§ 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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§ 54.4971–1 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.

(a) In general.
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(1) General rule.
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(4) Plan years beginning before January 1, 1992.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) *No tax when excess distributed within 2½ months of close of year or additional employer contributions made*—(1) *General rule.* No tax is imposed under this section on any excess contribution or excess aggregate contribution, as the case may be, to the extent the contribution (together with any income allