portion of a separate fundraising unit's communication. (For example, an electing public charity that has a separate fundraising unit may not count the cost of postage for a separate fundraising unit's communication as an exempt purpose expenditure even though, under the electing public charity's accounting system, that cost is attributable to the mailroom rather than to the separate fundraising unit.)

(3) For purposes of this section, a ''controlled grant'' is a grant made by an eligible organization described in § 1.501(h)–2(b) to an organization not described in section 501(c)(3) that meets the following requirements:

(i) The donor limits the grant to a specific project of the recipient that is in furtherance of the donor's (nonlobbying) exempt purposes; and

(ii) The donor maintains records to establish that the grant is used in furtherance of the donor's (nonlobbying) exempt purposes.

(4) A transfer, including a grant or payment of dues, is ''earmarked'' for a specific purpose—

(i) To the extent that the transferor directs the transferee to add the amount transferred to a fund established to accomplish the purpose, or

(ii) To the extent of the amount transferred or, if less, the amount agreed upon to the expended to accomplish the purpose, if there exists an agreement, oral or written, whereby the transferor may cause the transferee to expend amounts to accomplish the purpose or whereby the transferee agrees to expend an amount to accomplish the purpose.

(g) *Example*. The provisions of this section are illustrated by the following example:

Example. Organization X is an exempt organization described in section 501(c)(3) that is organized for the purpose of rehabilitating alcoholics. X elected to be subject to the provisions of section 501(h) in 1981. For 1981, X had the following expenditures that are included in its exempt purpose expenditures to the extent indicated.

Description	Total (dollars)	Includible (dollars)
Cost of real estate purchased for use as half-way house for alcoholics, attributable to the following:		
Land	30,000	.....
Building	200,000	.....
Depreciation 40-year useful life	.....	5,000
Expenses of operating its half-way house	170,000	170,000
Administrative expenses of the organization allocated to the operation of its half-way house	95,000	95,000
Depreciation and allowances for equipment	10,000	10,000
Expenses related to attempts to influence legislation (lobbying expenditures)	40,000	40,000
Amounts paid to Z by the Organization for fundraising	35,000	.....
Total	580,000	320,000

NOTE: For 1981, X's exempt purpose expenditures total $320,000. The $35,000 paid by X to Z for fundraising is not included in the exempt purpose expenditures total. All lobbying expenses are included in full. Only depreciation computed on a straight-line basis is included in exempt purpose expenditures.

§ 56.4911–5 Communications with members.

(a) *In general*. For purposes of section 4911, expenditures for certain communications between an organization and its members (''membership communications'') are treated more leniently than are communications to nonmembers. This § 56.4911–5 contains rules about the more lenient treatment. In certain cases, this section provides that expenditures for a membership communication are not lobbying expenditures even though those expenditures would be lobbying expenditures if the communication were to nonmembers. In other cases, this section provides that expenditures for a membership communication are direct lobbying expenditures even though those expenditures would be grass roots expenditures if the communication were to nonmembers. Paragraphs (b), (c) and (d) of this section set forth the more lenient rules that apply for communications that are directed only to members. Paragraph (e) of this section sets forth the more lenient rules that apply for communications that are directed primarily, but not solely, to members. Paragraph (f) of this section sets forth certain definitions and special rules.

(b) *Communications (directed only to members) that are not lobbying communications*. Expenditures for a communication that refers to, and reflects a view on, specific legislation are not

lobbying expenditures if the communication satisfies the following requirements:

(1) The communication is directed only to members of the organization;

(2) The specific legislation the communication refers to, and reflects a view on, is of direct interest to the organization and its members;

(3) The communication does not directly encourage the member to engage in direct lobbying (whether individually or through the organization); and

(4) The communication does not directly encourage the member to engage in grass roots lobbying (whether individually or through the organization).

(c) *Communications (directed only to members) that are direct lobbying communications.* Expenditures for a communication that refers to, and reflects a view on, specific legislation and that satisfies the requirements of paragraphs (b)(1), (b)(2), and (b)(4) of this section, but does not satisfy the requirements of paragraph (b)(3) of this section, are treated as expenditures for direct lobbying.

(d) *Communications (directed only to members) that are grass roots lobbying communications.* Expenditures for a communication that refers to, and reflects a view on, specific legislation and that satisfies the requirements of paragraphs (b)(1) and (b)(2) of this section, but does not satisfy the requirements of paragraph (b)(4) of this section, are treated as grass roots expenditures (whether or not the communication satisfies the requirements of paragraph (b)(3) of this section).

(e) *Written communications directed to members and nonmembers*—(1) *In general.* Expenditures for any written communication that is designed primarily for members of an organization (but not directed only to members) and that refers to, and reflects a view on, specific legislation of direct interest to the organization and its members, are treated as expenditures for direct or grass roots lobbying in accordance with paragraph (e)(2), (e)(3) or (e)(4) of this section. For purposes of this section, a communication is designed primarily for members of an organization if more than half of the recipients of the communication are members of the organization.

(2) *Direct lobbying directly encouraged*—(i) *Lobbying expenditure amount.* If a written communication described in paragraph (e)(1) of this section directly encourages readers to engage individually or through the organization in direct lobbying but does not directly encourage them to engage in grass roots lobbying, the cost of the communication is allocated between expenditures for direct lobbying and grass roots expenditures in accordance with paragraphs (e)(2) (ii) and (iii) of this section. The portion of the cost to be allocated includes all costs of preparing all the material with respect to which readers are urged to engage in direct lobbying plus the mechanical and distribution costs attributable to the lineage devoted to this material (see § 1.512(a)–1(f)(6)).

(ii) *Grass roots amount.* The amount allocable as a grass roots expenditure for a communication described in paragraph (e)(1) of this section is the amount calculated in paragraph (e)(2)(i) of this section multiplied by the sum of the nonmember subscribers percentage and all the other distribution percentage, both as defined in paragraph (f)(7) of this section. Solely for purposes of the allocation described in this paragraph (e)(2)(ii), the nonmember subscribers percentage is treated as zero unless it is greater than 15% of total distribution.

(iii) *Direct lobbying amount.* The amount allocable as an expenditure for direct lobbying for a communication described in paragraph (e)(1) of this section is the excess of the amount described in paragraph (e)(2)(i) of this section over the amount described in paragraph (e)(2)(ii) of this section.

(3) *Grass roots expenditure if grass roots lobbying directly encouraged.* If a written communication described in paragraph (e)(1) of this section directly encourages readers to engage individually or collectively (whether through the organization or otherwise) in grass roots lobbying (whether or not it also encourages readers to engage in direct lobbying), the grass roots expenditure includes all the costs of preparing all the material with respect to which readers are urged to engage in grass roots lobbying plus the mechanical and distribution costs attributable to the

lineage devoted to this material (see §1.512(a)–1(f)(6)).

(4) *No direct encouragement of direct lobbying or of grass roots lobbying.* If a written communication described in paragraph (e)(1) of this section does not directly encourage readers to engage in either direct lobbying or grass roots lobbying, expenditures for the communication are not lobbying expenditures.

(f) *Definitions and special rules.* For purposes of the regulations under section 4911—

(1) *Member; general rule.* A person is a member of an electing public charity if the person—

(i) Pays dues or makes a contribution of more than a nominal amount,

(ii) Makes a contribution of more than a nominal amount of time, or

(iii) Is one of a limited number of ''honorary'' or ''life'' members who have more than a nominal connection with the electing public charity and who have been chosen for a valid reason (such as length of service to the organization or involvement in activities forming the basis of the electing public charity's exemption) unrelated to the electing public charity's dissemination of information to its members.

(2) *Member; special rule.* A person not a member of an electing public charity within the meaning of paragraph (f)(1) of this section may be treated as a member if the electing public charity demonstrates to the satisfaction of the Internal Revenue Service that there is a good reason for its membership requirements not meeting the requirements of such paragraph (f)(1), and that its membership requirements do not operate to permit an abuse of the rules described in this section.

(3) *Member; affiliated group of organizations.* For purposes of this section, a person who is a member of an organization that is a member of an affiliated group of organizations (within the meaning of §56.4911–7(e)) is treated as a member of each organization in the affiliated group.

(4) *Member; limited affiliated group of organizations.* For purposes of this section, a person who is a member of an organization that is a member of a limited affiliated group of organizations (within the meaning of §56.4911–10(b)) is treated as a member of each organization in the limited affiliated group, but only to the extent that the communication relates to a national legislative issue (within the meaning of §56.4911–10(g)).

(5) *Subscriber.* A person is a subscriber to a written communication if—

(i) The person is a member of the publishing organization and the membership dues expressly include the right to receive the written communication, or

(ii) The person has affirmatively expressed a desire to receive the written communication and has paid more than a nominal amount of the communication.

(6) Directly encourages—(i) *Direct lobbying*—(A) *In general.* For purposes of this section, a communication directly encourages a recipient to engage in direct lobbying, whether individually or through the organization, if the communication:

(*1*) States that the recipient should contact a legislator or an employee of a legislative body, or should contact any other government official or employee who may participate in the formulation of legislation (but only if the principal purpose of urging contact with the government official or employee is to influence legislation);

(*2*) States the address, telephone number, or similar information of a legislator or an employee of a legislative body; or

(*3*) Provides a petition, tear-off postcard or similar material for the recipient to communicate his or her views to a legislator or an employee of a legislative body, or to any other government official or employee who may participate in the formulation of legislation (but only if the principal purpose of so facilitating contact with the government official or employee is to influence legislation).

(B) *''Self-defense'' exception for communications with members.* Notwithstanding the provisions of paragraph (f)(6)(i)(A) of this section, for purposes of paragraphs (b)(3), (e)(2)(i), (e)(3) and (e)(4) of this section, a communication that directly encourages a member to engage in direct lobbying activities that are described in section

4911(d)(2)(C) and that would not be attempts to influence legislation if engaged in directly by the organization is treated as a communication that does not directly encourage a member to engage in direct lobbying.

(ii) *Grass roots lobbying*. For purposes of paragraphs (b)(4), (e)(3) and (e)(4) of this section, a communication directly encourages recipients to engage individually or collectively (whether through the organization or otherwise) in grass roots lobbying if the communication:

(A) States that the recipient should encourage any nonmember to contact a legislator or an employee of a legislative body, or to contact any other government official or employee who may participate in the formulation of legislation (but only if the principal purpose of urging contact with the government official or employee is to influence legislation);

(B) States that the recipient should provide to any nonmember the address, telephone number, or similar information of a legislator or an employee of a legislative body; or

(C) Provides (or requests that the recipient provide to nonmembers) a petition, tear-off postcard or similar material for the recipient (or nonmember) to use to ask any nonmember to communicate views to a legislator or an employee of a legislative body, or to any other government official or employee who may participate in the formulation of legislation, but only if the principal purpose of so facilitating contact with the government official or employee is to influence legislation. For purposes of this paragraph (f)(6)(ii)(C), a petition is provided for the recipient to use to ask any nonmember to communicate views if, for example, the petition has an entire page of preprinted signature blocks. Similarly, for purposes of this paragraph (f)(6)(ii)(C), where a communication is distributed to a single member and provides several tear-off postcards addressed to a legislator, the postcards are presumed to be provided for the member to use to ask a nonmember to communicate with the legislator.

(7) *Percentages of total distribution*. With respect to a communication described in paragraph (e)(1) of this section—

(i) ''*Member percentage*'' means the percentage of total distribution that represents distribution of a single copy to any member;

(ii) ''*Nonmember subscribers percentage*'' means the percentage of total distribution that represents distribution to nonmember subscribers (including libraries); and

(iii) ''*All other distribution percentage*'' means 100% reduced by the sum of the member percentage and the nonmember subscribers percentage.

(8) *Reasonable allocation rule*. In the case of lobbying expenditures for a communication that also has a bona fide nonlobbying purpose and that is sent only or primarily to members, an electing public charity must make a reasonable allocation between the amount expended for the lobbying purpose and the amount expended for the nonlobbying purpose. See § 56.4911–3(a)(2)(ii).

§ 56.4911–6 Records of lobbying and grass roots expenditures.

(a) *Records of lobbying expenditures*. An electing public charity must keep a record of its lobbying expenditures for the taxable year. Lobbying expenditures of which an organization must keep a record include the following:

(1) Expenditures for grass roots lobbying, as described in paragraph (b) of this section;

(2) Amounts directly paid or incurred for direct lobbying, including payments to another organization earmarked for direct lobbying, fees and expenses paid to individuals or organizations for direct lobbying, and printing, mailing, and other direct costs of reproducing and distributing materials used in direct lobbying;

(3) The portion of amounts paid or incurred as current or deferred compensation for an employee's services for direct lobbying;

(4) Amounts paid for out-of-pocket expenditures incurred on behalf of the organization and for direct lobbying, whether or not incurred by an employee;

(5) The allocable portion of administrative, overhead, and other general expenditures attributable to direct lobbying;

(6) Expenditures for publications or for communications with members to the extent the expenditures are treated as expenditures for direct lobbying under § 56.4911–5; and

(7) Expenditures for direct lobbying of a controlled organization (within the meaning of § 56.4911–10(c)) to the extent included by a controlling organization (within the meaning of § 56.4911–10(c)) in its lobbying expenditures.

(b) *Records of grass roots expenditures.* An electing public charity must keep a record of its grass roots expenditures for the taxable year. Grass roots expenditures of which an organization must keep a record include the following:

(1) Amounts directly paid or incurred for grass roots lobbying, including payments to other organizations earmarked for grass roots lobbying, fees and expenses paid to individuals or organizations for grass roots lobbying, and the printing, mailing, and other direct costs of reproducing and distributing materials used in grass roots lobbying;

(2) The portion of amounts paid or incurred as current or deferred compensation for an employee's services for grass roots lobbying;

(3) Amounts paid for out-of-pocket expenditures incurred on behalf of the organization and for grass roots lobbying, whether or not incurred by an employee;

(4) The allocable portion of administrative, overhead and other general expenditures attributable to grass roots lobbying;

(5) Expenditures for publication or communications that are treated as expenditures for grass roots lobbying under § 56.4911–5; and

(6) Expenditures for grass roots lobbying of a controlled organization (within the meaning of § 56.4911–10(c)) to the extent included by a controlling organization (within the meaning of § 56.4911–10(c)) in its grass roots expenditures.

§ 56.4911–7 Affiliated group of organizations.

(a) *Affiliation between two organizations.* Sections 4911(f) (1) through (3) contain a limited anti-abuse rule for groups of affiliated organizations. In general, the rule operates to prevent numerous organizations from being created for the purpose of avoiding the sliding-scale percentage limitation on an electing public charity's lobbying expenditures (as well as avoiding the $1,000,000 cap on a single electing public charity's lobbying expenditures). This is generally accomplished by treating the members of an affiliated group as a single organization for purposes of measuring both lobbying expenditures and permitted lobbying expenditures. The anti-abuse rule is implemented by this § 56.4911–7 and §§ 56.4911–8 and 56.4911–9. This § 56.4911–7 defines the term ''affiliated group of organizations'' and defines the taxable year of an affiliated group of organizations. Section 56.4911–8 provides rules concerning the exempt purpose expenditures, lobbying expenditures and grass roots expenditures of an affiliated group of organizations, as well as rules concerning the application of the excise tax imposed by section 4911(a) on excess lobbying expenditures by the group. Section 56.4911–9 provides rules concerning the application of the section 501(h) lobbying expenditure limits to members of an affiliated group of organizations. (For additional rules for members of a limited affiliated group of organizations (generally, organizations that are affiliated solely by reason of governing instrument provisions that extend control solely with respect to national legislation), see section 4911(f)(4) and § 56.4911–10).

(1) *In general.* For purposes of the regulations under section 4911, two organizations are affiliated, subject to the limitation described in paragraph (a)(2) of this section, if one organization is able to control action on legislative issues by the other by reason of interlocking governing boards (see paragraph (b) of this section) or by reason of provisions of the governing instruments of the controlled organization (see paragraph (c) of this section). The ability of the controlling organization to control action on legislative issues

by the controlled organization is sufficient to establish that the organizations are affiliated; it is not necessary that the control be exercised.

(2) *Organizations not described in section 501(c)(3).* Two organizations, neither of which is described in section 501(c)(3), are affiliated only if there exists at least one organization described in section 501(c)(3) that is affiliated with both organizations.

(3) *Action on legislative issues.* For purposes of this section, the term ''action on legislative issues'' includes taking a position in the organization's name on legislation, authorizing any person to take a position in the organization's name on legislation, or authorizing any lobbying expenditures. The phrase does not include actions taken merely to correct unauthorized actions taken in the organization's name.

(b) *Interlocking governing boards*—(1) *In general.* Two organizations have interlocking governing boards if one organization (the controlling organization) has a sufficient number of representatives (within the meaning of paragraph (b)(5) of this section) on the governing board of the second organization (the controlled organization) so that by aggregating their votes, the representatives of the controlling organization can cause or prevent action on legislative issues by the controlled organization. If two organizations have interlocking governing boards, the organizations are affiliated without regard to how or whether the representatives of the controlling organization vote on any particular matter.

(2) *Majority or quorum.* Except as provided in paragraph (b) (3) or (4) of this section, the number of representatives of an organization (the controlling organization) who are members of the governing board of a second organization (the controlled organization) will be presumed sufficient to cause or prevent action on legislative issues by the controlled organization if that number either—

(i) Constitutes a majority of incumbents on the governing board, or

(ii) Constitutes a quorum, or is sufficient to prevent a quorum, for acting on legislative issues.

(3) *Votes required under governing instrument or local law.* Except as provided in paragraph (b)(4) of this section, if under the governing documents of an organization (the controlled organization), it can be determined that a lesser number of votes than the number described in paragraph (b)(2) of this section is necessary or sufficient to cause or to prevent action on legislative issues, the number of representatives of the controlling organization who are members of the governing board of the controlled organization will be considered sufficient to cause or prevent action on legislative issues if it equals or exceeds that number.

(4) *Representatives constituting less than 15% of governing board.* Notwithstanding paragraph (b) (2) or (3) of this section, if the number of representatives of one organization is less than 15 percent of the incumbents on the governing board of a second organization, the two organizations are not affiliated by reason of interlocking governing boards.

(5) *Representatives.* (i) This paragraph (b)(5) describes members of the governing board of one organization (the controlled organization) who are considered representatives of a second organization (the controlling organization). Under this paragraph (b)(5), a member of the governing board of a controlled organization may be a representative of more than one controlling organization. A person with no authority to vote on any issue being considered by the governing board is not a representative of any organization.

(ii) A board member of one organization (the controlled organization) is a representative of a second organization (the controlling organization) if the controlling organization has specifically designated that person to be a board member of the controlled organization. For purposes of this paragraph (b)(5)(ii) and paragraph (b)(5)(iii) of this section, a board member of the controlled organization is specifically designated by the controlling organization if the board member is selected by virtue of the right of the controlling organization, under the governing instruments of the controlled organization, either to designate a person to be a member of the controlled organization's governing board, or to select a person for a position that entitles the

holder of that position to be a member of the controlled organization's governing board.

(iii) A board member of one organization who is specifically designated by a second organization, a majority of the governing board of which is made up of representatives of a third organization, is a representative of the third organization as well as being a representative of the second organization pursuant to paragraph (b)(5)(ii) of this section.

(iv) A board member of one organization who is also a member of the governing board of a second organization is a representative of the second organization.

(v) A board member of one organization who is an officer or paid executive staff member of a second organization is a representative of the second organization. Although titles are significant in determining whether a person is a member of the executive staff of an organization, any employee of an organization who possesses authority commonly exercised by an executive is considered an executive staff member for purposes of this paragraph (b)(5)(v).

(c) *Governing instrument*. One organization (the ''controlling'' organization) is affiliated with a second organization (the ''controlled'' organization) by reason of the governing instruments of the controlled organization if the governing instruments of the controlled organization limit the independent action of the controlled organization on legislative issues by requiring it to be bound by decisions of the other organization on legislative issues.

(d) *Three or more organizations affiliated*—(1) *Two controlled organizations affiliated*. If a controlling organization described in this section is affiliated with each of two or more controlled organizations described in this section, then the controlled organizations are affiliated with each other.

(2) *Chain rule*. If one organization is a controlling organization described in this section with respect to a second organization and that second organization is a controlling organization with respect to a third organization, then the first organization is affiliated with the third.

(e) *Affiliated group of organizations*—(1) *Defined*. For purposes of the regulations under section 4911, an affiliated group of organizations is a group of organizations—

(i) Each of which is affiliated with every other member for at least thirty days of the taxable year of the affiliated group (determined without regard to the election provided for in paragraph (e)(5) of this section),

(ii) Each of which is an eligible organization (within the meaning of §1.501(h)–2(b)(1)), and

(iii) At least one of which is an electing member organization (within the meaning of paragraph (e)(4) of this section).

Each organization in a group of organizations that satisfies the requirements of the preceding sentence is a member of the affiliated group of organizations for the taxable year of the affiliated group.

(2) *Multiple membership*. For any taxable year of an organization, it may be a member of two or more affiliated groups of organizations.

(3) *Taxable year of affiliated group*. If all members of an affiliated group have the same taxable year, that taxable year is the taxable year of the affiliated group. If the members of an affiliated group do not all have the same taxable year, the taxable year of the affiliated group is the calendar year, unless the election under paragraph (e)(5) of this section is made.

(4) *Electing member organization*. For purposes of the regulations under section 4911, an ''electing member organization'' is an organization to which the expenditure test election under section 501(h) applies on at least one day of the taxable year of the affiliated group of which it is a member. For purposes of the preceding sentence (and notwithstanding §1.501(h)–2(a)), the expenditure test is not considered to apply to the organization on any day before the date on which it files the Form 5768 making the expenditure test election.

(5) *Election of member's year as group's taxable year*. The taxable year of an affiliated group may be determined according to the provisions of this paragraph (e)(5) if all of the members of the affiliated group so elect. Under this paragraph (e)(5), each member organization shall apply the provisions of section 501(h) and 4911, and the regulations

thereunder (unless the regulations provide otherwise), by treating its own taxable year as the taxable year of the affiliated group. The election may be made by an electing member organization by attaching to its annual return a statement from itself and every other member of the affiliated group that contains: the organization's name, address, and employer identification number; and its signed consent to the election provided for in this paragraph (e)(5). The election must be made no later than the due date of the first annual return of any electing member for its taxable year for which the member is liable for tax under section 4911(a), determined under § 56.4911–8(d). The election may not be made or revoked after the due date of the return referred to in the preceding sentence except upon such terms and conditions as the Commissioner may prescribe.

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

Example 1. M, N, and O are eligible organizations within the meaning of § 1.501(h)–2(b)(1). Each has a governing board made up of nine members. Five members on the board of N are also members of the board of M. N designates five individuals from among its board, officers, and executive staff members to serve on the board of O. M is affiliated with N, N is affiliated with O, and M is affiliated with O.

Example 2. X, an eligible organization, has a board consisting of 10 members. Five unaffiliated tax-exempt organizations each designate two individuals to serve on the governing board of X. A simple majority of the board of X is a quorum and may establish X's position on legislative issues. X is not affiliated with any of the five autonomous organizations by reason of interlocking governing boards.

Example 3. P and Q are eligible organizations. The governing instruments of Q state that it will not take a position on legislation if P disapproves of the position. In addition, there is regular correspondence between P and Q with regard to positions on legislation. P is affiliated with Q regardless of whether P has ever vetoed a position taken by Q.

Example 4. The governing board of organization R resolves to adopt the position taken on legislative issues by organization S. R and S are eligible organizations and do not have interlocking governing boards. The governing instruments of R do not mention organization S and do not indicate that R is to be bound by the decisions of legislation of any organization. R and S are not affiliated.

Example 5. Organization Z is bound, under the terms of its governing instruments, by the legislative positions of Organization Y. Organization Y, however, is bound, under the terms of its governing instruments, by the legislative positions of Organization X. Organization X is affiliated with Y and Z; Y is affiliated with X and Z; and Z is affiliated with X and Y.

Example 6. Organizations T and U have interlocking boards of directors. T is the controlling organization. Organization V is bound, under the terms of its governing instruments, by the legislative positions of U. T and V are affiliated because T may cause or prevent action on legislative issues by U, and V is bound by U's action. If U were the controlling organization, T and V would be affiliated as two organizations controlled by the same organization.

Example 7. Organization A is described in section 501(c)(4). It is affiliated, as the controlling organization, with organizations K and L, both of which are described in section 501(c)(3) and are eligible to elect under section 501(h). If K elects under section 501(h), K and L are an affiliated group of organizations. Even though A is affiliated with K and L, A is not a member of that affiliated group of organizations because A is not an eligible organization within the meaning of § 1.501(h)–2(b)(1) (see § 56.4911–7(e)(1) for the definition of which affiliated organizations may be members of an affiliated group of organizations).

Example 8. G, H, I, and J are eligible organizations. G, H, and I have elected the expenditure test under section 501(h). The governing board of J has nine members. Under the governing instruments of J, organizations G, H, and I each designate three members of the governing board of J. Also under the governing instruments of J, action on legislative issues requires the approval of any seven board members. Because the three representatives of G may prevent action on legislative issues, J is affiliated with G. Similarly, J is affiliated with each of H and I. However, under none of the rules of affiliation is G affiliated with H, or H with I, or I with G. Therefore J is a member of one affiliated group comprising G and J, of another group comprising H and J, and of a third group comprising I and J.

Example 9. Organizations C, D, and E have been affiliated for many years and have all elected the expenditure test. Each has a taxable year ending July 31. For every day of the year ending July 31, 1992, they were eligible organizations, electing member organizations, and affiliated with each other. On no day of that year were they affiliated with any other eligible organization having a different taxable year. Therefore, the year ending July 31, 1992, is the taxable year of the affiliated group comprising C, D, and E.

§ 56.4911–8 Excess lobbying expenditures of affiliated group.

(a) *Application*. This section provides rules concerning the exempt purpose expenditures, lobbying expenditures, and grass roots expenditures of an affiliated group of organizations, and the application of the excise tax imposed by section 4911(a) on the excess lobbying expenditures of the group.

(b) *Affiliated group treated as one organization*. Under section 4911(f), an affiliated group of organizations is treated as a single organization for purposes of the tax imposed by section 4911(a). For any taxable year of the affiliated group, the group's lobbying expenditures, grass roots expenditures, and exempt purpose expenditures are equal to the sum of the lobbying expenditures, grass roots expenditures, and exempt purpose expenditures, respectively, paid or incurred by each member during the taxable year of the affiliated group. The lobbying and grass roots nontaxable amounts for the affiliated group for a taxable year are determined under section 4911(c) (2) and (4) and § 56.4911–1(c) and are based on the sum of the exempt purpose expenditures described in the preceding sentence. The lobbying and grass roots ceiling amounts for the affiliated group for a taxable year are calculated under § 1.501(h)–3(c) (3) and (6) based upon the nontaxable amounts determined pursuant to the preceding sentence.

(c) *Tax imposed on excess lobbying expenditures of affiliated group*. The excise tax under section 4911(a) is imposed for a taxable year of an affiliated group if the group has excess lobbying expenditures. For any taxable year of an affiliated group, the group's excess lobbying expenditures are the greater of—

(1) The amount by which the group's lobbying expenditures exceed the group's lobbying nontaxable amount, or

(2) The amount by which the group's grass roots expenditures exceed the group's grass roots nontaxable amount.

(d) *Liability for tax*—(1) *Electing organizations*. As provided in this paragraph (d), an electing member organization is liable for all or a portion of the excise tax imposed by section 4911(a) on the excess lobbying expenditures of an affiliated group of organizations. An organization that is liable under this paragraph (d) is not liable for any excise tax under section 4911 based on its own excess lobbying expenditures. A member of the affiliated group that is not an electing member organization is not liable for any portion of the excise tax that is imposed with respect to the affiliated group.

(2) *Tax based on excess lobbying expenditures*. If the excise tax imposed by section 4911(a) on the excess lobbying expenditures of an affiliated group of organizations is based upon the amount described in paragraph (c)(1) of this section, and at least one electing member has made lobbying expenditures, each electing member organization is liable for a portion of the tax equal to the amount of the tax multiplied by a fraction, the numerator of which is the electing member organization's lobbying expenditures paid or incurred during the taxable year of the affiliated group, and the denominator of which is the sum of the lobbying expenditures of all electing member organizations in the group paid or incurred during the taxable year of the affiliated group.

(3) *Tax based on excess grass roots expenditures*. If the excise tax imposed by section 4911(a) on the excess lobbying expenditures of an affiliated group of organizations is based upon the amount described in paragraph (c)(2) of this section, and at least one electing member has made grass roots expenditures, each electing member organization is liable for a portion of the tax equal to the amount of the tax multiplied by the fraction described in paragraph (d)(2) of this section, except that ''grass roots expenditures'' is substituted for ''lobbying expenditures.''

(4) *Tax based on exempt purpose expenditures*. If the excise tax imposed by section 4911(a) on the excess lobbying expenditures of an affiliated group of organizations is based upon the amount described in paragraph (c)(2) of this section, and if paragraphs (d)(2) and (d)(3) of this section do not apply because no electing organization has made lobbying or grass roots expenditures, respectively, each electing member organization is liable for a portion of the tax equal to the amount of tax multiplied by a fraction the numerator

of which is the electing member organization's exempt purpose expenditures and the denominator of which is the exempt purpose expenditures of all the electing member organizations in the affiliated group.

(5) *Taxable year for which liable.* An electing member organization that is liable for all or a portion of the excise tax imposed by section 4911(a) on the excess lobbying expenditures of an affiliated group of organizations is liable for the tax as if the tax were imposed for its taxable year with which or within which ends the taxable year of the affiliated group.

(6) *Organization a member of more than one affiliated group.* If, under this paragraph (d), an organization is liable for its taxable year for two or more excise taxes imposed by section 4911(a) on the excess lobbying expenditures of two or more affiliated groups, then the organization is liable only for the greater of the two or more taxes.

(e) *Former member organization.* An electing member organization that ceases to be a member of an affiliated group of organizations, the taxable year of which is different from its own, must thereafter determine its liability under § 56.4911–1 for the excise tax imposed by section 4911(a) as if its taxable year were the taxable year of the affiliated group of which it was formerly a member. An organization to which this paragraph (e) applies that is liable for the excise tax imposed by section 4911(a) is liable for the tax as if the tax were imposed for its taxable year within which ends the taxable year of the affiliated group of which it was formerly a member. The Commissioner may, at the Commissioner's discretion, permit an organization to disregard the rules of this paragraph (e) and to determine any liability under section 4911(a) based upon its own taxable year.

§ 56.4911–9 Application of section 501(h) to affiliated groups of organizations.

(a) *Scope.* This section provides rules concerning the application of the limitations of section 501(h) to members of an affiliated group of organizations (as defined in § 56.4911–7(e)(1)).

(b) *Determination required.* For each taxable year of an affiliated group of organizations, the calculations described in § 1.501(h)–3(b)(1) (i) and (ii) must be made, based on the expenditures of the group. If, for a taxable year of an affiliated group, it is determined that the sum of the affiliated group's lobbying or grass roots expenditures for the group's base years exceeds 150 percent of the sum of the group's corresponding nontaxable amounts for the base years, then under section 501(h), each member organization that is an electing member organization (as defined in § 56.4911–7(e)(4)) at any time in the taxable year of the affiliated group shall be denied tax exemption beginning with its first taxable year beginning after the end of such taxable year of the affiliated group. Thereafter, exemption shall be denied unless (pursuant to § 1.501(h)–3(d)) the organization reapplies and is recognized as exempt as an organization described in section 501(c)(3). For purposes of this section, the term *base years* generally means the taxable year of the affiliated group for which a determination is made and the group's three preceding taxable years. Base years, however, do not include any year preceding the first year in which at least one member of the group was treated as described in section 501(c)(3).

(c) *Member organizations that are not electing organizations.* An organization that is a member of an affiliated group of organizations but that is not an electing member organization remains subject to the ''substantial part test'' described in section 501(c)(3) with respect to its activities involving attempts to influence legislation.

(d) *Filing of information relating to affiliated group of organizations*—(1) *Scope.* The filing requirements described in this paragraph (d) apply to each member of an affiliated group or organizations for the taxable year of the member with which, or within which, ends the taxable year of the affiliated group.

(2) *In general.* Each member of an affiliated group of organizations shall provide to every other member of the group, before the first day of the second month following the close of the affiliated group's taxable year, its name, identification number, and the information required under § 1.6033–

2(a)(2)(ii)(M) for its expenditures during the group's taxable year and for prior taxable years of the group that are base years under paragraph (b). For groups electing under §56.4911–7(e)(5) to have each member file information with respect to the group based on its taxable year, each member shall provide the information required by the preceding sentence by treating each taxable year of any member of the group as a taxable year for the group.

(3) *Additional information required*. In addition to the information required by §1.6033–2(a)(2)(ii)(M), each member of an affiliated group of organizations must provide on its annual return the group's taxable year and, if the election under §56.4911–7(e)(5) is made, the name, identification number, and taxable year identifying the return with which its consent to the election was filed.

(4) *Information required of electing member organization*. In addition to the information required by §1.6033–2(a)(2)(ii)(M) and paragraph (d)(3) of this section, each electing member organization (as defined in §56.4911–7(e)(4)) must provide on its annual return—

(i) The name and identification number of each member of the group, and

(ii) The appropriate calculation described in §56.4911–8(d), if the organization is an electing member organization liable for all or any portion of the excise tax imposed by section 4911(a).

(e) *Example*. The provisions of this section may be illustrated by the following example:

Example. (1) M, N, and O are affiliated organizations under §56.4911–7(a). M's taxable year ends November 30, N's, January 31, and O's, June 30. On June 20, 1979, O files Form 5768 to elect to be governed by the expenditure test. M files Form 5768 in December of 1979. Neither M nor O revokes the election, and no organization makes the election provided for in §56.4911–7(e)(5). M, N, and O constitute an affiliated group of organizations, the first taxable year of which is the calendar year 1979.

(2) Because the organizations did not elect under §56.4911–7(e)(5) to use their own taxable years as the group's taxable years, the expenditures of the affiliated group for its first taxable year are the expenditures made by M, N, and O during calendar year 1979, and are reported by M, N, and O on their returns for their taxable years within which falls December 31, 1979. M reports the expenditures of the affiliated group for 1979 on its return for its taxable year ending November 30, 1980; and O, on its return for its taxable year ending June 30, 1980. N is not an electing member (as defined in §56.4911–7(e)(4)). Accordingly, under paragraph (d)(3)(i) of this section, it reports the name and identification number of each member of the group.

(3) The following tables summarize the expenditures by the affiliated group for the calendar years indicated. None of the group's lobbying expenditures for its taxable years 1979 through 1982 were grass roots expenditures.

TABLE I—GROUP'S EXPENDITURES

Year	Exempt purpose expenditures (EPE)	Calculation	Lobbying nontaxable amount (LNTA)	Lobbying expenditures (LE)
1979	$400,000	(20% × $400,000=)	$80,000	$100,000
1980	300,000	(20% × $300,000=)	60,000	100,000
1981	600,000	(20% × $500,000 + 15% × $100,000=)	115,000	120,000
1982	500,000	(20% × $500,000=)	100,000	220,000
Total	1,800,000		355,000	540,000

TABLE II—EXPENDITURES OF M AND O

	Exempt purpose expenditures		Lobbying nontaxable amount		Lobbying expenditures		M plus O
	M	O	M	O	M	O	
1979	125,000	100,000	25,000	20,000	60,000	20,000	80,000
1980	100,000	50,000	20,000	10,000	40,000	40,000	80,000
1981	250,000	100,000	50,000	20,000	60,000	40,000	100,000
1982	200,000	100,000	40,000	20,000	160,000	40,000	200,000

(4) For the affiliated group's taxable years 1979, 1980, 1981, and 1982, the group has excess lobbying expenditures. Under section 4911(f)(1)(B) and § 56.4911–8(d), M and O, as electing member organizations, are liable for a portion of the 25 percent excise tax imposed on the group's excess lobbying expenditures, based on their respective shares of the lobbying expenditures of all electing member organizations. For 1979, the excess lobbying expenditures are $20,000 ($100,000 − $80,000). The tax is 25% of $20,000 or $5,000; M must pay $3,750 (($60,000/$80,000) × $5,000 = $3,750), and O must pay $1,250 (($20,000/$80,000) × $5,000 = $1,250). For 1980, the tax is $10,000 and each must pay $5,000. For 1981, the tax is $1,250, of which M must pay $750 and O must pay $500. For 1982, the tax is $30,000. M must pay $24,000 and O must pay $6,000. M and O are not liable for any separate 4911 excise tax that otherwise would have been imposed on their separate excess lobbying expenditures.

(5) Under § 56.4911–9(b), the group must make the calculation described in § 1.501(h)–3(b)(1) for each of the group's taxable years 1979 through 1982. The following illustrates only the required calculation for the group's taxable year 1982. For its taxable year 1982, the group must determine whether it normally has made lobbying expenditures in excess of its lobbying ceiling amount. The determination takes into account the group's expenditures in base years 1979 through 1982. The sum of the group's lobbying expenditures for the base years ($540,000) exceeds 150% of the sum of the group's lobbying nontaxable amounts for the base years (150% × $355,000 = $532,500). Therefore, for its taxable year 1982, the group normally has made lobbying expenditures in excess of its lobbying ceiling amount. Under section 501(h) and § 56.4911–9(b), M is not exempt from tax under section 501(a) as an organization described in section 501(c)(3) for its taxable year beginning December 1, 1983, and O is not exempt for its year beginning July 1, 1983. Whether N's lobbying expenditures disqualify it for tax exemption at any time after January 1, 1979, is determined under the substantial part test of section 501(c)(3).

(f) *Cross reference*. For other provisions relating to members of an affiliated group or organizations, see §§ 56.4911–2(c)(4)(ii), 56.4911–4(c)(2), 56.4911–4(e), and 56.4911–5(f)(3).

[T.D. 8308, 55 FR 35598, Aug. 31, 1990, as amended by T.D. 9898, 85 FR 31969, May 28, 2020]

§ 56.4911–10 Members of a limited affiliated group of organizations.

(a) *Scope*. This section provides additional rules for members of a limited affiliated group of organizations, as defined in paragraph (b) of this section (relating generally to organizations that are affiliated solely by reason of provisions of their governing instruments that extend control solely with respect to national legislation). Except as otherwise provided in this section, §§ 56.4911–8 and 56.4911–9 do not apply to members of a limited affiliated group. Thus, as modified by this section, the regulations under sections 501(h) and 4911 apply to electing members of a limited affiliated group individually. For example, §§ 56.4911–2 through 56.4911–4, which, by their terms, include amounts described in paragraph (d) of this section, are used in applying sections 501(h) and 4911 to controlling member organizations (within the meaning of paragraph (c) of this section). Except as otherwise provided in this section, members of a limited affiliated group that are not electing organizations are subject to the substantial part test.

(b) *Members of limited affiliated group*. For purposes of section 4911, a limited affiliated group consists of two or more organizations that meet the following requirements:

(1) Each organization is a member of an affiliated group of organizations as defined in § 56.4911–7(e);

(2) No two members of the affiliated group described in paragraph (b)(1) of this section are affiliated by reason of interlocking governing boards under § 56.4911–7(b); and

(3) No member of the affiliated group described in paragraph (b)(1) of this section is, under its governing instrument, bound by decisions of one or more of the other such members on legislative issues other than national legislative issues.

Each organization in a group of organizations that satisfies the requirements of the preceding sentence is a member of the limited affiliated group.

(c) *Controlling and controlled organizations*. For purposes of this section, a member of a limited affiliated group is a controlling member organization if it controls one or more of the other members of the limited affiliated group, and a member of a limited affiliated group is a controlled member organization if it is controlled by one or more of the

other members of the limited affiliated group. For purposes of the preceding sentence, whether an organization controls a second organization shall be determined by whether the second organization is bound, under its governing instruments, by actions taken by the first organization on national legislative issues.

(d) *Expenditures of controlling organization*—(1) *Scope*. This paragraph (d) applies to a controlling member organization that has the expenditure test election in effect for its taxable year. This paragraph (d) applies whether or not the organization is also a controlled member organization. In determining a controlling member organization's expenditures, no expenditure shall be counted twice.

(2) *Expenditures for direct lobbying*. A controlling member organization for which the expenditure test election is in effect shall include in its direct lobbying expenditures for its taxable year the direct lobbying expenditures (as defined in §§ 56.4911–2 and 56.4911–3) paid or incurred with respect to national legislative issues during such year by each organization that is a member of the limited affiliated group and is controlled (within the meaning of paragraph (c) of this section) by such controlling member organization.

(3) *Grass roots expenditures*. A controlling member organization for which the expenditure test election is in effect shall include in its grass roots expenditures for its taxable year the grass roots expenditures (as defined in §§ 56.4911–2 and 56.4911–3) paid or incurred with respect to national legislative issues during such year by each organization that is a member of the limited affiliated group and is controlled (within the meaning of paragraph (c) of this section) by such controlling member organization.

(4) *Exempt purpose expenditures*. The exempt purpose expenditures of a controlling member organization do not include the exempt purpose expenditures (other than lobbying expenditures described in paragraphs (d)(2) and (d)(3) of this section) of any organization that is a controlled member organization with respect to it.

(e) *Expenditures of controlled member*. A controlled member organization that is an electing organization but that does not control (within the meaning of paragraph (c) of this section) any organization in the limited affiliated group shall apply sections 501(h) and 4911 and the regulations thereunder without regard to the expenditures of any other member of the limited affiliated group.

(f) *Reports of members of limited affiliated groups*—(1) *Controlling member organization's additional information on annual return*. In addition to the information required by § 1.6033–2(a)(2)(ii)(M), each controlling member organization for which the expenditure test election is in effect must provide on its annual return the name and identification number of each member of the limited affiliated group.

(2) *Reports of controlling members to other members*. Each controlling member organization for which an expenditure test election is in effect must notify each member that it controls of its taxable year in order for the controlled organization to prepare the report required by paragraph (f)(3) of this section. Such notification must be made before the beginning of the second month after the close of each taxable year of the controlling member for which the election is in effect.

(3) *Reports of controlled member organization*. Every controlled member organization (whether or not the expenditure test election is in effect with respect to it) shall provide to each member of the limited affiliated group that controls it, before the first day of the second month following the close of the taxable year of each such controlling organization, its name, identification number, and the lobbying expenditures and grass roots expenditures on national legislative issues incurred by the controlled member organization.

(g) *National legislative issues*. The term ''national legislative issue'' means legislation, limited to action by the Congress of the United States or by the public in any national procedure. If an issue is both national and local, it is characterized as a national legislative issue if the contemplated legislation is Congressional legislation.

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

Example 1. State X has an income tax law that uses definitions contained in the Internal Revenue Code as it may be amended from time to time. Legislation to change a definition in the Internal Revenue Code is pending in Congress. This is a national legislative issue even though Congressional action may affect state law.

Example 2. Organization M takes a position favoring approval by Congress of a proposed amendment to the United States Constitution. This is a national legislative issue. After approval by Congress and submission to the states for ratification, the proposed amendment ceases to be a national legislative issue.

Example 3. N, O, and P are organizations described in section 501(c)(3) that do not have interlocking governing boards, within the meaning of § 56.4911–7(b). N has elected the expenditure test under section 501(h). By virtue of the governing instruments of O and P, any decision made by N on national legislative issues (such as issues concerning action on acts, bills, resolutions, or similar items by Congress) binds both O and P. Under their governing instruments, O and P are not bound on any other issues. Therefore, N, O, and P constitute a limited affiliated group. If P sends a series of letters and pamphlets to members of Congress in support of bill V, their cost will be included in N's and P's expenditures for direct lobbying and in N's and P's exempt purposes expenditures, but will not be included in O's lobbying expenditures. If N hires a lobbyist to solicit support for bill V, the cost of hiring the lobbyist will be includable only in N's lobbying expenditures. Any lobbying expenditures incurred by either O or P on any issue that is not a national legislative issue will not be included in N's lobbying expenditures.

Example 4. Y is an electing organization and a member of a limited affiliated group of organizations. Y controls organizations A, B, and C with respect to national legislative issues but is not controlled by any other organization.—Y's taxable year is the calendar year. During 1982, A dissolves on March 15th and D, also controlled by Y with respect to national legislative issues, is established on May 1st. For 1982 the limited affiliated group comprises Y, A, B, C, and D.

Example 5. P, Q, R, and S are electing organizations. The governing instruments of Q require it to adopt the positions on national legislative issues adopted by P. R is similarly bound by Q's positions. R and S have interlocking governing boards, within the meaning of § 56.4911–7(b), but S's governing instruments do not require it to adopt the position of any other organization on any legislative issues. Under § 56.4911–7(e)(1), P, Q, R, and S are members of an affiliated group. Applying paragraph (b) of this section, it is determined that (1) P, Q, R and S are members of an affiliated group; and (2) R and S are affiliated by reason of interlocking governing boards. Accordingly, P, Q, R and S are not a limited affiliated group. Similarly, P, Q, and R do not constitute a limited affiliated group because they are members of an affiliated group comprising P, Q, R, and S, two of whose members, R and S, are affiliated by reason of interlocking governing boards.

Example 6. T, U, V, and W are electing organizations. The governing instruments of U and V require them to adopt the positions on national legislative issues adopted by T, but do not require them to adopt the positions of any organization on any other legislative issues. The governing documents of W require it to adopt the positions of V on all legislative issues. Applying paragraph (b) of this section, it is determined that (1) T, U, V, and W are all members of an affiliated group; (2) no two of T, U, V, and W are affiliated by reason of interlocking governing boards; but (3) W is bound, under its governing instrument, by decisions of V on legislative issues that are not national legislative issues. Accordingly, T, U, V, and W do not constitute a limited affiliated group. Similarly, T, U, and V do not constitute a limited affiliated group. T, U, V, and W are an affiliated group under § 56.4911–7.

[T.D. 8308, 55 FR 35598, Aug. 31, 1990, as amended by T.D. 9898, 85 FR 31969, May 28, 2020]

§ 56.6001–1 Notice or regulations requiring records, statements, and special returns.

(a) *In general.* The provisions of § 53.6001–1 shall apply to any person subject to tax under chapter 41, subtitle D, of the Code, by treating each reference to chapter 42 in § 53.6001–1 as a reference to chapter 41.

(b) *Cross references.* See § 56.4911–6 for general information on records of lobbying expenditures. See §§ 56.4911–9(d) and 56.4911–10(f) for information that members of an affiliated group and a limited affiliated group, respectively, are to provide to other members of the group and to the Internal Revenue Service.

§ 56.6011–1 General requirement of return, statement, or list.

Every organization liable for the tax imposed by section 4911(a) shall file an annual return with respect to the tax on the form prescribed by the Internal Revenue Service for that purpose and shall include the information required by the form and its instructions.

§ 56.6011–4 Requirement of statement disclosing participation in certain transactions by taxpayers.

(a) *In general.* If a transaction is identified as a *listed transaction* or a *transaction of interest* as defined in § 1.6011–4 of this chapter by the Commissioner in published guidance (see § 601.601(d)(2) of this chapter), and the listed transaction or transaction of interest involves an excise tax under chapter 41 of subtitle D of the Internal Revenue Code (relating to public charities), the transaction must be disclosed in the manner stated in such published guidance.

(b) *Effective date.* This section applies to listed transactions entered into on or after January 1, 2003. This section applies to transactions of interest entered into on or after November 2, 2006.

[T.D. 9350, 72 FR 43154, Aug. 3, 2007]

§ 56.6060–1 Reporting requirements for tax return preparers.

(a) *In general.* A person that employs one or more tax return preparers to prepare a return or claim for refund of tax under chapter 41 of subtitle D of the Internal Revenue Code, other than for the person, at any time during a return period, shall satisfy the record keeping and inspection requirements in the manner stated in § 1.6060–1 of this chapter.

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

[T.D. 9436, 73 FR 78460, Dec. 22, 2008]

§ 56.6107–1 Tax return preparer must furnish copy of return and claim for refund to taxpayer and must retain a copy or record.

(a) *In general.* A person who is a signing tax return preparer of any return or claim for refund of tax under Chapter 41 of subtitle D of the Internal Revenue Code shall furnish a completed copy of the return or claim for refund to the public charity and retain a completed copy or record in the manner stated in § 1.6107–1 of this chapter.

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

[T.D. 9436, 73 FR 78460, Dec. 22, 2008]

§ 56.6109–1 Tax return preparers furnishing identifying numbers for returns or claims for refund.

(a) *In general.* Each tax return or claim for refund for tax under chapter 41 of subtitle D prepared by one or more signing tax return preparers must include the identifying number of the preparer required by § 1.6695–1(b) of this chapter to sign the return or claim for refund in the manner stated in § 1.6109–2 of this chapter.

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

[T.D. 9436, 73 FR 78460, Dec. 22, 2008]

§ 56.6694–1 Section 6694 penalties applicable to tax return preparer.

(a) *In general.* For general definitions regarding section 6694 penalties applicable to preparers of tax returns or claims for refund of tax under chapter 41 of subtitle D see § 1.6694–1 of this chapter.

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

[T.D. 9436, 73 FR 78460, Dec. 22, 2008]

§ 56.6694–2 Penalties for understatement due to an unreasonable position.

(a) *In general.* A person who is a tax return preparer of any return or claim for refund of excise tax under chapter 41 of subtitle D of the Internal Revenue Code (Code) shall be subject to penalties under section 6694(a) of the Code in the manner stated in § 1.6694–2 of this chapter.

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

[T.D. 9436, 73 FR 78460, Dec. 22, 2008]

§ 56.6694–3 Penalty for understatement due to willful, reckless, or intentional conduct.

(a) *In general.* A person who is a tax return preparer of any return or claim for refund of tax under chapter 41 of subtitle D of the Internal Revenue Code (Code) shall be subject to penalties under section 6694(b) of the Code in the manner stated in § 1.6694–3 of this chapter.

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

[T.D. 9436, 73 FR 78460, Dec. 22, 2008]

§ 56.6694–4 Extension of period of collection when tax return preparer pays 15 percent of a penalty for understatement of taxpayer's liability and certain other procedural matters.

(a) *In general.* For rules relating to the extension of period of collection when a tax return preparer who prepared a return or claim for refund for tax under chapter 41 of subtitle D of the Internal Revenue Code pays 15 percent of a penalty for understatement of taxpayer's liability and procedural matters relating to the investigation, assessment and collection of the penalties under section 6694(a) and (b), the rules under § 1.6694–4 of this chapter will apply.

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

[T.D. 9436, 73 FR 78461, Dec. 22, 2008]

§ 56.6695–1 Other assessable penalties with respect to the preparation of tax returns or claims for refund for other persons.

(a) *In general.* A person who is a tax return preparer of any return or claim for refund of tax under chapter 41 of subtitle D of the Internal Revenue Code (Code) shall be subject to penalties for failure to furnish a copy to the taxpayer under section 6695(a) of the Code, failure to sign the return under section 6695(b) of the Code, failure to furnish an identification number under section 6695(c) of the Code, failure to retain a copy or list under section 6695(d) of the Code, failure to file a correct information return under section 6695(e) of the Code, and negotiation of a check under section 6695(f) of the Code, in the manner stated in § 1.6695–1 of this chapter.

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

[T.D. 9436, 73 FR 78461, Dec. 22, 2008]

§ 56.6696–1 Claims for credit or refund by tax return preparers.

(a) *In general.* For rules relating to claims for credit or refund by a tax return preparer who prepared a return or claim for refund for tax under chapter 41 of subtitle D of the Internal Revenue Code, the rules under § 1.6696–1 of this chapter will apply.

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

[T.D. 9436, 73 FR 78461, Dec. 22, 2008]

§ 56.7701–1 Tax return preparer.

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

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

[T.D. 9436, 73 FR 78461, Dec. 22, 2008]

PART 57—HEALTH INSURANCE PROVIDERS FEE

Sec.

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57.6302–1 Method of paying the health insurance providers fee.

AUTHORITY: 26 U.S.C. 7805; sec. 9010, Pub. L. 111–148 (124 Stat. 119 (2010)).

Section 57.3 also issued under 26 U.S.C. 6071(a)

Section 57.7 also issued under 26 U.S.C. 6302(a).

Section 57.6302–1 also issued under 26 U.S.C. 6302(a).

SOURCE: T.D. 9643, 78 FR 71487, Nov. 29, 2013, unless otherwise noted.

§ 57.1 Overview.

(a) The regulations in this part are designated ''Health Insurance Providers Fee Regulations.''

(b) The regulations in this part provide guidance on the annual fee imposed on covered entities engaged in the business of providing health insurance by section 9010 of the Patient Protection and Affordable Care Act (PPACA), Public Law 111–148 (124 Stat. 119 (2010)), as amended by section 10905 of PPACA, and as further amended by section 1406 of the Health Care and Education Reconciliation Act of 2010, Public Law 111–152 (124 Stat. 1029 (2010)) (collectively, the Affordable Care Act or ACA). All references to section 9010 in this part 57 are references to section 9010 of the ACA. Unless otherwise indicated, all other references to subtitles, chapters, subchapters, and sections are references to subtitles, chapters, subchapters and sections in the Internal Revenue Code and the related regulations.

(c) Section 9010(e)(1) sets an applicable fee amount for each year, beginning with 2014, that will be apportioned among covered entities with aggregate net premiums written over $25 million for health insurance for United States health risks. Generally, each covered entity is liable for a fee in each fee year that is based on its net premiums written during the data year in an amount determined by the Internal Revenue Service (IRS) under the rules of this part.

§ 57.2 Explanation of terms.

(a) *In general.* This section explains the terms used in this part 57 for purposes of the fee.

(b) *Covered entity*—(1) *In general.* Except as provided in paragraph (b)(2) of this section, the term *covered entity* means any entity with net premiums written for health insurance for United States health risks in the fee year if the entity is—

(i) A health insurance issuer within the meaning of section 9832(b)(2), defined in section 9832(b)(2) as an insurance company, insurance service, or insurance organization that is 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 Employee Retirement Income Security Act of 1974 (ERISA));

(ii) A health maintenance organization within the meaning of section 9832(b)(3), defined in section 9832(b)(3) as—

(A) A Federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act);

(B) An organization recognized under State law as a health maintenance organization; or

(C) A similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization;

(iii) An insurance company subject to tax under part I or II of subchapter L, or that would be subject to tax under part I or II of subchapter L but for the entity being exempt from tax under section 501(a);

(iv) An entity that provides health insurance under Medicare Advantage, Medicare Part D, or Medicaid; or

(v) A multiple employer welfare arrangement (MEWA), within the meaning of section 3(40) of ERISA, to the extent not fully insured, provided that for this purpose a covered entity does not include a MEWA that with respect to the plan year ending with or within the section 9010 data year satisfies the requirements to be exempt from reporting under 29 CFR 2520.101–2(c)(2)(ii)(A), (B), or (C).

(2) *Exclusions*—(i) *Self-insured employer.* The term *covered entity* does not include any entity (including a voluntary employees' beneficiary association under section 501(c)(9) (VEBA)) that is part of a self-insured employer plan to the extent that such entity self-insures its employees' health risks. The term *self-insured employer* means an employer that sponsors a self-insured medical reimbursement plan within the meaning of § 1.105–11(b)(1)(i) of this chapter. Self-insured medical reimbursement plans include plans that do not involve shifting risk to an

unrelated third party as described in § 1.105–11(b)(1)(ii) of this chapter. A self-insured medical reimbursement plan may use an insurance company or other third party to provide administrative or bookkeeping functions. For purposes of this section, the term *self-insured employer* does not include a MEWA.

(ii) *Governmental entity*. The term *covered entity* does not include any governmental entity. For this purpose, the term *governmental entity* means—

(A) The government of the United States;

(B) Any State or a political subdivision thereof (as defined for purposes of section 103) including, for example, a State health department or a State insurance commission;

(C) Any Indian tribal government (as defined in section 7701(a)(40)) or a subdivision thereof (determined in accordance with section 7871(d)); or

(D) Any agency or instrumentality of any of the foregoing.

(iii) *Certain nonprofit corporations*. The term *covered entity* does not include any entity—

(A) That is incorporated as a nonprofit corporation under a State law;

(B) No part of the net earnings of which inures to the benefit of any private shareholder or individual (within the meaning of §§ 1.501(a)–1(c) and 1.501(c)(3)–1(c)(2) of this chapter);

(C) No substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation (within the meaning of § 1.501(c)(3)–1(c)(3)(ii) of this chapter) (or which is described in section 501(h)(3) and is not denied exemption under section 501(a) by reason of section 501(h));

(D) That does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office (within the meaning of § 1.501(c)(3)–1(c)(3)(iii) of this chapter); and

(E) More than 80 percent of the gross revenues of which is received from government programs that target low-income, elderly, or disabled populations under titles XVIII, XIX, and XXI of the Social Security Act.

(iv) *Certain voluntary employees' beneficiary associations (VEBAs)*. The term *covered entity* does not include any entity that is described in section 501(c)(9) that is established by an entity (other than by an employer or employers) for purposes of providing health care benefits. This exclusion applies to a VEBA that is established by a union or established pursuant to a collective bargaining agreement and having a joint board of trustees (such as in the case of a multiemployer plan within the meaning of section 3(37) of ERISA or a single-employer plan described in section 302(c)(5) of the Labor Management Relations Act, 29 U.S.C. 186(c)(5)). This exclusion does not apply to a MEWA.

(3) *Application of exclusions*—(i) *Test year*. An entity qualifies for an exclusion described in paragraphs (b)(2)(i) through (iv) of this section if it so qualifies in its test year. The term *test year* means either the entire data year or the entire fee year.

(ii) *Consistency rule*. For purposes of paragraph (b)(3)(i) of this section, an entity must use the same test year as it used in its first fee year beginning after December 31, 2014, and in each subsequent fee year. Thus, for example, if an entity used the 2014 data year as its test year for the 2015 fee year, that entity must use the data year as its test year for each subsequent fee year.

(iii) *Special rule for fee year as test year*. For purposes of paragraph (b)(3) of this section, any entity that uses the fee year as its test year but ultimately does not qualify for an exclusion described in paragraphs (b)(2)(i) through (iv) of this section for that entire fee year must use the data year as its test year for each subsequent fee year.

(4) *State*. Solely for purposes of paragraph (b) of this section, the term *State* means any of the 50 States, the District of Columbia, or any of the possessions of the United States, including American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands.

(c) *Controlled groups*—(1) *In general*. The term *controlled group* means a group of two or more persons, including at least one person that is a covered entity, that is treated as a single employer under section 52(a), 52(b), 414(m), or 414(o).

(2) *Treatment of controlled group.* A controlled group (as defined in paragraph (c)(1) of this section) is treated as a single covered entity for purposes of the fee.

(3) *Special rules.* For purposes of paragraph (c)(1) of this section (related to controlled groups)—

(i) A foreign entity subject to tax under section 881 is included within a controlled group under section 52(a) or (b); and

(ii) A person is treated as being a member of the controlled group if it is a member of the group at the end of the day on December 31st of the data year. However, a person's net premiums written are included in net premiums written for the controlled group only if the person would qualify as a covered entity in the fee year if the person were not a member of the controlled group.

(d) *Data year.* The term *data year* means the calendar year immediately before the fee year. Thus, for example, 2013 is the data year for fee year 2014.

(e) *Designated entity*—(1) *In general.* The term *designated entity* means the person within a controlled group that is designated to act on behalf of the controlled group regarding the fee with respect to—

(i) Filing Form 8963, ''Report of Health Insurance Provider Information'';

(ii) Receiving IRS communications about the fee for the group;

(iii) Filing a corrected Form 8963 for the group, if applicable, as described in § 57.6; and

(iv) Paying the fee for the group to the government.

(2) *Selection of designated entity*—(i) *In general.* Except as provided in paragraph (e)(2)(ii) of this section, each controlled group must select a designated entity by having that entity file the Form 8963 in accordance with the form instructions. The designated entity must state under penalties of perjury that all persons that provide health insurance for United States health risks that are members of the group have consented to the selection of the designated entity. Each member of a controlled group must maintain a record of its consent to the controlled group's selection of the designated entity. The designated entity must maintain a record of all member consents.

(ii) *Requirement for consolidated groups; common parent.* If a controlled group, without regard to foreign corporations included under section 9010(c)(3)(B), is also an affiliated group the common parent of which files a consolidated return for Federal income tax purposes, the designated entity is the agent for the group (within the meaning of § 1.1502–77 of this chapter) for the data year.

(iii) *Failure to select a designated entity.* Excepted as provided in paragraph (e)(2)(ii) of this section, if a controlled group fails to select a designated entity as provided in paragraph (e)(2)(i) of this section, then the IRS will select a member of the controlled group to be the designated entity. If the IRS selects the designated entity, then all members of the controlled group that provide health insurance for a United States health risk will be deemed to have consented to the IRS's selection of the designated entity.

(f) *Fee.* The term *fee* means the fee imposed by section 9010 on each covered entity engaged in the business of providing health insurance.

(g) *Fee year.* The term *fee year* means the calendar year in which the fee must be paid to the government. The first fee year is 2014.

(h) *Health insurance*—(1) *In general.* Except as provided in paragraph (h)(2) of this section, the term *health insurance* generally has the same meaning as the term *health insurance coverage* in section 9832(b)(1)(A), defined to mean 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 health maintenance organization contract, when these benefits are offered by an entity that is one of the types of entities described in paragraph (b)(1)(i) through (b)(1)(v) of this section. The term *health insurance* includes limited scope dental and vision benefits under section 9832(c)(2)(A) and retiree-only health insurance.

(2) *Exclusions.* The term *health insurance* does not include—

(i) Coverage only for accident, or disability income insurance, or any combination thereof, within the meaning of section 9832(c)(1)(A);

(ii) Coverage issued as a supplement to liability insurance within the meaning of section 9832(c)(1)(B);

(iii) Liability insurance, including general liability insurance and automobile liability insurance, within the meaning of section 9832(c)(1)(C);

(iv) Workers' compensation or similar insurance within the meaning of section 9832(c)(1)(D);

(v) Automobile medical payment insurance within the meaning of section 9832(c)(1)(E);

(vi) Credit-only insurance within the meaning of section 9832(c)(1)(F);

(vii) Coverage for on-site medical clinics within the meaning of section 9832(c)(1)(G);

(viii) Other insurance coverage that is similar to the insurance coverage in paragraph (h)(2)(i) through (vii) of this section under which benefits for medical care are secondary or incidental to other insurance benefits, within the meaning of section 9832(c)(1)(H), to the extent such insurance coverage is specified in regulations under section 9832(c)(1)(H);

(ix) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof, within the meaning of section 9832(c)(2)(B), and such other similar, limited benefits to the extent such benefits are specified in regulations under section 9832(c)(2)(C);

(x) Coverage only for a specified disease or illness within the meaning of section 9832(c)(3)(A);

(xi) Hospital indemnity or other fixed indemnity insurance within the meaning of section 9832(c)(3)(B);

(xii) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan, within the meaning of section 9832(c)(4);

(xiii) Coverage under an employee assistance plan, a disease management plan, or a wellness plan, if the benefits provided under the plan constitute excepted benefits under section 9832(c)(2) (or do not otherwise provide benefits consisting of health insurance under paragraph (h)(1) of this section);

(xiv) Student administrative health fee arrangements, as defined in paragraph (h)(3);

(xv) Travel insurance, as defined in paragraph (h)(4) of this section; or

(xvi) Indemnity reinsurance, as defined in paragraph (h)(5)(i) of this section.

(3) *Student administrative health fee arrangement.* For purposes of paragraph (h)(2)(xiv) of this section, the term *student administrative health fee arrangement* means an arrangement under which an educational institution, other than through an insured arrangement, charges student administrative health fees to students on a periodic basis to help cover the cost of student health clinic operations and care delivery (regardless of whether the student uses the clinic and regardless of whether the student purchases any available student health insurance coverage).

(4) *Travel insurance.* For purposes of paragraph (h)(2)(xv) of this section, the term *travel insurance* means insurance coverage for personal risks incident to planned travel, which may include, but is not limited to, interruption or cancellation of trip or event, loss of baggage or personal effects, damages to accommodations or rental vehicles, and sickness, accident, disability, or death occurring during travel, provided that the health benefits are not offered on a stand-alone basis and are incidental to other coverage. For this purpose, the term *travel insurance* does not include major medical plans that provide comprehensive medical protection for travelers with trips lasting 6 months or longer, including, for example, those working overseas as an expatriate or military personnel being deployed.

(5) *Reinsurance*—(i) *Indemnity reinsurance.* For purposes of paragraphs (h)(2)(xvi) and (k) of this section, the term *indemnity reinsurance* means an agreement between one or more reinsuring companies and a covered entity under which—

(A) The reinsuring company agrees to accept, and to indemnify the issuing company for, all or part of the risk of

loss under policies specified in the agreement; and

(B) The covered entity retains its liability to, and its contractual relationship with, the individuals whose health risks are insured under the policies specified in the agreement.

(ii) *Assumption reinsurance*. For purposes of paragraph (k) of this section, the term *assumption reinsurance* means reinsurance for which there is a novation and the reinsurer takes over the entire risk of loss pursuant to a new contract.

(i) *Located in the United States*. The term *located in the United States* means present in the United States (within the meaning of paragraph (m) of this section) under section 7701(b)(7) (for presence in the 50 States and the District of Columbia) or § 1.937–1(c)(3)(i) of this chapter (for presence in a possession of the United States).

(j) *NAIC*. The term *NAIC* means the National Association of Insurance Commissioners.

(k) *Net premiums written*—The term *net premiums written* means premiums written, including reinsurance premiums written, reduced by reinsurance ceded, and reduced by ceding commissions and medical loss ratio (MLR) rebates with respect to the data year. For this purpose, MLR rebates are computed on an accrual basis in determining net premiums written. Because indemnity reinsurance within the meaning of paragraph (h)(5)(i) of this section is not health insurance under paragraph (h)(1) of this section, the term *net premiums written* does not include premiums written for indemnity reinsurance and is not reduced by indemnity reinsurance ceded. However, in the case of assumption reinsurance within the meaning of paragraph (h)(5)(ii) of this section, the term *net premiums written* does include premiums written for assumption reinsurance and is reduced by assumption reinsurance premiums ceded.

(l) *SHCE*. The term *SHCE* means the Supplemental Health Care Exhibit. The SHCE is a form published by the NAIC that most covered entities are required to file annually under State law.

(m) *United States*. For purposes of paragraph (i) of this section, the term *United States* means the 50 States, the District of Columbia, and any possession of the United States, including American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands.

(n) *United States health risk*. The term *United States health risk* means the health risk of any individual who is—

(1) A United States citizen;

(2) A resident of the United States (within the meaning of section 7701(b)(1)(A)); or

(3) Located in the United States (within the meaning of paragraph (i) of this section) during the period such individual is so located.

[T.D. 9643, 78 FR 71487, Nov. 29, 2013, as amended by T.D. 9711, 80 FR 10334, Feb. 26, 2015; T.D. 9830, 83 FR 8174, Feb. 26, 2018]

§ 57.3 Reporting requirements and associated penalties.

(a) *Reporting requirement*—(1) *In general*. Annually, each covered entity, including each controlled group that is treated as a single covered entity, must report its net premiums written for health insurance of United States health risks during the data year to the IRS by April 15th of the fee year on Form 8963, ''Report of Health Insurance Provider Information,'' in accordance with the instructions for the form. A covered entity that has net premiums written during the data year is subject to this reporting requirement even if it does not have any amount taken into account as described in § 57.4(a)(4). If an entity is not in the business of providing health insurance for any United States health risk in the fee year, it is not a covered entity and does not have to report.

(2) *Manner of reporting*—(i) *In general*. The IRS may provide rules in guidance published in the Internal Revenue Bulletin for the manner of reporting by a covered entity under this section, including rules for reporting by a designated entity on behalf of a controlled group that is treated as a single covered entity.

(ii) *Electronic Filing Required*. Any Form 8963 (including corrected forms) filed pursuant to paragraph (a)(1) of this section and reporting more than $25 million in net premiums written must be filed electronically in accordance with the instructions to the form.

If a Form 8963 or corrected Form 8963 is required to be filed electronically under this paragraph (a)(2)(ii), any subsequently filed Form 8963 filed for the same fee year must also be filed electronically. For purposes of § 57.3(b), any Form 8963 required to be filed electronically under this section will not be considered filed unless it is filed electronically.

(3) *Disclosure of reported information.* Pursuant to section 9010(g)(4), the information reported on each original and corrected Form 8963 will be open for public inspection or available upon request.

(b) *Penalties*—(1) *Failure to report*—(i) *In general.* A covered entity that fails to timely submit a report containing the information required by paragraph (a) of this section is liable for a failure to report penalty in the amount described in paragraph (b)(1)(ii) of this section in addition to its fee liability and any other applicable penalty, unless the failure is due to reasonable cause as defined in paragraph (b)(1)(iii) of this section.

(ii) *Amount.* The amount of the failure to report penalty described in paragraph (b)(1)(i) of this section is—

(A) $10,000, plus

(B) The lesser of—

(*1*) An amount equal to $1,000 multiplied by the number of days during which such failure continues; or

(*2*) The amount of the covered entity's fee for which the report was required.

(iii) *Reasonable cause.* The failure to report penalty described in paragraph (b)(1)(i) of this section is waived if the failure is due to reasonable cause. A failure is due to reasonable cause if the covered entity exercised ordinary business care and prudence and was nevertheless unable to submit the report within the prescribed time. In determining whether the covered entity was unable to submit the report timely despite the exercise of ordinary business care and prudence, the IRS will consider all the facts and circumstances surrounding the failure to submit the report.

(iv) *Treatment of penalty.* The failure to report penalty described in this paragraph (b)(1)—

(A) Is treated as a penalty under subtitle F;

(B) Must be paid on notice and demand by the IRS and in the same manner as a tax under the Internal Revenue Code; and

(C) Is a penalty for which only civil actions for refund under procedures of subtitle F apply.

(2) *Accuracy-related penalty*—(i) *In general.* A covered entity that understates its net premiums written for health insurance of United States health risks in the report required under paragraph (a)(1) of this section is liable for an accuracy-related penalty in the amount described in paragraph (b)(2)(ii) of this section, in addition to its fee liability and any other applicable penalty.

(ii) *Amount.* The amount of the accuracy-related penalty described in paragraph (b)(2)(i) of this section is the excess of—

(A) The amount of the covered entity's fee for the fee year that the IRS determines should have been paid in the absence of any understatement; over

(B) The amount of the covered entity's fee for the fee year that the IRS determined based on the understatement.

(iii) *Understatement.* An understatement of a covered entity's net premiums written for health insurance of United States health risks is the difference between the amount of net premiums written that the covered entity reported and the amount of net premiums written that the IRS determines the covered entity should have reported.

(iv) *Treatment of penalty.* The accuracy-related penalty is subject to the provisions of subtitle F that apply to assessable penalties imposed under chapter 68.

(3) *Controlled groups.* Each member of a controlled group that is required to provide information to the controlled group's designated entity for purposes of the report required to be submitted by the designated entity on behalf of the controlled group is jointly and severally liable for any penalties described

in this paragraph (b) for any reporting failures by the designated entity.

[T.D. 9643, 78 FR 71487, Nov. 29, 2013, as amended by T.D. 9881, 84 FR 61547, Nov. 13, 2019]

§ 57.4 Fee calculation.

(a) *Fee components*—(1) *In general*. For every fee year, the IRS will calculate a covered entity's allocated fee as described in this section.

(2) *Calculation of net premiums written*. Each covered entity's allocated fee for any fee year is equal to an amount that bears the same ratio to the applicable amount as the covered entity's net premiums written for health insurance of United States health risks during the data year taken into account bears to the aggregate net premiums written for health insurance of United States health risks of all covered entities during the data year taken into account.

(3) *Applicable amount*. The applicable amounts for fee years are—

Fee year	Applicable amount
2014	$8,000,000,000
2015	$11,300,000,000
2016	$11,300,000,000
2017	$13,900,000,000
2018	$14,300,000,000
2019 and thereafter	The applicable amount in the preceding fee year increased by the rate of premium growth (within the meaning of section 36B(b)(3)(A)(ii)).

(4) *Net premiums written taken into account*—(i) *In general*. A covered entity's net premiums written for health insurance of United States health risks during any data year are taken into account as follows:

Covered entity's net premiums written during the data year that are:	Percentage of net premiums written taken into account is:
Not more than $25,000,000	0
More than $25,000,000 but not more than $50,000,000	50
More than $50,000,000	100

(ii) *Controlled groups*. In the case of a controlled group, paragraph (a)(4)(i) of this section applies to all net premiums written for health insurance of United States health risks during the data year, in the aggregate, of the entire controlled group, except that any net premiums written by any member of the controlled group that is a nonprofit corporation meeting the requirements of § 57.2(b)(2)(iii) or a voluntary employees' beneficiary association meeting the requirements of § 57.2(b)(2)(iv) are not taken into account.

(iii) *Partial exclusion for certain exempt activities*. After the application of paragraph (a)(4)(i) of this section, if the covered entity (or any member of a controlled group treated as a single covered entity) is exempt from Federal income tax under section 501(a) and is described in section 501(c)(3), (4), (26), or (29) as of December 31st of the data year, then only 50 percent of its remaining net premiums written for health insurance of United States health risks that are attributable to its exempt activities (and not to activities of an unrelated trade or business as defined in section 513) during the data year are taken into account. If an entity to which this partial exclusion applies is a member of a controlled group, then the partial exclusion applies to that entity after first applying paragraph (a)(4)(i) on a pro rata basis to all members of the controlled group.

(b) *Determination of net premiums written*—(1) *In general*. The IRS will determine net premiums written for health insurance of United States health risks for each covered entity based on the Form 8963, ''Report of Health Insurance Provider Information,'' submitted by each covered entity, together with any other source of information available to the IRS. Other sources of information that the IRS may use to determine net premiums written for each

covered entity include the SHCE, which supplements the annual statement filed with the NAIC pursuant to State law, the annual statement itself or the Accident and Health Policy Experience filed with the NAIC, the MLR Annual Reporting Form filed with the Center for Medicare & Medicaid Services' Center for Consumer Information and Insurance Oversight of the U.S. Department of Health and Human Services, or any similar statements filed with the NAIC, with any State government, or with the Federal government pursuant to applicable State or Federal requirements.

(2) *Presumption for United States health risks.* For any covered entity that files the SHCE with the NAIC, the entire amount reported on the SHCE as direct premiums written will be considered to be for health insurance of United States health risks as described in § 57.2(n) (subject to any applicable exclusions for amounts that are not health insurance as described in § 57.2(h)(2)) unless the covered entity can demonstrate otherwise.

(c) *Determination of amounts taken into account.* (1) For each fee year and for each covered entity, the IRS will calculate the net premiums written for health insurance of United States health risks taken into account during the data year. The resulting number is the numerator of the fraction described in paragraph (d)(1) of this section.

(2) For each fee year, the IRS will calculate the aggregate net premiums written for health insurance of United States health risks taken into account for all covered entities during the data year. The resulting number is the denominator of the fraction described in paragraph (d)(2) of this section.

(d) *Allocated fee calculated.* For each covered entity for each fee year, the IRS will calculate the covered entity's allocated fee by multiplying the applicable amount from paragraph (a)(3) of this section by a fraction—

(1) The numerator of which is the covered entity's net premiums written for health insurance of United States health risks during the data year taken into account (described in paragraph (c)(1) of this section); and

(2) The denominator of which is the aggregate net premiums written for health insurance of United States health risks for all covered entities during the data year taken into account (described in paragraph (c)(2) of this section).

§ 57.5 Notice of preliminary fee calculation.

(a) *Content of notice.* Each fee year, the IRS will make a preliminary calculation of the fee for each covered entity as described in § 57.4. The IRS will notify each covered entity of its preliminary fee calculation for that fee year. The notification to a covered entity of its preliminary fee calculation will include—

(1) The covered entity's allocated fee;

(2) The covered entity's net premiums written for health insurance of United States health risks;

(3) The covered entity's net premiums written for health insurance of United States health risks taken into account after the application of § 57.4(a)(4);

(4) The aggregate net premiums written for health insurance of United States health risks taken into account for all covered entities; and

(5) Instructions for how to submit a corrected Form 8963, ''Report of Health Insurance Provider Information,'' to correct any errors through the error correction process.

(b) *Timing of notice.* The IRS will specify in other guidance published in the Internal Revenue Bulletin the date by which it will send each covered entity a notice of its preliminary fee calculation.

§ 57.6 Error correction process.

(a) *In general.* Upon receipt of its preliminary fee calculation, each covered entity must review this calculation during the error correction period. If the covered entity identifies one or more errors in its preliminary fee calculation, the covered entity must timely submit to the IRS a corrected Form 8963, ''Report of Health Insurance Provider Information,'' during the error correction period. The corrected Form 8963 will replace the original Form 8963 for all purposes, including for the purpose of determining whether an accuracy-related penalty applies, except that a covered entity remains subject

to the failure to report penalty if it fails to timely submit the original Form 8963. In the case of a controlled group, if the preliminary fee calculation for the controlled group contains one or more errors, the corrected Form 8963 must include all of the required information for the entire controlled group, including members that do not have corrections.

(b) *Time and manner*. The IRS will specify in other guidance published in the Internal Revenue Bulletin the time and manner by which a covered entity must submit a corrected Form 8963. The IRS will provide its final determination regarding the covered entity's submission no later than the time the IRS provides a covered entity with a final fee calculation.

(c) *Finality*. Covered entities must assert any basis for contesting their preliminary fee calculation during the error correction period. In the interest of providing finality to the fee calculation process, the IRS will not accept a corrected Form 8963 after the end of the error correction period or alter final fee calculations on the basis of information provided after the end of the error correction period.

§ 57.7 Notification and fee payment.

(a) *Content of notice*. Each fee year, the IRS will make a final calculation of the fee for each covered entity as described in § 57.4. The IRS will base its final fee calculation on each covered entity's original or corrected Form 8963, ''Report of Health Insurance Provider Information,'' as adjusted by other sources of information described in § 57.4(b)(1). The notification to a covered entity of its final fee calculation will include—

(1) The covered entity's allocated fee;

(2) The covered entity's net premiums written for health insurance of United States health risks;

(3) The covered entity's net premiums written for health insurance of United States health risks taken into account after the application of § 57.4(a)(4);

(4) The aggregate net premiums written for health insurance of United States health risks taken into account for all covered entities; and

(5) The final determination on the covered entity's corrected Form 8963, ''Report of Health Insurance Provider Information,'' if any.

(b) *Timing of notice*. The IRS will send each covered entity a notice of its final fee calculation by August 31st of the fee year.

(c) *Differences in preliminary fee calculation and final calculation*. A covered entity's final fee calculation may differ from the covered entity's preliminary fee calculation because of changes made pursuant to the error correction process described in § 57.6 or because the IRS discovered additional information relevant to the fee calculation through other information sources as described in § 57.4(b)(1). Even if a covered entity did not file a corrected Form 8963 described in § 57.6, a covered entity's final fee may differ from a covered entity's preliminary fee because of information discovered about that covered entity through other information sources. In addition, a change in aggregate net premiums written for health insurance of United States health risks can affect every covered entity's fee because each covered entity's fee is equal to a fraction of the aggregate fee collected from all covered entities.

(d) *Payment of final fee*. Each covered entity must pay its final fee by September 30th of the fee year. For a controlled group, the payment must be made using the designated entity's Employer Identification Number as reported on Form 8963. The fee must be paid by electronic funds transfer as required by § 57.6302–1. There is no tax return to be filed with the payment of the fee.

(e) *Controlled groups*. In the case of a controlled group that is liable for the fee, all members of the controlled group are jointly and severally liable for the fee. Accordingly, if a controlled group's fee is not paid, the IRS may separately assess each member of the controlled group for the full amount of the controlled group's fee.

§ 57.8 Tax treatment of fee.

(a) *Treatment as an excise tax*. The fee is treated as an excise tax for purposes of subtitle F (sections 6001–7874). Thus, references in subtitle F to ''taxes imposed by this title,'' ''internal revenue

tax,'' and similar references, are also references to the fee. For example, the fee is assessed (section 6201), collected (sections 6301, 6321, and 6331), enforced (section 7602), and subject to examination and summons (section 7602) in the same manner as taxes imposed by the Code.

(b) *Deficiency procedures*. The deficiency procedures of sections 6211–6216 do not apply to the fee.

(c) *Limitation on assessment*. The IRS must assess the amount of the fee for any fee year within three years of September 30th of that fee year.

(d) *Application of section 275*. The fee is treated as a tax described in section 275(a)(6) (relating to taxes for which no deduction is allowed).

§ 57.9 Refund claims.

Any claim for a refund of the fee must be made by the entity that paid the fee to the government and must be made on Form 843, ''Claim for Refund and Request for Abatement,'' in accordance with the instructions for that form.

§ 57.10 Applicability date.

(a) Except as provided in paragraphs (b) and (c) of this section, §§ 57.1 through 57.9 apply to any fee that is due on or after September 30, 2014.

(b) *Paragraphs (b)(3) and (c)(3)(ii) of § 57.2*. Paragraphs (b)(3) and (c)(3)(ii) of § 57.2 apply on February 22, 2018.

(c) Section 57.3(a)(2)(ii) applies to Forms 8963, including corrected Forms 8963, filed after December 31, 2019.

[T.D. 9711, 80 FR 10335, Feb. 26, 2015, as amended by T.D. 9830, 83 FR 8175, Feb. 26, 2018; T.D. 9881, 84 FR 61547, Nov. 13, 2019]

§ 57.6302–1 Method of paying the health insurance providers fee.

(a) *Fee to be paid by electronic funds transfer*. Under the authority of section 6302(a), the fee imposed on covered entities engaged in the business of providing health insurance for United States health risks under section 9010 and § 57.4 must be paid by electronic funds transfer as defined in § 31.6302–1(h)(4)(i) of this chapter, as if the fee were a depository tax. For the time for paying the fee, see § 57.7.

(b) *Effective/Applicability date*. This section applies with respect to any fee that is due on or after September 30, 2014.

PART 141—TEMPORARY EXCISE TAX REGULATIONS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

§ 141.4975–13 Definition of "amount involved" and "correction".

Until superseded by permanent regulations under sections 4975(f) (4) and (5), § 53.4941(e)–1 of this chapter (Foundation Excise Tax Regulations) will be controlling to the extent such regulations describe terms appearing both in section 4941(e) and section 4975(f). Because of the need for immediate guidance with respect to the provisions contained in this Treasury decision, it is found impracticable to issue it with notice and public procedure thereon under subsection (b) of section 553 of title 5 of the United States Code or subject to the effective date limitation of subsection (d) of that section.

(Sec. 7805 of the Internal Revenue Code of 1954 (68A Stat. 917; 26 U.S.C. 7805))

[T.D. 7425, 41 FR 32890, Aug. 6, 1976, as amended by T.D. 8084, 51 FR 16305, May 2, 1986]

PART 143—TEMPORARY EXCISE TAX REGULATIONS UNDER THE TAX REFORM ACT OF 1969

Sec.

143.1 [Reserved]
143.2 Taxes on self-dealing; scholarship and fellowship grants by private foundations.
143.3–143.4 [Reserved]
143.5 Taxes on self-dealing; indirect transactions by a private foundation.
143.6 Election to shorten the period during which certain excess business holdings of private foundations are treated as permitted holdings.

AUTHORITY: Sec. 7805, 68A Stat. 917; 26 U.S.C. 7805.

§ 143.1 [Reserved]

§ 143.2 Taxes on self-dealing; scholarship and fellowship grants by private foundations.

(a) *In general*. Section 4941(d)(1)(D) of the Internal Revenue Code of 1954 as added by section 101(b) of the Tax Reform Act of 1969 (83 Stat. 500) provides that the term ''self-dealing'' includes

any direct or indirect payment of compensation (or payment or reimbursement of expenses) by a private foundation to a disqualified person. Section 4941(d)(1)(E) provides that the term ''self-dealing'' includes any direct or indirect transfer to, or use by, or for the benefit of, a disqualified person of the income or assets of a private foundation.

(b) *Scholarship and fellowship grants.* A scholarship or fellowship grant to a person other than a Government official paid or incurred by a private foundation in accordance with a program which is consistent with the allowance of a deduction under section 170 for contributions made to such private foundation shall not constitute an act of self-dealing. For example, a scholarship or fellowship grant made by a private foundation in accordance with a program to award scholarship or fellowship grants to the children of employees of the donor shall not constitute an act of self-dealing if the private foundation has, after disclosure of the method of carrying out such program, received a ruling or determination letter stating that it is exempt from taxation under section 501(c)(3) and that contributions to the private foundation are deductible by the donor under section 170.

[T.D. 7030, 35 FR 4293, Mar. 10, 1970]

§§ 143.3–143.4 [Reserved]

§ 143.5 Taxes on self-dealing; indirect transactions by a private foundation.

(a) *In general.* Section 4941(d)(1)(D) of the Internal Revenue Code of 1954 as added by section 101(b) of the Tax Reform Act of 1969 (83 Stat. 500) provides that the term ''self-dealing'' includes any direct or indirect payment of compensation (or payment or reimbursement of expenses) by a private foundation to a disqualified person. Section 4941(d)(1)(E) provides that the term ''self-dealing'' includes any direct or indirect transfer to, or use by, or for the benefit of, a disqualified person of the income or assets of a private foundation. Section 4941(d)(1)(F) provides that the term ''self-dealing'' includes any direct or indirect agreement by a private foundation to make any payment of money or other property to a government official other than an agreement to employ such individual for any period after the termination of his government service if such individual is terminating his government service within a 90–day period.

(b) *Indirect transactions by a private foundation.* A transaction engaged in directly with a Government official by an organization described in section 509(a) (1), (2), or (3) which is the recipient of a grant from a private foundation shall not constitute an indirect act of self-dealing between such private foundation and Government official if the private foundation does not earmark the use of the grant for any named Government official and does not control or retain any veto power over the selection of the Government official by the grantee organization. For purposes of the preceding sentence, a grant by a private foundation shall not constitute an indirect act of self-dealing even though such foundation had reason to believe that certain Government officials would derive benefits from such grant so long as the grantee, in fact, exercises control over the selecting process and actually makes the selection completely independent of the private foundation.

(c) *Example.* The provisions of subsection (b) of this section may be illustrated by the following example.

Example. A private foundation made a grant to an organization described in section 509(a) (1), (2), or (3) to conduct a judicial seminar. The grantee conducting the seminar made payments to certain Government officials. By the nature of the seminar the grantor foundation had reason to believe that Government officials would be compensated for participation in such seminar. The grantee, however, had complete independent control over the selection of such participants. Since the grantee has not acted as a conduit for the private foundation and has, in fact, exercised independent control over the use of the grant, such grant by the private foundation shall not constitute an act of self-dealing with respect to the Government officials.

[T.D. 7036, 35 FR 6322, Apr. 18, 1970]

§ 143.6 Election to shorten the period during which certain excess business holdings of private foundations are treated as permitted holdings.

(a) *In general.* Under section 4943(c)(4)(B)(ii), where the combined holdings on May 26, 1969, of a private foundation and all disqualified persons in any one business enterprise exceed 75 percent of the voting stock or more than a 75 percent interest in the value of all outstanding shares of all classes of stock in such enterprise, and the foundation's holdings on such date do not exceed 95 percent of the voting stock in such enterprise, then such combined holdings must be reduced to 50 percent of the voting stock of such enterprise by the end of a 15–year period beginning on May 26, 1969. However, under section 4943(c)(4)(E), the 15–year period during which such combined holdings in the enterprise must be reduced to 50 percent is to be shortened to a 10–year period, referred to in section 4943(c)(4)(B)(iii), if, at any time before January 1, 1971, one or more individuals:

(1) Who are substantial contributors (as described in section 507(d)(2)) or members of the family within the meaning of section 4946(d) of one or more substantial contributors to such private foundation, and

(2) Who on May 26, 1969, held in aggregate more than 15 percent of the voting stock of the enterprise, make an election in the manner described in paragraph (b). If an individual who owns 15 percent or less of the voting stock of the enterprise wishes to make an election under this paragraph, he and one or more other individuals who together own more than 15 percent of the voting stock of the enterprise may join in making an election by together filing the statement referred to in paragraph (b) of this section.

(b) *Manner of making election.* The election referred to in paragraph (a) of this section is made by filing two copies of a written statement with the Office of the Assistant Commissioner (Technical), Internal Revenue Service, Washington, DC 20224.

(c) *Additional copies.* The individual filing the written statement referred to in paragraph (b) of this section shall submit a copy of the statement to the private foundation with respect to which the election is being made and to the management of such business enterprise.

(d) *Content of statement.* The statement shall indicate that an election is being made under section 4943(c) (4)(E) of the Code, and shall be signed by each of the individuals making the election, and, in addition shall contain the following information:

(1) The name, address, and taxpayer identification number of each of the individuals making the election;

(2) The name and address of the foundation with respect to which such election is being made;

(3) The name and address of the business enterprise with respect to which the election is being made;

(4) The aggregate number of shares of voting stock in the business enterprise that were held on May 26, 1969, by each individual making the election, and, in addition, the percentage that such voting stock is of the total number of shares of voting stock issued and outstanding on such date;

(5) The aggregate number of shares of voting stock in the business enterprise held by the private foundation on May 26, 1969, and, in addition, the percentage that such voting stock is of the total number of shares of voting stock issued and outstanding on such date; and

(6) The total number of shares of voting stock in the business enterprise or the best available estimate thereof, that were issued and outstanding on May 26, 1969.

(e) *Time for making election.* The statement referred to in paragraph (b) of this section shall be filed before January 1, 1971.

[T.D. 7038, 35 FR 6962, May 1, 1970]

PART 145—TEMPORARY EXCISE TAX REGULATIONS UNDER THE HIGHWAY REVENUE ACT OF 1982 (PUB. L. 97–424)

Sec.

145.4051–1 Imposition of tax on heavy trucks and trailers sold at retail.
145.4052–1 Special rules and definitions.
145.4061–1 Application to manufacturers tax.

AUTHORITY: 26 U.S.C. 7805.

Sections 145.4051–1 and 145.4052–1 also issued under 26 U.S.C. 4051 and 4052.

SOURCE: T.D. 7882, 48 FR 14362, Apr. 4, 1983, unless otherwise noted.

§ 145.4051–1 Imposition of tax on heavy trucks and trailers sold at retail.

(a) *Imposition of tax*—(1) *In general.* Section 4051(a)(1) imposes a tax on the first retail sale (as defined in § 145.4052–1(a)) of the following articles (including in each case parts or accessories therefor sold on or in connection therewith or with the sale thereof):

(i) Automobile truck chassis and bodies;

(ii) Truck trailer and semitrailer chassis and bodies; and

(iii) Tractors of the kind chiefly used for highway transportation in combination with a trailer or semitrailer.

A sale of an automobile truck, truck trailer or semitrailer, shall be considered to be a sale of a chassis and of a body enumerated in this paragraph (a)(1).

(2) *Special rule applicable to chassis and bodies.* A chassis or body enumerated in paragraph (a)(1) of this section is taxable under section 4051(a)(1) only if such chassis or body is sold for use as a component part of a highway vehicle (as defined in paragraph (d) of § 48.4061(a)–1 (Regulations on Manufacturers and Retailers Excise Taxes)), which is an automobile truck, truck trailer or semitrailer, or a tractor of the kind chiefly used for highway transportation in combination with a trailer or semitrailer. Furthermore, a chassis or body which is not enumerated in paragraph (a)(1) of this section is not taxable under section 4051(a)(1) even though such chassis or body is used as a component part of a highway vehicle (e.g., a chassis or body of a passenger automobile). See paragraphs (e)(1) and (e)(2) of this section for the definitions of a tractor and truck. See paragraphs (e) (1) through (5) of § 145.4052–1 for other provisions applicable to this section. See paragraph (f) of this section, relating to tax-free sales of non-highway vehicles.

(3) *Parts or accessories sold on or in connection with chassis, bodies, etc.* The tax applies in respect of parts or accessories sold on or in connection with or with the sale of the vehicles specified in section 4051(a)(1). Thus, for example, if at the time the article is sold by the retailer, the part or accessory has been ordered from the retailer, the part or accessory will be considered as sold in connection with and with the sale of the vehicle. The tax applies in such a case whether or not the parts or accessories are billed separately by the retailer. If a taxable chassis, body, or tractor is sold by the retailer, without parts or accessories which are considered equipment essential for the operation or appearance of the taxable article, the sale of such parts or accessories by the retailer to the purchaser of the taxable article will be considered, in the absence of evidence to the contrary, to have been made in connection with the sale of the taxable article even though they are shipped separately, at the same time or on a different date. For example, if a retailer sells to any person a chassis and the bumpers for such chassis, or sells a taxable tractor and the fifth wheel and attachments, the tax applies to such parts or accessories regardless of the method of billing or the time at which the shipments were made. Parts and accessories that are spares or replacements are not subject to tax.

(4) *Exclusions.* No tax is imposed by section 4051(a)(1) on the sale of automobile truck chassis and bodies, suitable for use with a vehicle which has a gross vehicle weight of 33,000 pounds or less, or truck trailer and semitrailer chassis and bodies, suitable for use with a trailer or semitrailer which has a gross vehicle weight of 26,000 pounds or less. For purposes of this paragraph (a)(4) the term *suitable for use* means practical and commercial fitness for such use. A chassis or body possesses practical fitness for use with a vehicle if it performs its intended function up to a generally acceptable standard of efficiency with the vehicle, and a chassis or body possesses commercial fitness for use with a vehicle if it is generally available for use with the vehicle at a price that is reasonably competitive with other articles that may be used for the same purpose. Thus, a truck chassis which is suitable for use with a vehicle having a gross vehicle

weight of 33,000 pounds or less, is not subject to the tax imposed by section 4051(a)(1) regardless of the body actually mounted thereon. A truck trailer or semitrailer chassis suitable for use with a vehicle having a gross vehicle weight of 26,000 pounds or less, is not subject to tax regardless of the body actually mounted thereon. Where an exempt body is mounted on a taxable chassis, or a taxable body is mounted on an exempt chassis, the taxable chassis or body, as the case may be, nevertheless remains subject to such tax, if the resulting vehicle is a highway vehicle as defined in § 48.4061(a)–1.

(b) *Rate of tax*. With respect to the articles enumerated in paragraph (a)(1) of this section, the rate of tax imposed by section 4051(a)(1) is 12 percent of the price for which the article is sold on or after April 1, 1983. See paragraph (d) of this section relating to vehicles on which a 10 percent tax was imposed under section 4061(a)(1).

(c) *Separate purchase of truck or trailer and parts and accessories therefor*—(1) *In general*. If the owner, lessee, or operator of any vehicle, which contains an article taxable under paragraph (a)(1) of this section, installs (or causes to be installed) any part or accessory on such vehicle, and such installation is not later than 6 months after the date such vehicle (as it contains such article) was first placed in service, section 4051(b)(1) imposes a tax on such installation equal to 12 percent of the price of such part or accessory and its installation. For purposes of the tax imposed by section 4051(b)(1) and this paragraph (c)(1) the term ''parts and accessories'' does not include those parts and accessories which were previously exempt from tax under sections 4061(b) (1) and (2) as in effect prior to January 7, 1983. Thus, for example, articles of general use are exempt from tax. See § 48.4061(b)–2 (b). See paragraphs (d) (1) through (4) of § 145.4052–1 for determination of price.

(2) *Placed in service*. For purposes of paragraph (c)(1) of this section, a vehicle shall be considered placed in service on the date on which the owner of the vehicle took actual possession of the vehicle. This date can be established by the delivery ticket signed by the owner or other comparable document indicating delivery to and acceptance by the owner.

(3) *Exceptions*. The tax imposed by section 4051(b)(1) and paragraph (c)(1) of this section shall not apply if:

(i) The part or accessory installed is a replacement part or accessory, or

(ii) The aggregate price of the parts and accessories (and their installation) described in paragraph (c)(1) of this section with respect to any vehicle does not exceed $200.

For purposes of paragraph (c)(3)(i) of this section, a part is a replacement part, regardless of when it is ordered, if its use with a vehicle is as a replacement for a part on such vehicle. For purposes of paragraph (c)(3)(ii) of this section, the term *aggregate price of parts and accessories (and their installation)* refers to all purchases and installation charges, not including replacement parts and accessories, made with respect to a vehicle within the 6 month period provided for in paragraph (c)(1) of this section. If the aggregate price of parts and accessories (and their installation) during the 6 month period exceeds $200, the tax imposed under section 4051(b)(1) and paragraph (c)(1) of this section shall apply to the cost of all parts and accessories (and their installation) during such period. For example, a vehicle is purchased and placed in service on July 1, 1983. On August 1, 1983, the owner purchases and has installed parts and accessories at a cost of $150. On September 1, 1983, the owner purchases and has installed parts and accessories at a cost of $300. On September 1, 1983 a tax of $54 will be imposed (12 percent × $450). Any costs of additional parts and accessories installed with respect to the vehicle before January 1, 1984 (and the cost of installation) will also be subject to the 12 percent tax.

(d) *Transitional rule*. In the case of an article taxable under paragraph (a)(1) of this section, on which a tax was imposed under section 4061(a)(1), the rate of tax set forth in paragraph (b) shall be applied by substituting ''2 percent'' for ''12 percent.'' For example, if a manufacturer sells a tractor to a dealer on February 1, 1983, for $20,000 (which includes the Federal excise tax), for which a 10 percent tax was paid, and the dealer sells the tractor on April 10,

1983 for $25,000, a tax of 2 percent will be imposed on the $25,000 sales price. See paragraphs (d) (1) through (4) of § 145.4052–1 relating to determination of price.

(e) *Definitions*. For purposes of this section:

(1) *Tractor*. (i) The term ''tractor'' means a highway vehicle primarily designed to tow a vehicle, such as a trailer or semitrailer, but does not carry cargo on the same chassis as the engine. A vehicle equipped with air brakes and/or towing package will be presumed to be primarily designed as a tractor.

(ii) An incomplete chassis cab shall be treated as a tractor if it is equipped with one or more of the following:

(A) A device for supplying pressure from the chassis cab to the brake system (air or hydraulic) of the towed vehicle;

(B) A mechanism for protecting the chassis cab brake system from the effects of a loss of pressure in the brake system of the towed vehicle;

(C) A control linking the brake system of the chassis to the brake system of the towed vehicle;

(D) A control in the cab for operating the towed vehicle's brakes independently of the chassis cab's brakes; or

(E) Any other equipment designed to make it suitable for use as a tractor.

An incomplete chassis cab which is not equipped with any of the devices set forth in paragraphs (e)(1)(ii) (A) through (E) of this section shall be treated as a truck if the purchaser certifies in writing that the vehicle will not be equipped for use as a tractor.

(2) *Truck*. The term ''truck'' refers to a highway vehicle that is primarily designed to transport its load on the same chassis as the engine even if it is also equipped to tow a vehicle, such as a trailer or semitrailer.

(3) *Gross vehicle weight*. (i) For purposes of this section the term ''gross vehicle weight'' means the maximum total weight of a loaded vehicle. Except as otherwise provided in paragraphs (e)(3) (ii) through (v) of this section, such maximum total weight shall be the gross vehicle weight rating of the article as specified by the manufacturer or established by the seller of the completed article, unless the Commissioner finds that such rating is unreasonable in light of the facts and circumstances in a particular case.

(ii) A seller must specify or establish a weight rating for each chassis, body, or vehicle sold on or after April 1, 1983 if such article requires no additional manufacture other than (A) the addition of readily attachable articles, such as tire or rim assemblies or minor accessories, (B) the performance of minor finishing operations, such as painting, or (C) in the case of a chassis, the addition of a body. If an article is specially equipped to the purchaser's specifications, such specifications may be used to establish the gross vehicle weight of the article.

(iii) A seller shall maintain a record of the gross vehicle weight rating of each truck, trailer and semitrailer sold and excluded from the tax imposed by section 4051(a)(1) by reason of sections 4051(a) (2), (3) and paragraphs (e)(3) (i) through (v) of this section. For this purpose, a record of the serial number of each such article shall be treated as a record of the gross vehicle weight rating of the article if such rating is indicated by the serial number.

(iv) If (A) the seller's rating indicated in a label or identifying device affixed to an article, (B) the rating set forth in the sales invoice or warranty agreement, and (C) the advertised rating for that article (or two or more identical articles) are inconsistent, the highest of such ratings will be considered to be the seller's gross vehicle weight rating specified or established for purposes of the tax imposed by section 4051(a)(1).

(v) The seller's gross vehicle weight rating must take into account, among other things, the strength of the chassis frame and the axle capacity and placement. The Commissioner may exclude from the gross vehicle weight rating any readily attachable parts to the extent the Commissioner finds that the use of such parts in computing the gross vehicle weight rating is unreasonable.

(f) *Tax-free sales*. With respect to tax-free sales of a chassis or body for use as a component of a vehicle other than a highway vehicle, similar provisions to paragraphs (e)(2) (ii), (iii), and (iv) of § 48.4061(a)–1 shall apply.

(g) *Effective date*. The provisions of this section shall be effective for articles sold on or after April 1, 1983.

[T.D. 7882, 48 FR 14362, Apr. 4, 1983, as amended by T.D. 8879, 65 FR 17164, Mar. 31, 2000]

§ 145.4052–1 Special rules and definitions.

(a) *First retail sale*—(1) *General rule*. For purposes of section 4051(a)(1) and § 145.4051–1, the term ''first retail sale'' means a taxable sale described in paragraph (a)(2) of this section.

(2) *Taxable sale*. The sale of an article is a taxable sale unless—

(i) The sale is a tax-free sale under section 4221,

(ii) [Reserved]. For sales after June 30, 1998, see § 48.4052–1 of this chapter.

(iii) There has been a prior taxable sale of the article. Notwithstanding the preceding clause, the sale of a chassis or body of a trailer or semitrailer (''trailer or semitrailer'') less than six months after a taxable sale of the article shall be treated as a taxable sale.

(3) *Computation of tax*—(i) *In general*. If the sale of an article is a taxable sale under paragraph (a)(2) of this section, the tax shall be computed on the price as determined under paragraph (d) of this section.

(ii) *Exception*. If the taxable sale of an article is a taxable use of such article under paragraph (c) of this section, the tax shall be computed on the price as determined under paragraph (c) of this section.

(4) *Special rule for tax-paid trailer and semitrailer*. In the case of a taxable sale of a trailer or semitrailer less than six months after a taxable sale of the article, the seller in the subsequent sale (''the subsequent seller'') may claim a credit equal to the amount of tax previously paid by another person (''the previous taxpayer'') under section 4051(a)(1) with respect to the prior taxable sale of the article. The credit for such tax will be allowed to the subsequent seller only if the form on which the credit is claimed is accompanied by a statement, signed by the subsequent seller, indicating the amount of the credit being claimed under this paragraph (a)(4) and stating that—

(i) The subsequent seller has not been repaid any portion of such tax by the previous taxpayer,

(ii) The subsequent seller has not provided the previous taxpayer with written consent to allow the previous taxpayer to claim a credit or refund of such tax under section 6416 (a), and

(iii) The subsequent seller has records (e.g., invoices) substantiating the amount of tax paid by the previous taxpayer with respect to the prior taxable sale of such article.

In no case shall the amount of the credit allowable under this paragraph (a)(4) with respect to an article exceed the tax liability of the subsequent seller with respect to the sale of such article.

(5) *No installment payments of tax*. If a lease or an installment sale (or another form of sale under which the sales price is paid in installments) is, or is deemed to be, a taxable sale under this section, then the liability for the entire tax arises at the time of the lease or installment sale. No portion of the tax is deferred by reason of the fact that the sales price is paid in installments.

(6) *Certificate*. A certificate signed by the purchaser, or an officer or employee authorized by the purchaser to sign the certificate, may be accepted by a seller in support of a nontaxable sale to the purchaser. If it is impracticable to furnish a separate certificate for each sale because of the frequency of sales to such purchaser, a certificate covering all orders between given dates (such period not to exceed 12 calendar quarters) will be acceptable. The purchaser may revoke the certificate by sending a written revocation to the seller. The certificate and proper records of invoices, orders, etc., relating to sales made pursuant to such certificate, must be retained by the seller as provided in section 6001 and the regulations thereunder. The certificate shall be substantially in the following form:

EXEMPTION CERTIFICATE

I hereby certify that I am _____ (Title) of _____, (Name of purchaser) that I am authorized to execute this certificate, and that:

(Check appropriate line)

_____ the article or articles specified in the accompanying order, or on the reverse side hereof, (or)

_____ all orders placed by the purchaser for the period commencing _____ (Date)

(period not to exceed 12 calendar quarters), are purchased either for resale or for lease on a long-term basis.

I have filed Form 637 and have received registration number _____.

I understand that the fraudulent use of this certificate to secure exemption will subject me and all parties making such fraudulent use to a fine of not more than $10,000, or to imprisonment for not more than 5 years, or both, together with costs of prosecution.

_____

(Signature)

_____

(Address)

(b) *Tax treatment of leases*—(1) *Long-term lease*. For purposes of this section and § 145.4051–1, the leasing of an article on a long-term basis (as defined in paragraph (d)(6) of this section) will be deemed to be a sale of the article and will be deemed to be a taxable sale unless one of the exceptions contained in paragraph (a)(2) of this section applies. Thus, if a dealer purchases an article tax-free under an exception contained in paragraph (a)(2) of this section and then leases the article on a long-term basis, the leasing of the article will be treated as a taxable sale.

(2) *Short-term lease*. For purposes of this section and § 145.4051–1, the leasing of an article on a short-term basis (as defined in paragraph (d)(6) of this section) will be deemed to be a taxable use of such article under paragraph (c) of this section and will be deemed to be a taxable sale unless one of the exceptions contained in paragraph (a)(2) of this section applies.

(3) *Computation of tax*—(i) *Long-term lease by manufacturer, producer, or importer*. When a manufacturer, producer, or importer is the lessor of an article on a long-term basis (as defined in paragraph (d)(6) of this section) and such lease is deemed to be a taxable sale under paragraph (b)(1) of this section, the tax shall be computed on a presumptive retail sales price as determined under paragraph (d)(4)(i) of this section. The manufacturer, producer, or importer shall be liable for the tax as if the article were sold at retail by such manufacturer, importer, or retailer.

(ii) *Long-term lease by persons other than manufacturer, producer, or importer*. When a person other than a manufacturer, producer, or importer is the lessor of an article on a long-term basis (as defined in paragraph (d)(6) of this section) and such lease is deemed to be a taxable sale under paragraph (b)(1) of this section, the tax shall be computed on a presumptive retail sales price as determined under paragraph (d)(5) (i) of this section. Such person shall be liable for the tax as if the article were sold at retail by such person.

(c) *Use treated as sale*—(1) *In general*. For purposes of this section and § 145.4051–1, the use of an article will be deemed to be a sale of the article. Furthermore, if a person purchases a vehicle for which no tax was imposed under section 4051(a)(1) and thereafter converts such vehicle into an article which would have been taxable under section 4051(a)(1) and uses it, such person shall be liable for the tax as if such article were sold at retail by such person. For example, a truck having a gross vehicle weight rating of 24,000 pounds is sold at retail. The purchaser adds a lift axle, thereby increasing the gross vehicle weight rating to 34,000 pounds. If the purchaser thereafter uses the vehicle the purchaser shall be liable for the tax as if such article were sold at retail.

(2) *Exemption for use in further manufacture*. The tax on the use of an article to which paragraph (c)(1) of this section applies shall not apply to use of the article by such person as material in the manufacture or production of, or as a component part of, another article to be manufactured or produced by the same user.

(3) *Time of application of tax*. In the case of taxable use of an article by the seller, the tax attaches at the time such use begins. It tax applies by reason of the sale of an article on or in connection with, or with the sale of another article, the tax attaches at the time of the sale of such other article.

(4) *Events subsequent to taxable use of article*. Liability for tax incurred on the use of an article is not extinguished or reduced because of any subsequent sale or lease of the article even if such sale or lease would have been exempt if the article had been sold or leased prior to use. If a seller of an article incurs liability for tax on his or her use of an article, and thereafter sells or leases the article in a transaction which otherwise would be subject to tax, liability

for tax is not incurred on such sale or lease.

(5) *Computation of tax.* (i) Except as provided in paragraphs (c)(5)(ii) and (c)(5)(iii) of this section.

(ii) If the seller of an article regularly sells such articles at retail in arm's length transactions, tax liability on its use of any such article shall be computed on its lowest established retail price for such articles in effect at the time of the taxable use. In establishing such price, there shall be included and excluded, as applicable, the charges and readjustments specified in sections 4216(a), 4216(f), and 6416(b)(1) as in effect at the time the tax liability on the use of the article is incurred. If the seller of an article does not regularly sell such articles at retail in arm's length transactions, a constructive price on which the tax shall be computed will be determined by the Commissioner. This price will be established after considering the selling practices and price structures of sellers of similar articles.

(iii) In the case of any short-term lease (as defined in paragraph (d)(6) of this section) by any person other than a manufacturer, producer, or importer (or related person as defined in paragraph (d)(2)(ii) of this section) of an article that is deemed to be a taxable use of such article under paragraph (b)(2) of this section, the tax imposed by section 4051(a)(1) shall be computed on a price equal to the sum of—

(A) The price (as determined under paragraph (d) of this section) at which such article was sold to the lessor plus the cost of any parts and accessories installed by the lessor (or an agent of the lessor) on such article before the first use or lease by the lessor, plus

(B) The product of the sum described in paragraph (c)(5)(iii)(A) of this section and the presumed markup percentage (as defined in paragraph (d)(7) of this section).

(d) *Determination of price*—(1) *In general.* The price for which an article is sold includes the total consideration paid for the article whether that consideration is paid in money, services, or other forms. In addition, there shall be included any charge incident to placing the article in condition ready for use. Similar rules to section 4216(a) and the regulations thereunder, relating to charges to be included in the price and excluded from the price, shall apply. For example, charges for transportation, delivery, insurance, and installation (other than installation charges to which section 4051(b) applies), and other expenses actually incurred in connection with the delivery of an article to a purchaser pursuant to a bona fide sale shall be excluded from the price in computing the tax.

(2) *Presumptive retail sales price where tax paid by manufacturer, producer, or importer*—(i) *In general.* In the case of a taxable sale (other than a taxable sale described in paragraph (b)(1) of this section) where a manufacturer, producer, importer, or related person is liable for the tax imposed by section 4051, such tax shall be computed on a price equal to the sum of—

(A) The price that would (but for this paragraph (d)(2)) be determined under this paragraph (d), and

(B) The product of the price determined under paragraph (d)(2)(i)(A) of this section and the presumed markup percentage (as defined in paragraph (d)(7) of this section).

(ii) *Related person defined*—(A) *In general.* Except as provided in paragraph (d)(2)(ii)(B) of this section, the term ''related person'' means any person that is a member of the same controlled group (within the meaning of section 5061(e)(3)) as the manufacturer, producer, or importer.

(B) *Exception for permanent retail establishment.* A person shall not be treated as a related person with respect to the sale of any article if—

(*1*) Such person sells the article through a permanent retail establishment in the normal course of business of being a retailer, and

(*2*) Such person has records (e.g., invoices) that substantiate that the article was sold for a price that included a markup equal to or greater than the presumed markup percentage (as defined in paragraph (d)(7) of this section).

(3) *Retail sales price where tax paid by person other than a manufacturer, producer, importer, or related person*—(i) *In general.* In the case of a taxable sale (other than a taxable sale defined in paragraph (b)(1) of this section) where

a person other than a manufacturer, producer, importer, or related person is liable for the tax imposed by section 4051, such tax shall be computed on a price determined under paragraph (d)(1) of this section.

(ii) *Exception*. When a person other than a manufacturer, producer, importer, or related person is liable for the tax imposed by section 4051, such tax shall be computed on a price determined under paragraph (d)(2)(i) of this section if—

(A) Such person does not perform any significant activities relating to the processing of the sale of an article,

(B) The principal purpose for processing the sale through such person is to avoid or evade the presumed markup under paragraph (d)(2)(i)(B) of this section, and

(C) Such person does not have records (e.g., invoices) substantiating that the article was sold for a price that included a markup equal to or greater than the presumed markup percentage as defined in paragraph (d)(7) of this section.

(4) *Presumptive retail sales price in the case of a lease by a manufacturer, producer, or importer*. In the case of any long-term lease (as defined in paragraph (d)(6) of this section) by a manufacturer, producer, importer, or a related person (as defined in paragraph (d)(2)(ii) of this section) of an article that is deemed to be a taxable sale of such article under paragraph (b)(1) of this section, the tax imposed by section 4051(a)(1) shall be computed on a price equal to the sum of—

(i) A constructive sales price established by the Commissioner based on the price at which such article would be sold by a manufacturer, producer, or importer in a sale other than a taxable sale (e.g., a sale to which the exceptions contained in paragraph (a)(2)(ii) of this section applies) on the date the lease is made, and

(ii) The product of the constructive sales price referred to in paragraph (d)(4)(i) of this section and the presumed markup percentage as defined in paragraph (d)(7) of this section.

(5) *Presumptive retail sales price in the case of a long-term lease by any other person*. In the case of any long-term lease (as defined in paragraph (d)(6) of this section) of an article in which any person other than a manufacturer, producer, or importer (or related person as defined in paragraph (d)(2)(ii) of this section) is the lessor and the long-term lease is deemed to be a taxable sale of such article under paragraph (b)(1) of this section, the tax imposed by section 4051(a)(1) shall be computed on a price equal to the sum of—

(i) The price (as determined under this paragraph (d)) at which such article was sold to the lessor plus the cost of any parts and accessories installed by the lessor (or an agent of the lessor) on such article before the first use by the lessee or leased in connection with such long-term lease, and

(ii) The product of the sum described in paragraph (d)(5)(i) of this section and the presumed markup percentage as defined in paragraph (d)(7) of this section.

(6) *Long-term and short-term lease defined*. For purposes of this section, the term ''long-term lease'' means any lease with a term of one year or more. The term ''short-term lease'' means any lease with a term of less than one year. In determining a lease term, options to renew shall be taken into account. In addition, two or more successive leases that are part of the same transaction (or a series of related transactions) with respect to the same or substantially similar article, shall be treated as one lease.

(7) *Presumed markup percentage*—(i) *In general*. Except as provided in paragraph (d)(7)(ii) of this section, for purposes of this section the term ''presumed markup percentage'' shall be four percent.

(ii) *Exceptions*. For purposes of this section the ''presumed markup percentage'' for trailers, semitrailers, and remanufactured automobile truck chassis and bodies and tractors shall be zero percent. For purposes of this section an article is a remanufactured article if—

(A) The refurbishing, renovation, or repair of the article causes it to be subject to the tax imposed by section 4051, and

(B) Before remanufacture, such article was previously subject to the tax imposed by section 4051 (or section 4061 prior to its repeal).

(8) *Items excluded from price.* There shall be excluded from the price:

(i) The amount of tax imposed under sections 4051(a)(1) and (b)(1);

(ii) If stated as a separate charge, the amount of any retail sales tax imposed by any state or political subdivision thereof or the District of Columbia, whether the liability for such tax is imposed on the vendor or vendee; and

(iii) The fair market value (including any tax imposed by section 4071) at retail of any tires (not including any metal rim or rim base). For purposes of this paragraph (d)(8)(iii), fair market value at retail shall be determined by the lowest established price for which the vehicle retailer would sell such tires at retail in the ordinary course of trade. The lowest established price is the lowest price for which the vehicle retailer sells, or offers to sell, a single tire to an independent purchaser who would not ordinarily be expected to buy more than one. If the vehicle retailer has no lowest established price the Commissioner will accept any price provided, under the facts and circumstances, such price is not unreasonable. For vehicles sold on or after April 1, 1983, and before October 13, 1985, a price will not be considered unreasonable if it is no more than an amount equal to 50 percent of the manufacturer's suggested retail price.

(9) *Trade-ins.* If, in connection with the sale of an article subject to the tax imposed under section 4051(a)(1) or (b)(1) on the price for which sold, a vendor receives from its vendee another article in exchange, the tax on the vendor's sale shall be computed on the basis of the full price of the article sold, unreduced by any amount allowed for the article received from the vendee. For example, where a vehicle costing $20,000 is purchased for $16,000 cash plus a used vehicle valued at $4,000, tax is $2,400 (12 percent × $20,000).

(10) *Sales not at arm's length.* For purposes of § 145.4051–1 and this section, a sale is considered to be made under circumstances otherwise than at ''arm's length'' if:

(i) One of the parties is controlled (in law or in fact) by the other, or there is common control, whether or not such control is actually exercised to influence the sale price, or

(ii) The sale is made pursuant to special arrangements between a seller and a purchaser.

In the case of an article sold otherwise than at arm's length, and sold at less than the fair market price, the tax imposed under section 4051(a)(1) or (b)(1) shall be computed on the price for which similar articles are sold at retail in the ordinary course of trade, as determined by the Commissioner. Once such a price has been determined, no further adjustment of such price shall be made.

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

Example 1. M manufactures trucks that are taxable under section 4051. On July 11, 1988, D, a corporation that is a dealer, purchases one truck from M for $50,000. M does not own any stock in D. Prior to this transaction, D gave M a certificate that meets the specifications detailed in paragraph (a)(6) of this section. The certificate states that the truck will be resold or leased on a long-term basis. M's sale to D is not a taxable sale of the truck (within the meaning of paragraph (a)(2) of this section). On July 20, 1988, D resells the truck to a purchaser, P, for $52,000. The additional $2,000 includes the dealer's mark-up, costs of transporting the truck from M to D, and overhead. No parts or accessories were added to the truck. P did not give D a certificate and did not have an agreement with D under which all vehicles purchased were to be resold. The sale of the truck by D to P is a taxable sale within the meaning of paragraph (a)(3) of this section. Therefore, D has a tax liability of $6,240 (12% × $52,000).

Example 2. Assume the same facts as in example (1) except that M owns 80 percent of D's stock. D and M are members of the same controlled group (within the meaning of section 5061(e)(3)). Therefore, D is a related person under paragraph (d)(2)(ii)(A) of this section. On July 20, 1988, D sells the truck to P for $51,000. D does not have records substantiating that the truck was sold for a price that included a markup equal to or greater than the presumed markup percentage. The tax on the sale of the truck to P is determined under paragraph (d)(2)(i) of this section. Therefore, D has a tax liability of $6,240 [(12% × ($50,000 + ($50,000 × 4%))].

Example 3. Assume the same facts as in example (1) except that D does not perform any significant activities relating to the sale. Assume further that the principal purpose for processing the sale through D is to avoid the presumed markup and that D did not sell the truck for a price that included a markup

equal to or greater than the presumed markup percentage. D, however, is designated the seller of the truck on the invoice. Pursuant to paragraph (d)(3)(ii) of this section, the price of the truck shall be computed on a price determined under paragraph (d)(2)(i). Therefore, D, the taxpayer, has a tax liability of $6,240 [12% × ($50,000 + ($50,000 × 4%))].

Example 4. Assume the same facts as in example (1) except that on July 20, 1988, D leases the truck for a two-year period (*i.e.*, on a long-term basis) to L, a lessee. D's leasing of the truck to L is treated as a taxable sale under paragraph (b)(1) of this section and the tax is computed on the price as determined under paragraph (d)(5)(i) of this section. D has a tax liability of $6,240 [12% × ($50,000 + ($50,000 × 4%))].

Example 5. Assume the same facts as in example (1) except that on July 20, 1988. D leases the truck to L for a six-month period (*i.e.*, a short-term lease). The lease is treated as a use under paragraph (b)(2) of this section. The tax is computed on the price as determined under paragraph (c)(5) of this section. D has a tax liability of $6,240 [12% × ($50,000 + ($50,000 × 4%))].

Example 6. Assume the same facts as in example (1) except that D does not give M a certificate. The sale by M to D is a taxable sale of the truck under paragraph (a)(2) of this section. M's tax liability is $6,240 [12% × ($50,000 + ($50,000 × 4%))]. On July 20, 1988, D leases the truck to L, a lessee. The lease has a two-year term. Since the lease to L occurred after a taxable sale of the truck, paragraph (b)(1) of this section does not apply, and the lease is not treated as a taxable sale under this section.

Example 7. M manufactures trucks that are taxable under section 4051. On July 11, 1988, M leases a truck to a lessee, L. The lease has a two-year term. The lease is treated as a taxable sale under paragraph (b)(1) of this section and the tax is computed on the price as determined under paragraph (d)(4)(i) of this section. The constructive sales price established by the Commissioner, pursuant to paragraph (d)(4)(i) of this section, is $50,000. M has a tax liability of $6,240 [12% × ($50,000 + ($50,000 × 4%))].

Example 8. Assume the same facts as in example (7) except that the lease has a six-month term. The lease is treated as a taxable use under paragraph (b)(2) of this section and the tax is computed under paragraph (c)(5) of this section. The constructive sales price established by the Commissioner, pursuant to paragraph (c)(5)(i) of this section, is $52,000. M has a tax liability of $6,240 (12% × $52,000).

Example 9. M manufactures truck trailers and semitrailers that are taxable under section 4051. On July 5, 1988, D, a dealer, purchases a trailer from M for $10,000. Prior to this transaction, D did not give M a certificate and D did not have an agreement with M to resell all articles purchased. The sale by M to D is a taxable sale of the trailer under paragraph (a)(2) of this section. M has a tax liability of $1,200 (12% × $10,000 + ($10,000 × 0%)).

Example 10. Assume the same facts as in example (9) except that on July 12, 1988, D resells the trailer to P, a purchaser, for $10,500 (the additional $500 includes the dealer's markup, costs of transporting the trailer from M to D, and overhead). P did not give D a certificate and P did not have an agreement with D that stipulates that all articles purchased were to be leased on a long-term basis or resold. The sale of the trailer by D to P is a taxable sale within the meaning of paragraph (a)(3) of this section. Therefore, D has a tax liability of $1,260(12% × $10,500). D, however, may file for a credit of $1,200 under section 6402 provided that the requirements of paragraph (a)(4) of this section are met.

(f) *Other rules made applicable.* For purposes of § 145.4051–1 and this section, rules similar to the following provisions shall apply:

(1) Section 48.0–2, relating to general definitions and attachment of tax;

(2) Paragraphs (a) (2) and (3) of § 48.4061 (a)–1;

(3) The exemptions provided by sections 4063 (a) and (d) and the regulations thereunder;

(4) Section 4216(f) and the regulations thereunder, relating to the incorporation of used components; and

(5) Section 4221 and the regulations thereunder, relating to certain tax-free sales.

(g) *Effective date*—(1) *In general.* Except as provided below, the provisions of this section shall be effective for articles sold or leased on or after April 1, 1983.

(2) *Certain sales made prior to November 12, 1985.* If a sale to a lessor before November 12, 1985, was not taxable under § 145.4052–1 of the temporary regulations contained in 26 CFR part 145 revised as of April 1, 1983, (the ''prior regulations'') and it was so treated by the parties, a subsequent sale or lease that was or would have been treated as the first retail sale of the article under the prior regulations will be treated as a taxable sale for purposes of this section. The tax on such subsequent sale will be based on a price determined under paragraph (d) of this section. For example, if an article was sold to a purchaser who intended to lease such article long-term, the sale would not have

been taxable under the prior regulations even though the seller did not receive a certificate of the purchaser's intent to lease the vehicle. If such a sale was treated as nontaxable by the parties, and the purchaser leases it long-term on or after October 1, 1987, the lease will be treated as a taxable sale of the article. The tax is to be computed under paragraph (b)(3)(ii) of this section and the price will be computed under paragraph (d)(5).

(3) *Certain sales made after November 11, 1985, and before October 1, 1987*—(i) *Sales not treated as taxable by purchaser and seller*. If a sale to a purchaser after November 11, 1985, and before October 1, 1987, was not treated as taxable by the parties, a subsequent sale or lease that was or would have been treated as the first retail sale of the article under the temporary regulations published in the September 13, 1985, issue of the FEDERAL REGISTER (50 FR 37350) (''the interim regulations'') will be treated as a taxable sale for purposes of this section. The tax on a sale or lease after September 30, 1987, will be based on a price determined under paragraph (d) of this section. For example, if a vehicle was sold on January 3, 1987, to a purchaser who intended to resell the article and who was not in the business of leasing to any extent, the sale would not have been taxable under the interim regulations even though the seller did not receive a certificate indicating the purchaser's intent to resell the article. If such a sale was not treated as a taxable sale by the parties, and the purchaser resells the article, the resale will be treated as a taxable sale of the article under paragraph (a)(2) of this section.

(ii) *Sales treated as first retail sale by purchaser and seller*. If the sale of an article after November 11, 1985, and before October 1, 1987, was treated as a taxable sale by the parties and tax was paid with respect to the article under the interim regulations, the subsequent sale of the article by the purchaser will not be treated as a taxable sale under paragraph (a)(2) of this section.

[T.D. 7882, 48 FR 14362, Apr. 4, 1983, as amended by T.D. 8050, 50 FR 37351, Sept. 13, 1985; T.D. 8200, 53 FR 16869, May 12, 1988; T.D. 8774, 63 FR 35804, July 1, 1998; T.D. 8879, 65 FR 17164, Mar. 31, 2000]

§ 145.4061–1 Application to manufacturers tax.

The provisions of § 145.4051–1(e) (1) and (2), relating to the definition of tractors and trucks, shall apply to section 4061(a)(1) for sales made on or after January 7, 1983. However, an incomplete chassis cab will be treated as a truck chassis for sales made on or after January 7, 1983, and before April 1, 1983. For purposes of section 4061, gross vehicle weight shall be determined under § 48.4061(a)–1(f)(3) (i) through (iv) for sales made on or after January 7, 1983, and before April 1, 1983.

PARTS 151–155 [RESERVED]

PART 156—EXCISE TAX ON GREENMAIL

Subpart A—Tax on Greenmail

Sec.
156.5881–1 Imposition of excise tax on greenmail.

Subpart B—Procedure and Administration

156.6001–1 Notice or regulations requiring records, statements, and special returns.
156.6011–1 General requirement of return, statement, or list.
156.6060–1 Reporting requirements for tax return preparers.
156.6061–1 Signing of returns and other documents.
156.6065–1 Verification of returns.
156.6071–1 Time for filing returns relating to greenmail.
156.6081–1 Automatic extension of time for filing a return due under chapter 54.
156.6091–1 Place for filing chapter 54 (Greenmail) tax returns.
156.6091–2 Exceptional cases.
156.6107–1 Tax return preparer must furnish copy of return and claim for refund to taxpayer and must retain a copy or record.
156.6109–1 Tax return preparers furnishing identifying numbers for returns or claims for refund.
156.6151–1 Time and place for paying of tax shown on returns.

156.6161–1 Extension of time for paying tax or deficiency.
156.6165–1 Bonds where time to pay tax or deficiency has been extended.
156.6694–1 Section 6694 penalties applicable to tax return preparer.
156.6694–2 Penalties for understatement due to an unreasonable position.
156.6694–3 Penalty for understatement due to willful, reckless, or intentional conduct.
156.6694–4 Extension of period of collection when tax return preparer pays 15 percent of a penalty for understatement of taxpayer's liability and certain other procedural matters.
156.6695–1 Other assessable penalties with respect to the preparation of tax returns or claims for refund for other persons.
156.6696–1 Claims for credit or refund by tax return preparers.
156.7701–1 Tax return preparer.

AUTHORITY: 26 U.S.C. 6001, 6011, 6061, 6071, 6091, 6161, and 7805.

Section 156.6060–1 also issued under 26 U.S.C. 6060(a);

Section 156.6081–1 also issued under 26 U.S.C. 6081(a);

Section 156.6109–1 also issued under 26 U.S.C. 6109(a);

Section 156.6109–2 also issued under 26 U.S.C. 6109(a);

Section 156.6695–1 also issued under 26 U.S.C. 6695(b).

SOURCE: T.D. 8379, 56 FR 65685, Dec. 18, 1991, unless otherwise noted.

Subpart A—Tax on Greenmail

§ 156.5881–1 Imposition of excise tax on greenmail.

(a) *In general.* Section 5881 of the Code imposes a tax equal to 50 percent of the gain or other income realized by any person on the receipt of greenmail, whether or not the gain or other income is recognized.

(b) *Transactions occurring on or after March 31, 1988.* For transactions occurring on or after March 31, 1988, greenmail is defined as any consideration transferred by a corporation (or any person acting in concert with the corporation) to directly or indirectly acquire stock of the corporation from any shareholder if:

(1) The transferring shareholder has held the stock (as determined under section 1223) for less than two years before entering into the agreement to transfer the stock,

(2) The shareholder, any person acting in concert with the shareholder, or any person related to the shareholder or to a person acting in concert with the shareholder made or threatened to make a public tender offer for stock of the corporation at some time during the two-year period ending on the date of the acquisition of the stock by the corporation, and

(3) The acquisition is pursuant to an offer that was not made on the same terms to all shareholders.

(c) *Transactions occurring before March 31, 1988.* For transactions occurring before March 31, 1988, greenmail has the same meaning as in paragraph (b) of this section, except that it does not include any consideration transferred by any person acting in concert with the corporation described in that paragraph.

(d) *Effective date.* Generally, section 5881 of the Code applies to consideration received after December 22, 1987, in taxable years ending after that date. However, section 5881 does not apply to any acquisition of stock pursuant to a written binding contract in effect on December 15, 1987, and at all times thereafter before the acquisition.

Subpart B—Procedure and Administration

§ 156.6001–1 Notice or regulations requiring records, statements, and special returns.

(a) *In general.* Any person subject to tax under chapter 54 (Greenmail) of the Code shall keep such complete and detailed records as are sufficient to enable the district director to determine accurately the amount of liability under chapter 54.

(b) *Notice by district director requiring returns, statements, or the keeping of records.* The district director may require any person, by notice served upon him, to make such returns, render such statements, or keep such specific records as will enable the district director to determine whether or not the person is liable for tax under chapter 54 of the Code.

(c) *Retention of records.* The records required by this section shall be kept at all times available for inspection by authorized internal revenue officers or

employees, and shall be retained so long as the contents thereof may become material in the administration of any internal revenue law.

[T.D. 8379, 56 FR 65685, Dec. 18, 1991; 57 FR 5931, Feb. 18, 1992]

§ 156.6011–1 General requirement of return, statement, or list.

Every person liable for tax under section 5881 of the Code shall file a return with respect to the tax on the form prescribed by the Internal Revenue Service (Form 8725). Each such person shall include therein the information required by the form and the instructions issued with respect thereto.

§ 156.6060–1 Reporting requirements for tax return preparers.

(a) *In general.* A person that employs one or more tax return preparers to prepare a return or claim for refund under section 5881 of the Internal Revenue Code, other than for the person, at any time during a return period, shall satisfy the record keeping and inspection requirements in the manner stated in § 1.6060–1 of this chapter.

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

[T.D. 9436, 73 FR 78461, Dec. 22, 2008]

§ 156.6061–1 Signing of returns and other documents.

Any return, statement, or other document required to be made with respect to a tax imposed by chapter 54 (Greenmail) of the Code or the regulations thereunder shall be signed by the person required to file the return, statement, or other document, or by the persons required or duly authorized to sign in accordance with the regulations, forms, or instructions prescribed with respect to such return, statement, or document. An individual's signature on such a return, statement, or other document shall be prima facie evidence that the individual is authorized to sign the return, statement, or other document.

§ 156.6065–1 Verification of returns.

If a return, statement, or other document made under the provisions of chapter 54 (Greenmail) or of subtitle F of the Code, or the regulations thereunder with respect to any tax imposed by chapter 54, or the form and instructions issued with respect to such return, statement, or other document, requires that it shall contain or be verified by a written declaration that it is made under the penalties of perjury, it must be so verified by the person or persons required to sign such return, statement, or other document. In addition, any other statement or document submitted under any provision of chapter 54 or of subtitle F of the Code, or the regulations thereunder with respect to any tax imposed by chapter 54 may be required to contain or be verified by written declaration that is made under the penalties of perjury.

§ 156.6071–1 Time for filing returns relating to greenmail.

(a) *In general.* Returns required by § 156.6011–1 (relating to liability for tax on greenmail under section 5881) shall be filed on or before the ninetieth day following receipt of any portion of the greenmail. Greenmail is considered to be received when gain or other income is realized, as determined according to the taxpayer's method of accounting, without regard to any provision of the Code providing for deferral of recognition.

(b) *Returns relating to greenmail received before the date these regulations become final.* Returns required by § 156.6011–1 that relate to greenmail received on or before December 18, 1991, shall be filed on or before March 18, 1992.

§ 156.6081–1 Automatic extension of time for filing a return due under chapter 54.

(a) *In general.* A taxpayer required to file a return on Form 8725, ''Excise Tax on Greenmail,'' will be allowed an automatic 6-month extension of time to file the return after the date prescribed for filing the return if the taxpayer files an application under this section in accordance with paragraph (b) of this section.

(b) *Requirements.* To satisfy this paragraph (b), a taxpayer must—

(1) Submit a complete application on Form 7004, ''Application for Automatic

Extension of Time to File Certain Business Income Tax, Information, and Other Returns,'' or in any other manner prescribed by the Commissioner;

(2) File the application on or before the date prescribed for filing the return with the Internal Revenue Service office designated in the application's instructions; and

(3) Remit the amount of the properly estimated unpaid tax liability on or before the date prescribed for payment.

(c) *No extension of time for the payment of tax*. An automatic extension of time for filing a return granted under paragraph (a) of this section will not extend the time for payment of any tax due on such return.

(d) *Termination of automatic extension*. The Commissioner may terminate an automatic extension at any time by mailing to the taxpayer a notice of termination at least 10 days prior to the termination date designated in such notice. The Commissioner must mail the notice of termination to the address shown on the Form 7004 or to the taxpayer's last known address. For further guidance regarding the definition of last known address, see § 301.6212–2 of this chapter.

(e) *Penalties*. See section 6651 for failure to file or failure to pay the amount shown as tax on the return.

(f) *Effective/applicable dates*. This section is applicable for applications for an automatic extension of time to file a return due under chapter 54, filed after July 1, 2008.

[T.D. 9407, 73 FR 37370, July 1, 2008]

§ 156.6091–1 Place for filing chapter 54 (Greenmail) tax returns.

Except as provided in § 156.6091–2 (relating to exceptional cases):

(a) *Individuals, estates, and trusts*. In general, tax returns under chapter 54 of the Code of individuals, estates, and trusts shall be filed with any person assigned the responsibility to receive returns in the local Internal Revenue Service office that serves the legal residence or the principal place of business of the person required to make the return.

(b) *Corporations*. In general, tax returns under chapter 54 of the Code of corporations shall be filed with any person assigned the responsibility to receive returns in the local Internal Revenue Service office that serves the principal place of business or the principal office or agency of the corporation.

(c) *Partnerships*. In general, tax returns under chapter 54 of the Code of partnerships shall be filed with any person assigned the responsibility to receive returns in the local Internal Revenue Service office that serves the principal place of business or the principal office or agency of the partnership.

(d) *Returns of taxpayers outside the United States*. The return of a person (other than a partnership or a corporation) outside the United States having no legal residence or principal place of business or agency in the United States, or the return of a partnership or a corporation having no principal place of business or principal office or agency in the United States, shall be filed with the Internal Revenue Service, Philadelphia, PA 19255, or as otherwise directed in the applicable forms and instructions.

(e) *Returns filed with service centers or by hand carrying*. Notwithstanding paragraph (a), (b), (c), or (d) of this section, unless a return is filed by hand carrying, whenever instructions applicable to tax returns under chapter 54 of the Code provide that the returns be filed with a service center, the returns must be so filed in accordance with the instructions. Returns that are filed by hand carrying shall be filed with any person assigned the responsibility to receive hand-carried returns in the local Internal Revenue Service office in accordance with paragraphs (a), (b), (c), or (d) of this section.

[T.D. 8379, 56 FR 65685, Dec. 18, 1991; 57 FR 5931, Feb. 18, 1992, as amended by T.D. 9156, 69 FR 55746, Sept. 16, 2004]

§ 156.6091–2 Exceptional cases.

Notwithstanding the provisions of § 156.6091–1, the Commissioner may permit the filing of any tax return under chapter 54 (Greenmail) of the Code in any local Internal Revenue Service office.

[T.D. 8379, 56 FR 65685, Dec. 18, 1991, as amended by T.D. 9156, 69 FR 55747, Sept. 16, 2004]

§ 156.6107–1 Tax return preparer must furnish copy of return and claim for refund to taxpayer and must retain a copy or record.

(a) *In general.* A person who is a signing tax return preparer of any return or claim for refund of tax under section 5881 of the Internal Revenue Code shall furnish a completed copy of the return or claim for refund to the taxpayer and retain a completed copy or record in the manner stated in § 1.6107–1 of this chapter.

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

[T.D. 9436, 73 FR 78461, Dec. 22, 2008]

§ 156.6109–1 Tax return preparers furnishing identifying numbers for returns or claims for refund.

(a) *In general.* Each tax return or claim for refund for tax under section 5881 of the Internal Revenue Code prepared by one or more signing tax return preparers must include the identifying number of the preparer required by § 1.6695–1(b) of this chapter to sign the return or claim for refund in the manner stated in § 1.6109–2 of this chapter.

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

[T.D. 9436, 73 FR 78461, Dec. 22, 2008]

§ 156.6151–1 Time and place for paying of tax shown on returns.

The tax under chapter 54 (Greenmail) of the Code shown on any return shall, without notice of assessment and demand, be paid to the internal revenue officer with whom the return is filed at the time and place for filing such return (determined without regard to any extension of time for filing the return). For provisions relating to the time and place for filing such return, see §§ 156.6071–1 and 156.6091–1. For provisions relating to the extension of time for paying the tax, see § 156.6161–1.

§ 156.6161–1 Extension of time for paying tax or deficiency.

(a) *In general*—(1) *Tax shown or required to be shown on return.* A reasonable extension of the time for payment of the amount of any tax imposed by chapter 54 (Greenmail) of the Code and shown or required to be shown on any return may be granted by the appropriate district director at the request of the taxpayer. The period of such extension shall not exceed 6 months from the date for payment of such tax.

(2) *Deficiency.* The time for payment of any amount determined as a deficiency in respect of tax imposed by chapter 54 of the Code may, at the request of the taxpayer, be extended by the internal revenue officer to whom the tax is required to be paid. The extension may be for a period not to exceed 18 months from the date fixed for payment of the deficiency, as shown on the notice and demand. In exceptional cases, a further extension for a period not in excess of 12 months may be granted. No extension of time for payment of a deficiency shall be granted if the deficiency is due to negligence, to intentional disregard of rules and regulations, or to fraud with intent to evade tax.

(3) *Extension of time for filing distinguished.* The granting of an extension of time for filing a return does not operate to extend the time for the payment of the tax or any part thereof unless so specified in the extension.

(b) *Certain rules relating to extensions of time for paying income tax to apply.* The provisions of § 1.6161–1 (b), (c), and (d) of this chapter (relating to a requirement for undue hardship, to the application for extension, and to payment pursuant to an extension) shall apply to extensions of time for payment of the tax imposed by chapter 54 of the Code.

§ 156.6165–1 Bonds where time to pay tax or deficiency has been extended.

If an extension of time for payment is granted under section 6161 of the Code, the district director or the director of the service center may, if he deems it necessary, require a bond for the payment of the amount in respect to which the extension is granted in accordance with the terms of the extension. However, the bond shall not exceed double the amount with respect to which the extension is granted. For

provisions relating to form of bonds, see the regulations under section 7101 of the Code contained in part 301 of title 26 (Regulations on Procedure and Administration).

§ 156.6694–1 Section 6694 penalties applicable to tax return preparer.

(a) *In general.* For general definitions regarding section 6694 penalties applicable to preparers of tax returns or claims for refund for tax under section 5881 of the Internal Revenue Code, see § 1.6694–1 of this chapter.

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

[T.D. 9436, 73 FR 78461, Dec. 22, 2008]

§ 156.6694–2 Penalties for understatement due to an unreasonable position.

(a) *In general.* A person who is a tax return preparer of any return or claim for refund of tax under section 5881 of the Internal Revenue Code (Code) shall be subject to penalties under section 6694(a) of the Code in the manner stated in § 1.6694–2 of this chapter.

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

[T.D. 9436, 73 FR 78461, Dec. 22, 2008]

§ 156.6694–3 Penalty for understatement due to willful, reckless, or intentional conduct.

(a) *In general.* A person who is a tax return preparer of any return or claim for refund of tax under section 5881 of the Internal Revenue Code (Code) shall be subject to penalties under section 6694(b) of the Code in the manner stated in § 1.6694–3 of this chapter.

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

[T.D. 9436, 73 FR 78461, Dec. 22, 2008]

§ 156.6694–4 Extension of period of collection when tax return preparer pays 15 percent of a penalty for understatement of taxpayer's liability and certain other procedural matters.

(a) *In general.* For rules relating to the extension of period of collection when a tax return preparer who prepared a return or claim for refund for tax under section 5881 of the Internal Revenue Code pays 15 percent of a penalty for understatement of taxpayer's liability and procedural matters relating to the investigation, assessment and collection of the penalties under section 6694(a) and (b), the rules under § 1.6694–4 of this chapter will apply.

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

[T.D. 9436, 73 FR 78461, Dec. 22, 2008]

§ 156.6695–1 Other assessable penalties with respect to the preparation of tax returns or claims for refund for other persons.

(a) *In general.* A person who is a tax return preparer of any return or claim for refund of tax under section 5881 of the Internal Revenue Code (Code) shall be subject to penalties for failure to furnish a copy to the taxpayer under section 6695(a) of the Code, failure to sign the return under section 6695(b) of the Code, failure to furnish an identification number under section 6695(c) of the Code, failure to retain a copy or list under section 6695(d) of the Code, failure to file a correct information return under section 6695(e) of the Code, and negotiation of a check under section 6695(f) of the Code, in the manner stated in § 1.6695–1 of this chapter.

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

[T.D. 9436, 73 FR 78462, Dec. 22, 2008]

§ 156.6696–1 Claims for credit or refund by tax return preparers.

(a) *In general.* For rules for claims for credit or refund by a tax return preparer who prepared a return or claim for refund for tax under section 5881 of the Internal Revenue Code, the rules

under §1.6696–1 of this chapter will apply.

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

[T.D. 9436, 73 FR 78462, Dec. 22, 2008]

§ 156.7701–1 Tax return preparer.

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

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

[T.D. 9436, 73 FR 78462, Dec. 22, 2008]

PART 157—EXCISE TAX ON STRUCTURED SETTLEMENT FACTORING TRANSACTIONS

Subpart A—Tax on Structured Settlement Factoring Transactions

Sec.

157.5891–1 Imposition of excise tax on structured settlement factoring transactions.

Subpart B—Procedure and Administration

157.6001–1 Records, statements, and special returns.
157.6011–1 General requirement of return, statement, or list.
157.6060–1 Reporting requirements for tax return preparers.
157.6061–1 Signing of returns and other documents.
157.6065–1 Verification of returns.
157.6071–1 Time for filing returns.
157.6081–1 Automatic extension of time for filing a return due under chapter 55.
157.6091–1 Place for filing returns.
157.6107–1 Tax return preparer must furnish copy of return or claim for refund to taxpayer and must retain a copy or record.
157.6109–1 Tax return preparers furnishing identifying numbers for returns or claims for refund.
157.6151–1 Time and place for paying of tax shown on returns.
157.6161–1 Extension of time for paying tax.
157.6165–1 Bonds where time to pay tax has been extended.
157.6694–1 Section 6694 penalties applicable to tax return preparer.
157.6694–2 Penalties for understatement due to an unreasonable position.
157.6694–3 Penalty for understatement due to willful, reckless, or intentional conduct.
157.6694–4 Extension of period of collection when preparer pays 15 percent of a penalty for understatement of taxpayer's liability and certain other procedural matters.
157.6695–1 Other assessable penalties with respect to the preparation of tax returns or claims for refund for other persons.
157.6696–1 Claims for credit or refund by tax return preparers.
157.7701–1 Tax return preparer.

AUTHORITY: 26 U.S.C. 7805.

Section 157.6001–1 also issued under 26 U.S.C. 6001;

Section 157.6011–1 also issued under 26 U.S.C. 6011;

Section 157.6061–1 also issued under 26 U.S.C. 6061;

Section 157.6071–1 also issued under 26 U.S.C. 6071;

Section 157.6081–1 also issued under 26 U.S.C. 6081(a);

Section 157.6091–1 also issued under 26 U.S.C. 6091;

Section 157.6060–1 also issued under 26 U.S.C. 6060(a);

Section 157.6109–1 also issued under 26 U.S.C. 6109(a);

Section 157.6109–2 also issued under 26 U.S.C. 6109(a);

Section 157.6161–1 also issued under 26 U.S.C. 6161;

Section 157.6695–1 also issued under 26 U.S.C. 6695(b).

SOURCE: T.D. 9134, 69 FR 41193, July 8, 2004, unless otherwise noted.

Subpart A—Tax on Structured Settlement Factoring Transactions

§ 157.5891–1 Imposition of excise tax on structured settlement factoring transactions.

(a) *In general.* Section 5891 imposes on any person who acquires, directly or indirectly, structured settlement payment rights in a structured settlement factoring transaction a tax equal to 40 percent of the factoring discount with respect to such factoring transaction.

(b) *Exceptions for certain approved transactions*—(1) *In general.* The excise tax shall not apply to a structured settlement factoring transaction if the transfer of structured settlement payment rights is approved in advance in a qualified order.

(2) *Qualified order dispositive.* A qualified order shall be treated as dispositive for purposes of this exception.

(c) *Definitions*—(1) *Applicable state statute* means—

(i) A statute that is enacted by the state in which the payee of the structured settlement is domiciled and provides for the entry of an order, judgment, or decree described in paragraph (c)(4)(i) of this section; or

(ii) If there is no such statute, a statute that—

(A) Is enacted by the state in which either the party to the structured settlement (including an assignee under a qualified assignment under section 130) or the person issuing the funding asset for the structured settlement is domiciled or has its principal place of business; and

(B) Provides for the entry of such an order, judgment, or decree.

(2) *Applicable state court* means, with respect to any applicable state statute, a court of the state that enacted such statute. If the payee of the structured settlement is not domiciled in the state that enacted the statute, the term also includes a court of the state in which the payee is domiciled.

(3) *Factoring discount* means an amount equal to the excess of—

(i) The aggregate undiscounted amount of structured settlement payments being acquired in the structured settlement factoring transaction; over

(ii) The total amount actually paid by the acquirer to the person from whom such structured settlement payments are acquired.

(4) *Qualified order* means a final order, judgment, or decree that—

(i) Finds that the transfer of structured settlement payment rights does not contravene any Federal or state statute, or the order of any court or responsible administrative authority, and is in the best interest of the payee, taking into account the welfare and support of the payee's dependents; and

(ii) Is issued under the authority of an applicable state statute by an applicable state court, or is issued by the responsible administrative authority (if any) which has exclusive jurisdiction over the underlying action or proceeding which was resolved by means of the structured settlement.

(5) *Responsible administrative authority* means the administrative authority that had jurisdiction over the underlying action or proceeding that was resolved by means of the structured settlement.

(6) *State* includes the Commonwealth of Puerto Rico and any possession of the United States.

(7) *Structured settlement* means an arrangement—

(i) That is established by—

(A) Suit or agreement for the periodic payment of damages excludable from the gross income of the recipient under section 104(a)(2); or

(B) Agreement for the periodic payment of compensation under any workers' compensation law excludable from the gross income of the recipient under section 104(a)(1); and

(ii) Under which the periodic payments are—

(A) Of the character described in section 130(c)(2)(A) and (B); and

(B) Payable by a person who is a party to the suit or agreement or to the workers' compensation claim or by a person who has assumed the liability for such periodic payments under a qualified assignment in accordance with section 130.

(8) *Structured settlement factoring transaction* means a transfer of structured settlement payment rights (including portions of structured settlement payments) made for consideration by means of sale, assignment, pledge, or other form of encumbrance or alienation for consideration other than—

(i) The creation or perfection of a security interest in structured settlement payment rights under a blanket security agreement entered into with an insured depository institution in the absence of any action to redirect the structured settlement payments to such institution (or agent or successor thereof) or otherwise to enforce such blanket security interest as against the structured settlement payment rights; or

(ii) A subsequent transfer of structured settlement payment rights acquired in a structured settlement factoring transaction.

(9) *Structured settlement payment rights* means rights to receive payments under a structured settlement.

(d) *Coordination with other provisions of the Internal Revenue Code*—(1) *In general.* If the applicable requirements of

sections 72, 104(a)(1), 104(a)(2), 130, and 461(h) were satisfied at the time the structured settlement involving structured settlement payment rights was entered into, the subsequent occurrence of a structured settlement factoring transaction shall not affect the application of the provisions of such sections to the parties to the structured settlement (including an assignee under a qualified assignment under section 130) in any taxable year.

(2) *No withholding of tax.* The provisions of section 3405 regarding withholding of tax shall not apply to the person making the payments in the event of a structured settlement factoring transaction.

(e) *Effective dates.* This section applies to structured settlement factoring transactions entered into on or after July 8, 2004. For structured settlement factoring transactions entered into before July 8, 2004, *see* § 157.5891–1T of this chapter (2003–1 C.B. 564. *See* § 601.601(d)(2) of this chapter.), as it appeared in the April 1, 2003, edition of 26 CFR part 157.

Subpart B—Procedure and Administration

§ 157.6001–1 Records, statements, and special returns.

(a) *In general.* Any person subject to tax under chapter 55 (Structured Settlement Factoring Transactions) of the Internal Revenue Code must keep such complete and detailed records as are sufficient to enable the Internal Revenue Service (IRS) to determine accurately the amount of liability under chapter 55.

(b) *Notice by the IRS requiring returns, statements, or the keeping of records.* The IRS may require any person, by notice served upon him, to make such returns, render such statements, or keep such specific records as will enable the IRS to determine whether or not the person is liable for tax under chapter 55.

(c) *Retention of records.* The records required by this section must be kept at all times available for inspection by the IRS, and shall be retained so long as the contents thereof may become material in the administration of any internal revenue law.

§ 157.6011–1 General requirement of return, statement, or list.

Every person liable for tax under section 5891 must file a return with respect to the tax in accordance with the forms and instructions provided by the Internal Revenue Service.

§ 157.6060–1 Reporting requirements for tax return preparers.

(a) *In general.* A person that employs one or more tax return preparers to prepare a return or claim for refund for tax under section 5891 of the Internal Revenue Code, other than for the person, at any time during a return period, shall satisfy the record keeping and inspection requirements in the manner stated in § 1.6060–1 of this chapter.

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

[T.D. 9436, 73 FR 78462, Dec. 22, 2008]

§ 157.6061–1 Signing of returns and other documents.

Any return, statement, or other document required to be made with respect to a tax imposed by chapter 55 (Structured Settlement Factoring Transactions) of the Internal Revenue Code or the regulations under chapter 55 must be signed by the person required to file the return, statement, or other document, or by the persons required or duly authorized to sign in accordance with the regulations, forms, or instructions prescribed with respect to such return, statement, or document. An individual's signature on such return, statement, or other document shall be prima facie evidence that the individual is authorized to sign the return, statement, or other document.

§ 157.6065–1 Verification of returns.

If a return, statement, or other document made under the provisions of chapter 55 (Structured Settlement Factoring Transactions) or of subtitle F of the Internal Revenue Code, or the regulations under those provisions with respect to any tax imposed by chapter 55, or the form and instructions issued with respect to such return, statement, or other document, requires that it

shall contain or be verified by a written declaration that it is made under the penalties of perjury, it must be so verified by the person or persons required to sign such return, statement, or other document. In addition, any other statement or document submitted under any provision of chapter 55 or subtitle F, or the regulations under those provisions, with respect to any tax imposed by chapter 55 may be required to contain or be verified by written declaration that it is made under the penalties of perjury.

§ 157.6071–1 Time for filing returns.

(a) *In general*. Except as provided in paragraph (b) of this section, returns required by § 157.6011–1 (relating to returns of tax with respect to structured settlement factoring transactions) must be filed on or before the ninetieth day following the receipt of structured settlement payment rights in a structured settlement factoring transaction.

(b) *Returns relating to structured settlement payment rights received before February 19, 2003*. Returns required by § 157.6011–1 that relate to structured settlement payment rights received on or before February 19, 2003, must be filed on or before May 20, 2003.

§ 157.6081–1 Automatic extension of time for filing a return due under chapter 55.

(a) *In general*. A taxpayer required to file a return on Form 8876, ''Excise Tax on Structured Settlement Factoring Transactions'', will be allowed an automatic 6-month extension of time to file the return after the date prescribed for filing the return if the taxpayer files an application under this section in accordance with paragraph (b) of this section.

(b) *Requirements*. To satisfy this paragraph (b), the taxpayer must—

(1) Submit a complete application on Form 7004, ''Application for Automatic Extension of Time to File Certain Business Income Tax, Information, and Other Returns,'' or in any other manner prescribed by the Commissioner;

(2) File the application on or before the date prescribed for filing the return with the Internal Revenue Service office designated in the application's instructions; and

(3) Remit the amount of the properly estimated unpaid tax liability on or before the date prescribed for payment.

(c) *No extension of time for the payment of tax*. An automatic extension of time for filing a return granted under paragraph (a) of this section will not extend the time for payment of any tax due on such return.

(d) *Termination of automatic extension*. The Commissioner may terminate an automatic extension at any time by mailing to the taxpayer a notice of termination at least 10 days prior to the termination date designated in such notice. The Commissioner must mail the notice of termination to the address shown on the Form 7004 or to the taxpayer's last known address. For further guidance regarding the definition of last known address, see § 301.6212–2 of this chapter.

(e) *Penalties*. See section 6651 for failure to file or failure to pay the amount shown as tax on the return.

(f) *Effective/applicability dates*. This section is applicable for applications for an automatic extension of time to file a return due under chapter 55, filed after July 1, 2008.

[T.D. 9407, 73 FR 37370, July 1, 2008]

§ 157.6091–1 Place for filing returns.

The return required by § 157.6011–1 (relating to returns of tax with respect to structured settlement factoring transactions) must be filed at the place specified in the forms and instructions provided by the Internal Revenue Service.

§ 157.6107–1 Tax return preparer must furnish copy of return or claim for refund to taxpayer and must retain a copy or record.

(a) *In general*. A person who is a signing tax return preparer of any return or claim for refund of tax under section 5891 of the Internal Revenue Code shall furnish a completed copy of the return or claim for refund to the taxpayer and retain a completed copy or record in the manner stated in § 1.6107–1 of this chapter.

(b) *Effective/applicability date*. This section is applicable to returns and

claims for refund filed after December 31, 2008.

[T.D. 9436, 73 FR 78462, Dec. 22, 2008]

§ 157.6109–1 Tax return preparers furnishing identifying numbers for returns or claims for refund.

(a) *In general.* Each tax return or claim for refund for tax under section 5891 of the Internal Revenue Code prepared by one or more signing tax return preparers must include the identifying number of the preparer required by § 1.6695–1(b) of this chapter to sign the return or claim for refund in the manner stated in § 1.6109–2 of this chapter.

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

[T.D. 9436, 73 FR 78462, Dec. 22, 2008]

§ 157.6151–1 Time and place for paying of tax shown on returns.

The tax under chapter 55 (Structured Settlement Factoring Transactions) of the Internal Revenue Code shown on any return must, without assessment or notice and demand, be paid at the time and place specified in the forms and instructions provided by the Internal Revenue Service. For provisions relating to the time and place for filing such return, see § 157.6071–1 and § 157.6091–1. For provisions relating to the extension of time for paying the tax, see § 157.6161–1.

§ 157.6161–1 Extension of time for paying tax.

(a) *In general*—(1) *Tax shown or required to be shown on return.* The Internal Revenue Service may, at the request of the taxpayer, grant a reasonable extension of time for payment of the amount of any tax imposed by chapter 55 (Structured Settlement Factoring Transactions) of the Internal Revenue Code and shown or required to be shown on any return. The period of such extension shall not exceed 6 months from the date fixed for payment of such tax, except that in the case of a taxpayer that is abroad, such extension may exceed 6 months.

(2) *Extension of time for filing distinguished.* The granting of an extension of time for filing a return does not extend the time for the payment of the tax or any part thereof unless so specified in the extension.

(b) *Certain rules relating to extension of time for paying income tax to apply.* The provisions of § 1.6161–1(b), (c), and (d) of this chapter (relating to a requirement for undue hardship, to the application for extension, and to payment pursuant to an extension) shall apply to extensions of time for payment of the tax imposed by chapter 55 of the Code.

§ 157.6165–1 Bonds where time to pay tax has been extended.

If an extension of time for payment is granted under section 6161, the Internal Revenue Service may, if it deems necessary, require a bond for the payment, in accordance with the terms of the extension, of the amount with respect to which the extension is granted. However, the bond shall not exceed double the amount with respect to which the extension is granted. For provisions relating to the form of bonds, see the regulations under section 7101 contained in part 301 (Regulations on Procedure and Administration) of this chapter.

§ 157.6694–1 Section 6694 penalties applicable to tax return preparer.

(a) *In general.* For general definitions regarding section 6694 penalties applicable to preparers of tax returns or claims for refund for tax under section 5891 of the Internal Revenue Code see § 1.6694–1 of this chapter.

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

[T.D. 9436, 73 FR 78462, Dec. 22, 2008]

§ 157.6694–2 Penalties for understatement due to an unreasonable position.

(a) *In general.* A person who is a tax return preparer of any return or claim for refund of tax under section 5891 of the Internal Revenue Code (Code) shall be subject to penalties under section 6694(a) of the Code in the manner stated in § 1.6694–2 of this chapter.

(b) *Effective/applicability date.* This section is applicable to returns and

claims for refund filed, and advice provided, after December 31, 2008.

[T.D. 9436, 73 FR 78462, Dec. 22, 2008]

§ 157.6694–3 Penalty for understatement due to willful, reckless, or intentional conduct.

(a) *In general.* A person who is a tax return preparer of any return or claim for refund of tax under section 5891 of the Internal Revenue Code (Code) shall be subject to penalties under section 6694(b) of the Code in the manner stated in § 1.6694–3 of this chapter.

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

[T.D. 9436, 73 FR 78462, Dec. 22, 2008]

§ 157.6694–4 Extension of period of collection when preparer pays 15 percent of a penalty for understatement of taxpayer's liability and certain other procedural matters.

(a) *In general.* For rules relating to the extension of period of collection when a tax return preparer who prepared a return or claim for refund for tax under section 5891 of the Internal Revenue Code pays 15 percent of a penalty for understatement of taxpayer's liability and procedural matters relating to the investigation, assessment and collection of the penalties under section 6694(a) and (b), the rules under § 1.6694–4 of this chapter will apply.

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

[T.D. 9436, 73 FR 78462, Dec. 22, 2008]

§ 157.6695–1 Other assessable penalties with respect to the preparation of tax returns or claims for refund for other persons.

(a) *In general.* A person who is a tax return preparer of any return or claim for refund of tax under section 5891 of the Internal Revenue Code (Code) shall be subject to penalties for failure to furnish a copy to the taxpayer under section 6695(a) of the Code, failure to sign the return under section 6695(b) of the Code, failure to furnish an identification number under section 6695(c) of the Code, failure to retain a copy or list under section 6695(d) of the Code, failure to file a correct information return under section 6695(e) of the Code, and negotiation of a check under section 6695(f) of the Code, in the manner stated in § 1.6695–1 of this chapter.

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

[T.D. 9436, 73 FR 78463, Dec. 22, 2008]

§ 157.6696–1 Claims for credit or refund by tax return preparers.

(a) *In general.* For rules for claims for credit or refund by a tax return preparer who prepared a return or claim for refund for tax under section 5891 of the Internal Revenue Code, the rules under § 1.6696–1 of this chapter will apply.

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

[T.D. 9436, 73 FR 78463, Dec. 22, 2008]

§ 157.7701–1 Tax return preparer.

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

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

[T.D. 9436, 73 FR 78463, Dec. 22, 2008]

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FINDING AIDS

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Table of OMB Control Numbers

The OMB control numbers for chapter I of title 26 were consolidated into §§ 601.9000 and 602.101 at 50 FR 10221, Mar. 14, 1985. At 61 FR 58008, Nov. 12, 1996, § 601.9000 was removed. Section 602.101 is reprinted below for the convenience of the user.

PART 602—OMB CONTROL NUMBERS UNDER THE PAPERWORK REDUCTION ACT

AUTHORITY: 26 U.S.C. 7805.

§ 602.101 OMB Control numbers.

(a) *Purpose*. This part collects and displays the control numbers assigned to collections of information in Internal Revenue Service regulations by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1980. The Internal Revenue Service intends that this part comply with the requirements of §§ 1320.7(f), 1320.12, 1320.13, and 1320.14 of 5 CFR part 1320 (OMB regulations implementing the Paperwork Reduction Act), for the display of control numbers assigned by OMB to collections of information in Internal Revenue Service regulations. This part does not display control numbers assigned by the Office of Management and Budget to collections of information of the Bureau of Alcohol, Tobacco, and Firearms.

(b) *Display*.

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1.162–7	1545–0139
1.162–8	1545–0139
1.162–9	1545–0139
1.162–10	1545–0139
1.162–11	1545–0139
1.162–12	1545–0139
1.162–13	1545–0139
1.162–14	1545–0139
1.162–15	1545–0139
1.162–16	1545–0139
1.162–17	1545–0139
1.162–18	1545–0139
1.162–19	1545–0139
1.162–20	1545–0139
1.162–24	1545–2115
1.162–27	1545–1466
1.163–5	1545–0786
	1545–1132
1.163–8T	1545–0995
1.163–10T	1545–0074
1.163–13	1545–1491
1.163(d)–1	1545–1421
1.165–1	1545–0177
1.165–2	1545–0177
1.165–3	1545–0177
1.165–4	1545–0177
1.165–5	1545–0177
1.165–6	1545–0177
1.165–7	1545–0177
1.165–8	1545–0177
1.165–9	1545–0177
1.165–10	1545–0177
1.165–11	1545–0074
	1545–0177
	1545–0786
1.165–12	1545–0786
1.166–1	1545–0123
1.166–2	1545–1254
1.166–4	1545–0123
1.166–10	1545–0123
1.167(a)–5T	1545–1021
1.167(a)–7	1545–0172
1.167(a)–11	1545–0152
	1545–0172
1.167(a)–12	1545–0172
1.167(d)–1	1545–0172
1.167(e)–1	1545–0172
1.167(f)–11	1545–0172
1.167(l)–1	1545–0172
1.168(d)–1	1545–1146
1.168(i)–1	1545–1331

CFR part or section where identified and described	Current OMB control No.
1.168–5	1545–0172
1.169–4	1545–0172
1.170–1	1545–0074
1.170–2	1545–0074
1.170–3	1545–0123
1.170A–1	1545–0074
1.170A–2	1545–0074
1.170A–4(A)(b)	1545–0123
1.170A–8	1545–0074
1.170A–9	1545–0052
	1545–0074
1.170A–11	1545–0074
	1545–0123
	1545–1868
1.170A–12	1545–0020
	1545–0074
1.170A–13	1545–0074
	1545–0754
	1545–0908
	1545–1431
1.170A–13(f)	1545–1464
1.170A–14	1545–0763
1.170A–15	1545–1953
1.170A–16	1545–1953
1.170A–17	1545–1953
1.170A–18	1545–1953
1.171–4	1545–1491
1.171–5	1545–1491
1.172–1	1545–0172
1.172–13	1545–0863
1.173–1	1545–0172
1.174–3	1545–0152
1.174–4	1545–0152
1.175–3	1545–0187
1.175–6	1545–0152
1.179–2	1545–1201
1.179–3	1545–1201
1.179–5	1545–0172
	1545–1201
1.179B–1T	1545–2076
1.179C–1	1545–2103
1.179C–1T	1545–2103
1.180–2	1545–0074
1.181–1	1545–2059
1.181–2	1545–2059
1.181–3	1545–2059
1.182–6	1545–0074
1.183–1	1545–0195
1.183–2	1545–0195
1.183–3	1545–0195
1.183–4	1545–0195
1.190–3	1545–0074
1.194–2	1545–0735
1.194–4	1545–0735
1.195–1	1545–1582
1.197–1T	1545–1425
1.197–2	1545–1671
1.199–6	1545–1966
1.213–1	1545–0074
1.215–1T	1545–0074
1.217–2	1545–0182
1.243–3	1545–0123
1.243–4	1545–0123
1.243–5	1545–0123
1.248–1	1545–0172
1.261–1	1545–1041
1.263(a)–1	1545–2248
1.263(a)–3	1545–2248
1.263(a)–5	1545–1870
1.263(e)–1	1545–0123
1.263A–1	1545–0987
1.263A–1T	1545–0187
1.263A–2	1545–0987
1.263A–3	1545–0987
1.263A–8(b)(2)(iii)	1545–1265
1.263A–9(d)(1)	1545–1265
1.263A–9(f)(1)(ii)	1545–1265
1.263A–9(f)(2)(iv)	1545–1265
1.263A–9(g)(2)(iv)(C)	1545–1265
1.263A–9(g)(3)(iv)	1545–1265
1.265–1	1545–0074
1.265–2	1545–0123
1.266–1	1545–0123
1.267(f)–1	1545–0885
1.268–1	1545–0184
1.274–1	1545–0139
1.274–2	1545–0139
1.274–3	1545–0139
1.274–4	1545–0139
1.274–5	1545–0771
1.274–5A	1545–0139
	1545–0771
1.274–5T	1545–0074
	1545–0172
	1545–0771
1.274–6	1545–0139
	1545–0771
1.274–6T	1545–0074
	1545–0771
1.274–7	1545–0139
1.274–8	1545–0139
1.279–6	1545–0123
1.280C–4	1545–1155
1.280F–3T	1545–0074
1.280G–1	1545–1851
1.281–4	1545–0123
1.302–4	1545–0074
1.305–3	1545–0123
1.305–5	1545–1438
1.307–2	1545–0074
1.312–15	1545–0172
1.316–1	1545–0123
1.331–1	1545–0074
1.332–4	1545–0123
1.332–6	1545–2019
1.336–2	1545–2125
1.336–4	1545–2125
1.337(d)–1	1545–1160
1.337(d)–2	1545–1160
	1545–1774
1.337(d)–4	1545–1633
1.337(d)–5	1545–1672
1.337(d)–6	1545–1672
1.337(d)–7	1545–1672
1.338–2	1545–1658
1.338–5	1545–1658
1.338–10	1545–1658
1.338–11	1545–1990
1.338(h)(10)–1	1545–1658
1.338(i)–1	1545–1990
1.351–3	1545–2019
1.355–5	1545–2019
1.362–2	1545–0123
1.362–4	1545–2247
1.367(a)–1T	1545–0026
1.367(a)–2T	1545–0026
1.367(a)–3	1545–0026
	1545–1478
1.367(a)–3T	1545–2183
1.367(a)–6T	1545–0026
1.367(a)–7	1545–2183
1.367(a)–7T	1545–2183
1.367(a)–8	1545–1271
	1545–2056

CFR part or section where identified and described	Current OMB control No.
	1545–2183
1.367(b)–1	1545–1271
1.367(b)–3T	1545–1666
1.367(d)–1T	1545–0026
1.367(e)–1	1545–1487
1.367(e)–2	1545–1487
1.368–1	1545–1691
1.368–3	1545–2019
1.371–1	1545–0123
1.371–2	1545–0123
1.374–3	1545–0123
1.381(b)–1	1545–0123
1.381(c)(4)–1	1545–0123
	1545–0152
	1545–0879
1.381(c)(5)–1	1545–0123
	1545–0152
1.381(c)(6)–1	1545–0123
	1545–0152
1.381(c)(8)–1	1545–0123
1.381(c)(10)–1	1545–0123
1.381(c)(11)–1(k)	1545–0123
1.381(c)(13)–1	1545–0123
1.381(c)(17)–1	1545–0045
1.381(c)(22)–1	1545–1990
1.381(c)(25)–1	1545–0045
1.382–1T	1545–0123
1.382–2	1545–0123
1.382–2T	1545–0123
1.382–3	1545–1281
	1545–1345
1.382–4	1545–1120
1.382–6	1545–1381
1.382–8	1545–1434
1.382–9	1545–1120
	1545–1260
	1545–1275
	1545–1324
1.382–11	1545–2019
1.382–91	1545–1260
	1545–1324
1.383–1	1545–0074
	1545–1120
1.401–1	1545–0020
	1545–0197
	1545–0200
	1545–0534
	1545–0710
1.401(a)–11	1545–0710
1.401(a)–20	1545–0928
1.401(a)–31	1545–1341
1.401(a)–50	1545–0710
1.401(a)(9)–1	1545–1573
1.401(a)(9)–3	1545–1466
1.401(a)(9)–4	1545–1573
1.401(a)(9)–6	1545–2234
1.401(a)(31)–1	1545–1341
1.401(b)–1	1545–0197
1.401(f)–1	1545–0710
1.401(k)–1	1545–1039
	1545–1069
	1545–1669
	1545–1930
1.401(k)–2	1545–1669
1.401(k)–3	1545–1669
1.401(k)–4	1545–1669
1.401(m)–3	1545–1699
1.401–14	1545–0710
1.402(c)–2	1545–1341
1.402(f)–1	1545–1341
	1545-1632
1.402A–1	1545–1992

CFR part or section where identified and described	Current OMB control No.
1.403(b)–1	1545–0710
1.403(b)–3	1545–0996
1.403(b)–7	1545–1341
1.403(b)–10	1545–2068
1.404(a)–12	1545–0710
1.404A–2	1545–0123
1.404A–6	1545–0123
1.408–2	1545–0390
1.408–5	1545–0747
1.408–6	1545–0203
	1545–0390
1.408–7	1545–0119
1.408(q)–1	1545–1841
1.408A–2	1545–1616
1.408A–4	1545–1616
1.408A–5	1545–1616
1.408A–7	1545–1616
1.410(a)–2	1545–0710
1.410(d)–1	1545–0710
1.411(a)–11	1545–1471
	1545–1632
1.411(d)–4	1545–1545
1.411(d)–6	1545–1477
1.412(c)(1)–2	1545–0710
1.412(c)(2)–1	1545–0710
1.412(c)(3)–2	1545–0710
1.414(c)–5	1545–0797
1.414(r)–1	1545–1221
1.415–2	1545–0710
1.415–6	1545–0710
1.417(a)(3)–1	1545–0928
1.417(e)–1	1545–1471
	1545–1724
1.417(e)–1T	1545–1471
1.419A(f)(6)–1	1545–1795
1.422–1	1545–0820
1.430(f)–1	1545–2095
1.430(g)–1	1545–2095
1.430(h)(2)–1	1545–2095
1.432(e)(9)–1T	1545–2260
1.436–1	1545–2095
1.441–2	1545–1748
1.442–1	1545–0074
	1545–0123
	1545–0134
	1545–0152
	1545–0820
	1545–1748
1.443–1	1545–0123
1.444–3T	1545–1036
1.444–4	1545–1591
1.446–1	1545–0074
	1545–0152
1.446–4(d)	1545–1412
1.448–1(g)	1545–0152
1.448–1(h)	1545–0152
1.448–1(i)	1545–0152
1.448–2	1545–1855
1.448–2T	1545–0152
	1545–1855
1.451–1	1545–0091
1.451–4	1545–0123
1.451–6	1545–0074
1.451–7	1545–0074
1.453–1	1545–0152
1.453–2	1545–0152
1.453–8	1545–0152
	1545–0228
1.453A–1	1545–0152
	1545–1134
1.453A–3	1545–0963
1.454–1	1545–0074

CFR part or section where identified and described	Current OMB control No.
1.455–2	1545–0152
1.455–6	1545–0123
1.456–2	1545–0123
1.456–6	1545–0123
1.456–7	1545–0123
1.457–8	1545–1580
1.458–1	1545–0879
1.458–2	1545–0152
1.460–1	1545–1650
1.460–6	1545–1031
	1545–1572
	1545–1732
1.461–1	1545–0074
1.461–2	1545–0096
1.461–4	1545–0917
1.461–5	1545–0917
1.463–1T	1545–0916
1.465–1T	1545–0712
1.466–1T	1545–0152
1.466–4	1545–0152
1.468A–3	1545–1269
	1545–1378
	1545–1511
1.468A–3(h), 1.468A–7, and 1.468A–8(d)	1545–2091
1.468A–4	1545–0954
1.468A–7	1545–0954
	1545–1511
1.468A–8	1545–1269
1.468B–1	1545–1631
1.468B–1(j)	1545–1299
1.468B–2(k)	1545–1299
1.468B–2(l)	1545–1299
1.468B–3(b)	1545–1299
1.468B–3(e)	1545–1299
1.468B–5(b)	1545–1299
1.468B–9	1545–1631
1.469–1	1545–1008
1.469–2T	1545–0712
	1545–1091
1.469–4T	1545–0985
	1545–1037
1.469–7	1545–1244
1.471–2	1545–0123
1.471–5	1545–0123
1.471–6	1545–0123
1.471–8	1545–0123
1.471–11	1545–0123
	1545–0152
1.472–1	1545–0042
	1545–0152
1.472–2	1545–0152
1.472–3	1545–0042
1.472–5	1545–0152
1.472–8	1545–0028
	1545–0042
	1545–1767
1.475(a)–4	1545–1945
1.481–4	1545–0152
1.481–5	1545–0152
1.482–1	1545–1364
1.482–4	1545–1364
1.482–7	1545–1364
	1545–1794
1.482–9(b)	1545–2149
1.501(a)–1	1545–0056
	1545–0057
1.501(c)(3)–1	1545–0056
1.501(c)(9)–5	1545–0047
1.501(c)(17)–3	1545–0047
1.501(e)–1	1545–0814
1.501(r)–3	1545–0047
1.501(r)–4	1545–0047
1.501(r)–6	1545–0047
1.503(c)–1	1545–0047
	1545–0052
1.505(c)–1T	1545–0916
1.506–1	1545–2268
1.507–1	1545–0052
1.507–2	1545–0052
1.508–1	1545–0052
	1545–0056
1.509(a)–3	1545–0047
1.509(a)–4	1545–2157
1.509(a)–5	1545–0047
1.509(c)–1	1545–0052
1.512(a)–1	1545–0687
1.512(a)–4	1545–0047
	1545–0687
1.521–1	1545–0051
	1545–0058
1.527–2	1545–0129
1.527–5	1545–0129
1.527–6	1545–0129
1.527–9	1545–0129
1.528–8	1545–0127
1.529A–2	1545–2293
1.529A–5	1545–2262
1.529A–6	1545–2262
1.529A–7	1545–2262
1.533–2	1545–0123
1.534–2	1545–0123
1.542–3	1545–0123
1.545–2	1545–0123
1.545–3	1545–0123
1.547–2	1545–0045
	1545–0123
1.547–3	1545–0123
1.561–1	1545–0044
1.561–2	1545–0123
1.562–3	1545–0123
1.563–2	1545–0123
1.564–1	1545–0123
1.565–1	1545–0043
	1545–0123
1.565–2	1545–0043
1.565–3	1545–0043
1.565–5	1545–0043
1.565–6	1545–0043
1.585–1	1545–0123
1.585–3	1545–0123
1.585–8	1545–1290
1.597–2	1545–1300
1.597–4	1545–1300
1.597–6	1545–1300
1.597–7	1545–1300
1.611–2	1545–0099
1.611–3	1545–0007
	1545–0099
	1545–1784
1.612–4	1545–0074
1.612–5	1545–0099
1.613–3	1545–0099
1.613–4	1545–0099
1.613–6	1545–0099
1.613–7	1545–0099
1.613A–3	1545–0919
1.613A–3(e)	1545–1251
1.613A–3(l)	1545–0919
1.613A–5	1545–0099
1.613A–6	1545–0099
1.614–2	1545–0099
1.614–3	1545–0099
1.614–5	1545–0099
1.614–6	1545–0099

CFR part or section where identified and described	Current OMB control No.
1.614–8	1545–0099
1.617–1	1545–0099
1.617–3	1545–0099
1.617–4	1545–0099
1.631–1	1545–0007
1.631–2	1545–0007
1.641(b)–2	1545–0092
1.642(c)–1	1545–0092
1.642(c)–2	1545–0092
1.642(c)–5	1545–0074
1.642(c)–6	1545–0020
	1545–0074
	1545–0092
1.642(g)–1	1545–0092
1.642(i)–1	1545–0092
1.645–1	1545–1578
1.663(b)–2	1545–0092
1.664–1	1545–0196
1.664–1(a)(7)	1545–1536
1.664–1(c)	1545–2101
1.664–2	1545–0196
1.664–3	1545–0196
1.664–4	1545–0020
	1545–0196
1.665(a)–0A through	
1.665(g)–2A	1545–0192
1.666(d)–1A	1545–0092
1.671–4	1545–1442
1.671–5	1545–1540
1.701–1	1545–0099
1.702–1	1545–0074
1.703–1	1545–0099
1.704–2	1545–1090
1.706–1	1545–0074
	1545–0099
	1545–0134
1.706–1T	1545–0099
1.706–4(f)	1545–0123
1.707–3(c)(2)	1545–1243
1.707–5(a)(7)(ii)	1545–1243
1.707–6(c)	1545–1243
1.707–8	1545–1243
1.708–1	1545–0099
1.732–1	1545–0099
	1545–1588
1.736–1	1545–0074
1.743–1	1545–0074
	1545–1588
1.751–1	1545–0074
	1545–0099
	1545–0941
1.752–2	1545–1905
1.752–5	1545–1090
1.752–7	1545–1843
1.754–1	1545–0099
1.755–1	1545–0099
1.761–2	1545–1338
1.801–1	1545–0123
	1545–0128
1.801–3	1545–0123
1.801–5	1545–0128
1.801–8	1545–0128
1.804–4	1545–0128
1.811–2	1545–0128
1.812–2	1545–0128
1.815–6	1545–0128
1.818–4	1545–0128
1.818–5	1545–0128
1.818–8	1545–0128
1.819–2	1545–0128
1.822–5	1545–1027
1.822–6	1545–1027
1.822–8	1545–1027
1.822–9	1545–1027
1.826–1	1545–1027
1.826–2	1545–1027
1.826–3	1545–1027
1.826–4	1545–1027
1.826–6	1545–1027
1.831–3	1545–0123
1.832–4	1545–1227
1.832–5	1545–0123
1.848–2(g)(8)	1545–1287
1.848–2(h)(3)	1545–1287
1.848–2(i)(4)	1545–1287
1.851–2	1545–1010
1.851–4	1545–0123
1.852–1	1545–0123
1.852–4	1545–0123
	1545–0145
1.852–6	1545–0123
	1545–0144
1.852–7	1545–0074
1.852–9	1545–0074
	1545–0123
	1545–0144
	1545–0145
	1545–1783
1.852–11	1545–1094
1.853–3	1545–2035
1.853–4	1545–2035
1.854–2	1545–0123
1.855–1	1545–0123
1.856–2	1545–0123
	1545–1004
1.856–6	1545–0123
1.856–7	1545–0123
1.856–8	1545–0123
1.857–8	1545–0123
1.857–9	1545–0074
1.858–1	1545–0123
1.860–2	1545–0045
1.860–4	1545–0045
	1545–1054
	1545–1057
1.860E–1	1545–1675
1.860E–2(a)(5)	1545–1276
1.860E–2(a)(7)	1545–1276
1.860E–2(b)(2)	1545–1276
1.860G–2	1545–2110
1.861–2	1545–0089
1.861–3	1545–0089
1.861–4	1545–1900
1.861–8	1545–0126
1.861–8(e)(6) and (g)	1545–1224
1.861–9T	1545–0121
	1545–1072
1.861–18	1545–1594
1.863–1	1545–1476
1.863–3	1545–1476
	1545–1556
1.863–3A	1545–0126
1.863–4	1545–0126
1.863–7	1545–0132
1.863–8	1545–1718
1.863–9	1545–1718
1.864–4	1545–0126
1.871–1	1545–0096
1.871–6	1545–0795
1.871–7	1545–0089
1.871–10	1545–0089
	1545–0165
1.874–1	1545–0089
1.881–4	1545–1440

CFR part or section where identified and described	Current OMB control No.
1.882–4	1545–0126
1.883–0	1545–1677
1.883–1	1545–1677
1.883–2	1545–1677
1.883–3	1545–1677
1.883–4	1545–1677
1.883–5	1545–1677
1.884–0	1545–1070
1.884–1	1545–1070
1.884–2	1545–1070
1.884–2T	1545–0126
	1545–1070
1.884–4	1545–1070
1.884–5	1545–1070
1.892–1T	1545–1053
1.892–2T	1545–1053
1.892–3T	1545–1053
1.892–4T	1545–1053
1.892–5T	1545–1053
1.892–6T	1545–1053
1.892–7T	1545–1053
1.897–2	1545–0123
	1545–0902
1.897–3	1545–0123
1.897–5T	1545–0902
1.897–6T	1545–0902
1.901–2	1545–0746
1.901–2A	1545–0746
1.901–3	1545–0122
1.902–1	1545–0122
	1545–1458
1.904–1	1545–0121
	1545–0122
1.904–2	1545–0121
	1545–0122
1.904–3	1545–0121
1.904–4	1545–0121
1.904–5	1545–0121
1.904–7	1545–2104
1.904–7T	1545–2104
1.904(f)–1	1545–0121
	1545–0122
1.904(f)–2	1545–0121
1.904(f)–3	1545–0121
1.904(f)–4	1545–0121
1.904(f)–5	1545–0121
1.904(f)–6	1545–0121
1.904(f)–7	1545–1127
1.905–2	1545–0122
1.905–3T	1545–1056
1.905–4T	1545–1056
1.905–5T	1545–1056
1.911–1	1545–0067
	1545–0070
1.911–2	1545–0067
	1545–0070
1.911–3	1545–0067
	1545–0070
1.911–4	1545–0067
	1545–0070
1.911–5	1545–0067
	1545–0070
1.911–6	1545–0067
	1545–0070
1.911–7	1545–0067
	1545–0070
1.913–13	1545–0067
1.921–1T	1545–0190
	1545–0884
	1545–0935
	1545–0939
1.921–2	1545–0884

CFR part or section where identified and described	Current OMB control No.
1.927(a)–1T	1545–0935
1.927(d)–2T	1545–0935
1.931–1	1545–0074
	1545–0123
1.934–1	1545–0782
1.935–1	1545–0074
	1545–0087
	1545–0803
1.936–1	1545–0215
	1545–0217
1.936–4	1545–0215
1.936–5	1545–0704
1.936–6	1545–0215
1.936–7	1545–0215
1.936–10(c)	1545–1138
1.937–1	1545–1930
1.952–2	1545–0126
1.953–2	1545–0126
1.954–1	1545–1068
1.954–2	1545–1068
1.955–2	1545–0123
1.955–3	1545–0123
1.955A–2	1545–0755
1.955A–3	1545–0755
1.956–1	1545–0704
1.956–2	1545–0704
1.959–1	1545–0704
1.959–2	1545–0704
1.960–1	1545–0122
1.962–2	1545–0704
1.962–3	1545–0704
1.964–1	1545–0126
	1545–0704
	1545–1072
	1545–2104
1.964–3	1545–0126
1.970–2	1545–0126
1.985–2	1545–1051
	1545–1131
1.985–3	1545–1051
1.987–1	1545–2265
1.987–3	1545–2265
1.987–9	1545–2265
1.987–10	1545–2265
1.988–0	1545–1131
1.988–1	1545–1131
1.988–2	1545–1131
1.988–3	1545–1131
1.988–4	1545–1131
1.988–5	1545–1131
1.988–6	1545–1831
1.992–1	1545–0190
	1545–0938
1.992–2	1545–0190
	1545–0884
	1545–0938
1.992–3	1545–0190
	1545–0938
1.992–4	1545–0190
	1545–0938
1.993–3	1545–0938
1.993–4	1545–0938
1.994–1	1545–0938
1.995–5	1545–0938
1.1001–1	1545–1902
1.1012–1	1545–0074
	1545–1139
1.1014–4	1545–0184
1.1015–1	1545–0020
1.1017–1	1545–1539
1.1031(d)–1T	1545–1021
1.1033(a)–2	1545–0184

CFR part or section where identified and described	Current OMB control No.
1.1033(g)–1	1545–0184
1.1039–1	1545–0184
1.1041–1T	1545–0074
1.1041–2	1545–1751
1.1042–1T	1545–0916
1.1044(a)–1	1545–1421
1.1045–1	1545–1893
1.1060–1	1545–1658
	1545–1990
1.1071–1	1545–0184
1.1071–4	1545–0184
1.1081–4	1545–0028
	1545–0046
	1545–0123
1.1081–11	1545–2019
1.1082–1	1545–0046
1.1082–2	1545–0046
1.1082–3	1545–0046
	1545–0184
1.1082–4	1545–0046
1.1082–5	1545–0046
1.1082–6	1545–0046
1.1083–1	1545–0123
1.1092(b)–1T	1545–0644
1.1092(b)–2T	1545–0644
1.1092(b)–3T	1545–0644
1.1092(b)–4T	1545–0644
1.1092(b)–5T	1545–0644
1.1211–1	1545–0074
1.1212–1	1545–0074
1.1221–2	1545–1480
1.1231–1	1545–0177
	1545–0184
1.1231–2	1545–0177
	1545–0184
1.1231–2	1545–0074
1.1232–3	1545–0074
1.1237–1	1545–0184
1.1239–1	1545–0091
1.1242–1	1545–0184
1.1243–1	1545–0123
1.1244(e)–1	1545–0123
	1545–1447
1.1245–1	1545–0184
1.1245–2	1545–0184
1.1245–3	1545–0184
1.1245–4	1545–0184
1.1245–5	1545–0184
1.1245–6	1545–0184
1.1248–7	1545–0074
1.1248(f)–2	1545–2183
1.1248(f)–3T	1545–2183
1.1250–1	1545–0184
1.1250–2	1545–0184
1.1250–3	1545–0184
1.1250–4	1545–0184
1.1250–5	1545–0184
1.1251–1	1545–0184
1.1251–2	1545–0074
	1545–0184
1.1251–3	1545–0184
1.1251–4	1545–0184
1.1252–1	1545–0184
1.1252–2	1545–0184
1.1254–1(c)(3)	1545–1352
1.1254–4	1545–1493
1.1254–5(d)(2)	1545–1352
1.1258–1	1545–1452
1.1272–3	1545–1353
1.1273–2(f)(9)	1545–1353
1.1273–2(h)(2)	1545–1353
1.1274–3(d)	1545–1353
1.1274–5(b)	1545–1353
1.1274A–1(c)	1545–1353
1.1275–2	1545–1450
1.1275–3	1545–0887
	1545–1353
	1545–1450
1.1275–4	1545–1450
1.1275–6	1545–1450
1.1287–1	1545–0786
1.1291–9	1545–1507
1.1291–10	1545–1304
	1545–1507
1.1294–1T	1545–1002
	1545–1028
1.1295–1	1545–1555
1.1295–3	1545–1555
1.1298–3	1545–1507
1.1301–1	1545–1662
1.1311(a)–1	1545–0074
1.1361–1	1545–0731
	1545–1591
	1545–2114
1.1361–3	1545–1590
1.1361–5	1545–1590
1.1362–1	1545–1308
1.1362–2	1545–1308
1.1362–3	1545–1308
1.1362–4	1545–1308
1.1362–5	1545–1308
1.1362–6	1545–1308
1.1362–7	1545–1308
1.1362–8	1545–1590
1.1363–2	1545–1906
1.1366–1	1545–1613
1.1367–1(f)	1545–1139
1.1368–1(f)(2)	1545–1139
1.1368–1(f)(3)	1545–1139
1.1368–1(f)(4)	1545–1139
1.1368–1(g)(2)	1545–1139
1.1374–1A	1545–0130
1.1377–1	1545–1462
1.1378–1	1545–1748
1.1383–1	1545–0074
1.1385–1	1545–0074
	1545–0098
1.1388–1	1545–0118
	1545–0123
1.1397E–1	1545–1908
1.1398–1	1545–1375
1.1398–2	1545–1375
1.1402(a)–2	1545–0074
1.1402(a)–5	1545–0074
1.1402(a)–11	1545–0074
1.1402(a)–15	1545–0074
1.1402(a)–16	1545–0074
1.1402(b)–1	1545–0171
1.1402(c)–2	1545–0074
1.1402(e)(1)–1	1545–0074
1.1402(e)(2)–1	1545–0074
1.1402(e)–1A	1545–0168
1.1402(e)–2A	1545–0168
1.1402(e)–3A	1545–0168
1.1402(e)–4A	1545–0168
1.1402(e)–5A	1545–0168
1.1402(f)–1	1545–0074
1.1402(h)–1	1545–0064
1.1411–10(g)	1545–2227
1.1441–1	1545–1484
1.1441–2	1545–0795
1.1441–3	1545–0165
	1545–0795
1.1441–4	1545–1484

CFR part or section where identified and described	Current OMB control No.
1.1441–5	1545–0096
	1545–0795
	1545–1484
1.1441–6	1545–0055
	1545–0795
	1545–1484
1.1441–7	1545–0795
1.1441–8	1545–1053
	1545–1484
1.1441–9	1545–1484
1.1443–1	1545–0096
1.1445–1	1545–0902
1.1445–2	1545–0902
	1545–1060
	1545–1797
1.1445–3	1545–0902
	1545–1060
	1545–1797
1.1445–4	1545–0902
1.1445–5	1545–0902
1.1445–6	1545–0902
	1545–1060
1.1445–7	1545–0902
1.1445–8	1545–0096
1.1445–9T	1545–0902
1.1445–10T	1545–0902
1.1446–1	1545–1934
1.1446–3	1545–1934
1.1446–4	1545–1934
1.1446–5	1545–1934
1.1446–6	1545–1934
1.1451–1	1545–0054
1.1451–2	1545–0054
1.1461–1	1545–0054
	1545–0055
	1545–0795
	1545–1484
1.1461–2	1545–0054
	1545–0055
	1545–0096
	1545–0795
1.1462–1	1545–0795
1.1502–5	1545–0257
1.1502–9	1545–1634
1.1502–9A	1545–0121
1.1502–13	1545–0123
	1545–0885
	1545–1161
	1545–1433
1.1502–16	1545–0123
1.1502–18	1545–0123
1.1502–19	1545–0123
	1545–1774
1.1502–20	1545–1774
1.1502–21	1545–1237
1.1502.21T	1545–0123
1.1502–31	1545–1344
1.1502–32	1545–1344
	1545–1774
1.1502–33	1545–1344
1.1502–35	1545–1828
1.1502–36	1545–2096
1.1502–47	1545–0123
1.1502–75	1545–0025
	1545–0123
	1545–0133
	1545–0152
1.1502–76	1545–1344
1.1502–76T	1545–2019
1.1502–77	1545–1699
1.1502–77A	1545–0123
	1545–1046
1.1502–77B	1545–1699
1.1502–78	1545–0582
1.1502–95	1545–1218
1.1502–95A	1545–1218
1.1502–96	1545–1218
1.1503–2	1545–1583
1.1503–2A	1545–1083
1.1503(d)–1	1545–1946
1.1503(d)–3	1545–1946
1.1503(d)–4	1545–1946
1.1503(d)–5	1545–1946
1.1503(d)–6	1545–1946
1.1552–1	1545–0123
1.1561–3	1545–0123
1.1563–1	1545–0123
	1545–0797
	1545–2019
1.1563–3	1545–0123
1.5000A–3	1545–0074
1.5000A–4	1545–0074
1.5000C–2	1545–0096
	1545–2263
1.5000C–3	1545–0096
	1545–2263
1.5000C–4	1545–1223
	1545–0074
1.6001–1	1545–0058
	1545–0074
	1545–0099
	1545–0123
	1545–0865
1.6011–1	1545–0055
	1545–0074
	1545–0085
	1545–0089
	1545–0090
	1545–0091
	1545–0096
	1545–0121
	1545–0458
	1545–0666
	1545–0675
	1545–0908
1.6011–2	1545–0055
	1545–0938
1.6011–3	1545–0238
	1545–0239
1.6011–4	1545–1685
1.6012–1	1545–0067
	1545–0074
	1545–0085
	1545–0089
	1545–0675
1.6012–2	1545–0047
	1545–0051
	1545–0067
	1545–0123
	1545–0126
	1545–0128
	1545–0130
	1545–0175
	1545–0687
	1545–0890
	1545–1023
	1545–1027
1.6012–3	1545–0047
	1545–0067
	1545–0092
	1545–0196
	1545–0687
1.6012–4	1545–0067
1.6012–5	1545–0067

CFR part or section where identified and described	Current OMB control No.
	1545–0936
	1545–0967
	1545–0970
	1545–0991
	1545–1023
	1545–1033
	1545–1079
1.6012–6	1545–0067
	1545–0089
	1545–0129
1.6013–1	1545–0074
1.6013–2	1545–0091
1.6013–6	1545–0074
1.6013–7	1545–0074
1.6015–5	1545–1719
1.6015(a)–1	1545–0087
1.6015(b)–1	1545–0087
1.6015(d)–1	1545–0087
1.6015(e)–1	1545–0087
1.6015(f)–1	1545–0087
1.6015(g)–1	1545–0087
1.6015(h)–1	1545–0087
1.6015(i)–1	1545–0087
1.6017–1	1545–0074
	1545–0087
	1545–0090
1.6031(a)–1	1545–1583
1.6031(b)–1T	1545–0099
1.6031(c)–1T	1545–0099
1.6032–1	1545–0099
1.6033–2	1545–0047
	1545–0049
	1545–0052
	1545–0092
	1545–0687
	1545–1150
	1545–2117
1.6033–3	1545–0052
1.6034–1	1545–0092
	1545–0094
1.6035–2	1545–0704
1.6037–1	1545–0130
	1545–1023
1.6038–2	1545–1617
	1545–2020
1.6038–3	1545–1617
1.6038A–2	1545–1191
1.6038A–3	1545–1191
	1545–1440
1.6038B–1	1545–1617
	1545–2183
1.6038B–1T	1545–0026
	1545–2183
1.6038B–2	1545–1617
1.6039–2	1545–0820
1.6041–1	1545–0008
	1545–0108
	1545–0112
	1545–0115
	1545–0120
	1545–0295
	1545–0350
	1545–0367
	1545–0387
	1545–0441
	1545–0957
	1545–1705
1.6041–2	1545–0008
	1545–0119
	1545–0350
	1545–0441
	1545–1729
1.6041–3	1545–1148
1.6041–4	1545–0115
	1545–0295
	1545–0367
	1545–0387
	1545–0957
1.6041–5	1545–0295
	1545–0367
	1545–0387
	1545–0957
1.6041–6	1545–0008
	1545–0115
1.6041–7	1545–0112
	1545–0295
	1545–0350
	1545–0367
	1545–0387
	1545–0441
	1545–0957
1.6042–1	1545–0110
1.6042–2	1545–0110
	1545–0295
	1545–0367
	1545–0387
	1545–0957
1.6042–3	1545–0295
	1545–0367
	1545–0387
	1545–0957
1.6042–4	1545–0110
1.6043–1	1545–0041
1.6043–2	1545–0041
	1545–0110
	1545–0295
	1545–0387
1.6043–3	1545–0047
1.6044–1	1545–0118
1.6044–2	1545–0118
1.6044–3	1545–0118
1.6044–4	1545–0118
1.6044–5	1545–0118
1.6045–1	1545–0715
	1545–1705
1.6045–1(c)(3)(xi)(C)	1545–2186
1.6045–1(n)(5)	1545–2186
1.6045A–1	1545–2186
1.6045–2	1545–0115
1.6045–4	1545–1085
1.6046–1	1545–0704
	1545–0794
	1545–1317
1.6046–2	1545–0704
1.6046–3	1545–0704
1.6046A	1545–1646
1.6047–1	1545–0119
	1545–0295
	1545–0387
1.6047–2	1545–2234
1.6049–1	1545–0112
	1545–0117
	1545–0295
	1545–0367
	1545–0387
	1545–0597
	1545–0957
1.6049–2	1545–0117
1.6049–3	1545–0117
1.6049–4	1545–0096
	1545–0112
	1545–0117
	1545–1018
	1545–1050

CFR part or section where identified and described	Current OMB control No.
1.6049–5	1545–0096
	1545–0112
	1545–0117
1.6049–6	1545–0096
1.6049–7	1545–1018
1.6050A–1	1545–0115
1.6050B–1	1545–0120
1.6050D–1	1545–0120
	1545–0232
1.6050E–1	1545–0120
1.6050H–1	1545–0901
	1545–1380
1.6050H–2	1545–0901
	1545–1339
	1545–1380
1.6050I–2	1545–1449
1.6050J–1T	1545–0877
1.6050K–1	1545–0941
1.6050S–1	1545–1678
1.6050S–2	1545–1729
1.6050S–3	1545–1678
1.6050S–4	1545–1729
1.6052–1	1545–0008
1.6052–2	1545–0008
1.6055–1	1545–2252
1.6055–2	1545–2252
1.6060–1	1545–0074
1.6060–1(a)(1)	1545–1231
1.6061–1	1545–0123
1.6062–1	1545–0123
1.6063–1	1545–0123
1.6065–1	1545–0123
1.6071–1	1545–0123
	1545–0810
1.6072–1	1545–0074
1.6072–2	1545–0123
	1545–0807
1.6073–1	1545–0087
1.6073–2	1545–0087
1.6073–3	1545–0087
1.6073–4	1545–0087
1.6074–1	1545–0123
1.6074–2	1545–0123
1.6081–1	1545–0066
	1545–0148
	1545–0233
	1545–1057
	1545–1081
1.6081–2	1545–0148
	1545–1036
	1545–1054
1.6081–3	1545–0233
1.6081–4	1545–0188
	1545–1479
1.6081–6	1545–0148
	1545–1054
1.6081–7	1545–0148
	1545–1054
1.6091–3	1545–0089
1.6107–1	1545–0074
	1545–1231
1.6109–1	1545–0074
1.6109–2	1545–2176
1.6115–1	1545–1464
1.6151–1	1545–0074
1.6153–1	1545–0087
1.6153–4	1545–0087
1.6161–1	1545–0087
1.6162–1	1545–0087
1.6164–1	1545–0135
1.6164–2	1545–0135
1.6164–3	1545–0135
1.6164–5	1545–0135
1.6164–6	1545–0135
1.6164–7	1545–0135
1.6164–8	1545–0135
1.6164–9	1545–0135
1.6302–1	1545–0257
1.6302–2	1545–0098
	1545–0257
1.6411–1	1545–0098
	1545–0135
	1545–0582
1.6411–2	1545–0098
	1545–0582
1.6411–3	1545–0098
	1545–0582
1.6411–4	1545–0582
1.6414–1	1545–0096
1.6425–1	1545–0170
1.6425–2	1545–0170
1.6425–3	1545–0170
1.6654–1	1545–0087
	1545–0140
1.6654–2	1545–0087
1.6654–3	1545–0087
1.6655(e)–1	1545–1421
1.6662–3(c)	1545–0889
1.6662–4(e) and (f)	1545–0889
1.6662–6	1545–1426
1.6694–1	1545–0074
1.6694–2	1545–0074
1.6694–2(c)	1545–1231
1.6694–2(c)(3)	1545–1231
1.6694–3(e)	1545–1231
1.6695–1	1545–0074
	1545–1385
1.6696–1	1545–0074
	1545–0240
1.6851–1	1545–0086
	1545–0138
1.6851–2	1545–0086
	1545–0138
1.7476–1	1545–0197
1.7476–2	1545–0197
1.7519–2T	1545–1036
1.7520–1	1545–1343
1.7520–2	1545–1343
1.7520–3	1545–1343
1.7520–4	1545–1343
1.7701(l)–3	1545–1642
1.7872–15	1545–1792
1.9100–1	1545–0074
1.9101–1	1545–0008
2.1–4	1545–0123
2.1–5	1545–0123
2.1–6	1545–0123
2.1–10	1545–0123
2.1–11	1545–0123
2.1–12	1545–0123
2.1–13	1545–0123
2.1–20	1545–0123
2.1–22	1545–0123
2.1–26	1545–0123
3.2	1545–0123
4.954–1	1545–1068
4.954–2	1545–1068
5.6411–1	1545–0042
	1545–0074
	1545–0098
	1545–0129
	1545–0172
	1545–0582
	1545–0619

CFR part or section where identified and described	Current OMB control No.
5c.44F–1	1545–0619
5c.128–1	1545–0123
5c.305–1	1545–0110
5c.442–1	1545–0152
5f.103–1	1545–0720
5f.6045–1	1545–0715
6a.103A–2	1545–0123
	1545–0720
6a.103A–3	1545–0720
7.465–1	1545–0712
7.465–2	1545–0712
7.465–3	1545–0712
7.465–4	1545–0712
7.465–5	1545–0712
7.936–1	1545–0217
7.999–1	1545–0216
7.6039A–1	1545–0015
7.6041–1	1545–0115
11.410–1	1545–0710
11.412(c)–7	1545–0710
11.412(c)–11	1545–0710
12.7	1545–0190
12.8	1545–0191
12.9	1545–0195
14a.422A–1	1545–0123
15A.453–1	1545–0228
16A.126–2	1545–0074
16A.1255–1	1545–0184
16A.1255–2	1545–0184
18.1371–1	1545–0130
18.1378–1	1545–0130
18.1379–1	1545–0130
18.1379–2	1545–0130
20.2010–2	1545–0015
20.2011–1	1545–0015
20.2014–5	1545–0015
	1545–0260
20.2014–6	1545–0015
20.2016–1	1545–0015
20.2031–2	1545–0015
20.2031–3	1545–0015
20.2031–4	1545–0015
20.2031–6	1545–0015
20.2031–7	1545–0020
20.2031–10	1545–0015
20.2032–1	1545–0015
20.2032A–3	1545–0015
20.2032A–4	1545–0015
20.2032A–8	1545–0015
20.2039–4	1545–0015
20.2051–1	1545–0015
20.2053–3	1545–0015
20.2053–9	1545–0015
20.2053–10	1545–0015
20.2055–1	1545–0015
20.2055–2	1545–0015
	1545–0092
20.2055–3	1545–0015
20.2056(b)–4	1545–0015
20.2056(b)–7	1545–0015
	1545–1612
20.2056A–2	1545–1443
20.2056A–3	1545–1360
20.2056A–4	1545–1360
20.2056A–10	1545–1360
20.2106–1	1545–0015
20.2106–2	1545–0015
20.2204–1	1545–0015
20.2204–2	1545–0015
20.6001–1	1545–0015
20.6011–1	1545–0015
20.6018–1	1545–0015
	1545–0531
20.6018–2	1545–0015
20.6018–3	1545–0015
20.6018–4	1545–0015
	1545–0022
20.6036–2	1545–0015
20.6060–1(a)(1)	1545–1231
20.6061–1	1545–0015
20.6065–1	1545–0015
20.6075–1	1545–0015
20.6081–1	1545–0015
	1545–0181
	1545–1707
20.6091–1	1545–0015
20.6107–1	1545–1231
20.6161–1	1545–0015
	1545–0181
20.6161–2	1545–0015
	1545–0181
20.6163–1	1545–0015
20.6166–1	1545–0181
20.6166A–1	1545–0015
20.6166A–3	1545–0015
20.6324A–1	1545–0754
20.7520–1	1545–1343
20.7520–2	1545–1343
20.7520–3	1545–1343
20.7520–4	1545–1343
22.0	1545–0015
25.2511–2	1545–0020
25.2512–2	1545–0020
25.2512–3	1545–0020
25.2512–5	1545–0020
25.2512–9	1545–0020
25.2513–1	1545–0020
25.2513–2	1545–0020
	1545–0021
25.2513–3	1545–0020
25.2518–2	1545–0959
25.2522(a)–1	1545–0196
25.2522(c)–3	1545–0020
	1545–0196
25.2523(a)–1	1545–0020
	1545–0196
25.2523(f)–1	1545–0015
25.2701–2	1545–1241
25.2701–4	1545–1241
25.2701–5	1545–1273
25.2702–5	1545–1485
25.2702–6	1545–1273
25.6001–1	1545–0020
	1545–0022
25.6011–1	1545–0020
25.6019–1	1545–0020
25.6019–2	1545–0020
25.6019–3	1545–0020
25.6019–4	1545–0020
25.6060–1(a)(1)	1545–1231
25.6061–1	1545–0020
25.6065–1	1545–0020
25.6075–1	1545–0020
25.6081–1	1545–0020
25.6091–1	1545–0020
25.6091–2	1545–0020
25.6107–1	1545–1231
25.6151–1	1545–0020
25.6161–1	1545–0020
25.7520–1	1545–1343
25.7520–2	1545–1343
25.7520–3	1545–1343
25.7520–4	1545–1343
26.2601–1	1545–0985

CFR part or section where identified and described	Current OMB control No.
26.2632–1	1545–0985
	1545–1892
26.2642–1	1545–0985
26.2642–2	1545–0985
26.2642–3	1545–0985
26.2642–4	1545–0985
26.2642–6	1545–1902
26.2652–2	1545–0985
26.2654–1	1545–1902
26.2662–1	1545–0015
	1545–0985
26.2662–2	1545–0985
26.6060–1(a)(1)	1545–1231
26.6107–1	1545–1231
31.3102–3	1545–0029
	1545–0059
	1545–0065
31.3121(b)(19)–1	1545–0029
31.3121(d)–1	1545–0004
31.3121(i)–1	1545–0034
31.3121(r)–1	1545–0029
31.3121(s)–1	1545–0029
31.3121(v)(2)–1	1545–1643
31.3302(a)–2	1545–0028
31.3302(a)–3	1545–0028
31.3302(b)–2	1545–0028
31.3302(e)–1	1545–0028
31.3306(c)(18)–1	1545–0029
31.3401(a)–1	1545–0029
31.3401(a)(6)	1545–1484
31.3401(a)(6)–1	1545–0029
	1545–0096
	1545–0795
31.3401(a)(7)–1	1545–0029
31.3401(a)(8)(A)–1	1545–0029
	1545–0666
31.3401(a)(8)(C)–1	1545–0029
31.3401(a)(15)–1	1545–0182
31.3401(c)–1	1545–0004
31.3402(b)–1	1545–0010
31.3402(c)–1	1545–0010
31.3402(f)(1)–1	1545–0010
31.3402(f)(2)–1	1545–0010
	1545–0410
31.3402(f)(3)–1	1545–0010
31.3402(f)(4)–1	1545–0010
31.3402(f)(4)–2	1545–0010
31.3402(f)(5)–1	1545–0010
	1545–1435
31.3402(h)(1)–1	1545–0029
31.3402(h)(3)–1	1545–0010
	1545–0029
31.3402(h)(4)–1	1545–0010
31.3402(i)–(1)	1545–0010
31.3402(i)–(2)	1545–0010
31.3402(k)–1	1545–0065
31.3402(l)–(1)	1545–0010
31.3402(m)–(1)	1545–0010
31.3402(n)–(1)	1545–0010
31.3402(o)–2	1545–0415
31.3402(o)–3	1545–0008
	1545–0010
	1545–0415
	1545–0717
31.3402(p)–1	1545–0415
	1545–0717
31.3402(q)–1	1545–0238
	1545–0239
31.3404–1	1545–0029
31.3405(c)–1	1545–1341
31.3406(a)–1	1545–0112
31.3406(a)–2	1545–0112
31.3406(a)–3	1545–0112
31.3406(a)–4	1545–0112
31.3406(b)(2)–1	1545–0112
31.3406(b)(2)–2	1545–0112
31.3406(b)(2)–3	1545–0112
31.3406(b)(2)–4	1545–0112
31.3406(b)(2)–5	1545–0112
31.3406(b)(3)–1	1545–0112
31.3406(b)(3)–2	1545–0112
31.3406(b)(3)–3	1545–0112
31.3406(b)(3)–4	1545–0112
31.3406(b)(4)–1	1545–0112
31.3406(c)–1	1545–0112
31.3406(d)–1	1545–0112
31.3406(d)–2	1545–0112
31.3406(d)–3	1545–0112
31.3406(d)–4	1545–0112
31.3406(d)–5	1545–0112
31.3406(e)–1	1545–0112
31.3406(f)–1	1545–0112
31.3406(g)–1	1545–0096
	1545–0112
	1545–1819
31.3406(g)–2	1545–0112
31.3406(g)–3	1545–0112
31.3406(h)–1	1545–0112
31.3406(h)–2	1545–0112
31.3406(h)–3	1545–0112
31.3406(i)–1	1545–0112
31.3501(a)–1T	1545–0771
31.3503–1	1545–0024
31.3504–1	1545–0029
31.3511–1	1545–2266
31.6001–1	1545–0798
31.6001–2	1545–0034
	1545–0798
31.6001–3	1545–0798
31.6001–4	1545–0028
31.6001–5	1545–0798
31.6001–6	1545–0029
	1459–0798
31.6011(a)–1	1545–0029
	1545–0034
	1545–0035
	1545–0059
	1545–0074
	1545–0256
	1545–0718
	1545–2097
31.6011(a)–2	1545–0001
	1545–0002
31.6011(a)–3	1545–0028
31.6011(a)–3A	1545–0955
31.6011(a)–4	1545–0034
	1545–0035
	1545–0718
	1545–1413
	1545–2097
31.6011(a)–5	1545–0028
	1545–0718
	1545–2097
31.6011(a)–6	1545–0028
31.6011(a)–7	1545–0074
31.6011(a)–8	1545–0028
31.6011(a)–9	1545–0028
31.6011(a)–10	1545–0112
31.6011(b)–1	1545–0003
31.6011(b)–2	1545–0029
31.6051–1	1545–0008
	1545–0182
	1545–0458
	1545–1729

CFR part or section where identified and described	Current OMB control No.
31.6051–2	1545–0008
31.6051–3	1545–0008
31.6053–1	1545–0029
	1545–0062
	1545–0064
	1545–0065
	1545–1603
31.6053–2	1545–0008
31.6053–3	1545–0065
	1545–0714
31.6053–4	1545–0065
	1545–1603
31.6060–1(a)(1)	1545–1231
31.6065(a)–1	1545–0029
31.6071(a)–1	1545–0001
	1545–0028
	1545–0029
31.6071(a)–1A	1545–0955
31.6081(a)–1	1545–0008
	1545–0028
31.6091–1	1545–0028
	1545–0029
31.6107–1	1545–1231
31.6157–1	1545–0955
31.6205–1	1545–0029
	1545–2097
31.6301(c)–1AT	1545–0035
	1545–0112
	1545–0257
31.6302–1	1545–1413
31.6302–2	1545–1413
31.6302–3	1545–1413
31.6302–4	1545–1413
31.6302(c)–2	1545–0001
	1545–0257
31.6302(c)–2A	1545–0955
31.6302(c)–3	1545–0257
31.6402(a)–2	1545–0256
	1545–2097
31.6413(a)–1	1545–0029
	1545–2097
31.6413(a)–2	1545–0029
	1545–0256
	1545–2097
31.6413(c)–1	1545–0029
	1545–0171
31.6414–1	1545–0029
	1545–2097
32.1	1545–0029
	1545–0415
32.2	1545–0029
35a.3406–2	1545–0112
35a.9999–5	1545–0029
36.3121(l)(1)–1	1545–0137
36.3121(l)(1)–2	1545–0137
36.3121(l)(3)–1	1545–0123
36.3121(1)(7)–1	1545–0123
36.3121(1)(10)–1	1545–0029
36.3121(1)(10)–3	1545–0029
36.3121(1)(10)–4	1545–0257
40.6060–1(a)(1)	1545–1231
40.6107–1	1545–1231
40.6302(c)–3(b)(2)(ii)	1545–1296
40.6302(c)–3(b)(2)(iii)	1545–1296
40.6302(c)–3(e)	1545–1296
40.6302(c)–3(f)(2)(ii)	1545–1296
41.4481–1	1545–0143
41.4481–2	1545–0143
41.4483–3	1545–0143
41.6001–1	1545–0143
41.6001–2	1545–0143
41.6001–3	1545–0143

CFR part or section where identified and described	Current OMB control No.
41.6060–1(a)(1)	1545–1231
41.6071(a)–1	1545–0143
41.6081(a)–1	1545–0143
41.6091–1	1545–0143
41.6107–1	1545–1231
41.6109–1	1545–0143
41.6151(a)–1	1545–0143
41.6156–1	1545–0143
41.6161(a)(1)–1	1545–0143
44.4401–1	1545–0235
44.4403–1	1545–0235
44.4412–1	1545–0236
44.4901–1	1545–0236
44.4905–1	1545–0236
44.4905–2	1545–0236
44.6001–1	1545–0235
44.6011(a)–1	1545–0235
	1545–0236
44.6060–1(a)(1)	1545–1231
44.6071–1	1545–0235
44.6091–1	1545–0235
44.6107–1	1545–1231
44.6151–1	1545–0235
44.6419–1	1545–0235
44.6419–2	1545–0235
46.4371–4	1545–0023
46.4374–1	1545–0023
46.4375–1	1545–2238
46.4376–1	1545–2238
46.4701–1	1545–0023
	1545–0257
48.4041–4	1545–0023
48.4041–5	1545–0023
48.4041–6	1545–0023
48.4041–7	1545–0023
48.4041–9	1545–0023
48.4041–10	1545–0023
48.4041–11	1545–0023
48.4041–12	1545–0023
48.4041–13	1545–0023
48.4041–19	1545–0023
48.4041–20	1545–0023
48.4041–21	1545–1270
48.4042–2	1545–0023
48.4052–1	1545–1418
48.4061(a)–1	1545–0023
48.4061(a)–2	1545–0023
48.4061(b)–3	1545–0023
48.4064–1	1545–0014
	1545–0242
48.4071–1	1545–0023
48.4073–1	1545–0023
48.4073–3	1545–0023
	1545–1074
	1545–1087
48.4081–2	1545–1270
	1545–1418
48.4081–3	1545–1270
	1545–1418
	1545–1897
48.4081–4(b)(2)(ii)	1545–1270
48.4081–4(b)(3)(i)	1545–1270
48.4081–4(c)	1545–1270
48.4081–6(c)(1)(ii)	1545–1270
48.4081–7	1545–1270
	1545–1418
48.4082–1T	1545–1418
48.4082–2	1545–1418
48.4082–6	1545–1418
48.4082–7	1545–1418
48.4101–1	1545–1418
48.4101–1T	1545–1418

CFR part or section where identified and described	Current OMB control No.
48.4101–2	1545–1418
48.4161(a)–1	1545–0723
48.4161(a)–2	1545–0723
48.4161(a)–3	1545–0723
48.4161(b)–1	1545–0723
48.4216(a)–2	1545–0023
48.4216(a)–3	1545–0023
48.4216(c)–1	1545–0023
48.4221–1	1545–0023
48.4221–2	1545–0023
48.4221–3	1545–0023
48.4221–4	1545–0023
48.4221–5	1545–0023
48.4221–6	1545–0023
48.4221–7	1545–0023
48.4222(a)–1	1545–0014
	1545–0023
48.4223–1	1545–0023
	1545–0257
	1545–0723
48.6302(c)–1	1545–0023
	1545–0257
48.6412–1	1545–0723
48.6416(a)–1	1545–0023
	1545–0723
48.6416(a)–2	1545–0723
48.6416(a)–3	1545–0723
48.6416(b)(1)–1	1545–0723
48.6416(b)(1)–2	1545–0723
48.6416(b)(1)–3	1545–0723
48.6416(b)(1)–4	1545–0723
48.6416(b)(2)–1	1545–0723
48.6416(b)(2)–2	1545–0723
48.6416(b)(2)–3	1545–0723
	1545–1087
48.6416(b)(2)–4	1545–0723
48.6416(b)(3)–1	1545–0723
48.6416(b)(3)–2	1545–0723
48.6416(b)(3)–3	1545–0723
48.6416(b)(4)–1	1545–0723
48.6416(b)(5)–1	1545–0723
48.6416(c)–1	1545–0723
48.6416(e)–1	1545–0023
	1545–0723
48.6416(f)–1	1545–0023
	1545–0723
48.6416(g)–1	1545–0723
48.6416(h)–1	1545–0723
48.6420(c)–2	1545–0023
48.6420(f)–1	1545–0023
48.6420–1	1545–0162
	1545–0723
48.6420–2	1545–0162
	1545–0723
48.6420–3	1545–0162
	1545–0723
48.6420–4	1545–0162
	1545–0723
48.6420–5	1545–0162
	1545–0723
48.6420–6	1545–0162
	1545–0723
48.6421–0	1545–0162
	1545–0723
48.6421–1	1545–0162
	1545–0723
48.6421–2	1545–0162
	1545–0723
48.6421–3	1545–0162
	1545–0723
48.6421–4	1545–0162
	1545–0723
48.6421–5	1545–0162
	1545–0723
48.6421–6	1545–0162
	1545–0723
48.6421–7	1545–0162
	1545–0723
48.6424–0	1545–0723
48.6424–1	1545–0723
48.6424–2	1545–0723
48.6424–3	1545–0723
48.6424–4	1545–0723
48.6424–5	1545–0723
48.6424–6	1545–0723
48.6427–0	1545–0723
48.6427–1	1545–0023
	1545–0162
	1545–0723
48.6427–2	1545–0162
	1545–0723
48.6427–3	1545–0723
48.6427–4	1545–0723
48.6427–5	1545–0723
48.6427–8	1545–1418
48.6427–9	1545–1418
48.6427–10	1545–1418
48.6427–11	1545–1418
49.4251–1	1545–1075
49.4251–2	1545–1075
49.4251–4(d)(2)	1545–1628
49.4253–3	1545–0023
49.4253–4	1545–0023
49.4264(b)–1	1545–0023
	1545–0224
	1545–0225
	1545–0226
	1545–0230
	1545–0257
	1545–0912
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[T.D. 8011, 50 FR 10222, Mar. 14, 1985]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 602.101, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.govinfo.gov*.

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All changes in this volume of the Code of Federal Regulations (CFR) that were made by documents published in the FEDERAL REGISTER since January 1, 2017 are enumerated in the following list. Entries indicate the nature of the changes effected. Page numbers refer to FEDERAL REGISTER pages. The user should consult the entries for chapters, parts and subparts as well as sections for revisions.

For changes to this volume of the CFR prior to this listing, consult the annual edition of the monthly List of CFR Sections Affected (LSA). The LSA is available at *www.govinfo.gov*. For changes to this volume of the CFR prior to 2001, see the ''List of CFR Sections Affected, 1949–1963, 1964–1972, 1973–1985, and 1986–2000'' published in 11 separate volumes. The ''List of CFR Sections Affected 1986–2000'' is available at *www.govinfo.gov*.

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51 Authority citation revised 34611
51.2 (e)(3) revised 34612
51.2T Removed 34612
51.11 Heading and (b) revised; (c) removed 34612
51.11T Removed 34612
54 Policy statement 55507
54.9815-2713 (a)(1) introductory text and (iv) revised; interim 47828
54.9815-2713T Added; interim 47828
(a)(1)(iv) amended; interim 47861
54.9815-2713A Revised; interim 47829
54.9815-2713AT Added; interim 47829
(a)(1), (2), (b)(1)(ii) introductory text, (B), (c)(1)(ii) introductory text, (B) and (2) introductory text amended; interim 47861

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54 Notification 19431
54.9801-2 Amended 38241
54.9815-2713 (a)(1) introductory text and (iv) revised 57586
54.9815-2713 (a)(1)(iv) amended 57630
54.9815-2713A Revised 57586

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54.9815-2713A (a)(1), (2), (b)(1)(ii) introductory text, (B), (c)(1)(ii) introductory text, (B), and (2) amended 57630
54.9815-2713T Removed 57589
54.9815-2713AT Removed 57589
54.9833-1 Amended 38242
57.2 (b)(3) and (c)(3)(ii) revised 8174
57.2T Removed 8174
57.10 (b) revised 8175
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53.4963-1 (a) and (c) amended 14009
53.6011-1 (b) amended 14009
53.6071-1 (i) redesignated as (j); new (i) and (j)(3) added 14009
54 Authority citation amended 28987
54.4972-1 Removed 9239
54.4981A-1T Removed 9239
54.9801-2 Amended 28987
54.9802-4 Added 28987
54.9815-2711 (c), (d), and (e) revised 28997
54.9831-1 (c)(3)(i) revised; (c)(3)(viii) added 28999
55 Authority citation amended 9239

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55.4981-1 Removed 9239
55.4981-2 Amended 9239
57.3 (a)(2) revised 61547
57.10 Heading and (a) revised; (c) added 61547
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53.4968-1 Added 65557
53.4968-2 Added 65557
53.4968-3 Added 65557
53.4968-4 Added 65557
54 Policy statement 26351
54 Authority citation amended 72294
54.9815-1251 (g)(3) and (4) redesignated as (g)(4) and (5); new (g)(3) added; new (g)(4)(i) and new (ii) revised; (g)(1) introductory text, (iii), (iv)(A), (B), (v), and new (5) amended 81116
54.9815-2713T Added; interim 71193
54.9815-2715A1 Added 72295
54.9815-2715A2 Added 72295
54.9815-2715A3 Added 72295
56.4911-9 (d)(2), (3), and (4) introductory text amended 31969
56.4911-10 (f)(1) amended 31969

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53 Authority citation revised 6219

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54.9801-1T Added; interim 36947
54.9801-2T Added; interim 36948
54.9815-2719AT Added; interim 36950
54.9815-2719T Added; interim 56092
54.9816-1T Added; interim 36950
54.9816-1T Revised; interim 56099
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54.9816-2T (a) and (b) introductory text revised 56100
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54.9816-4T Added; interim 36950
54.9816-5T Added; interim 36950
54.9816-6T Added; interim 36950
54.9816-7T Added; interim 36950
54.9816-8T Added; interim 56100
54.9817-1T Added; interim 36950
54.9817-2T Added; interim 56109
54.9822-1T Added; interim 36950
54.9825-1T Added; interim 66696
54.9825-2T Added; interim 66696
54.9825-3T Added; interim 66696
54.9825-4T Added; interim 66696
54.9825-5T Added; interim 66696
54.9825-6T Added; interim 66696

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(No regulations published from January 1, 2022, through April 1, 2022)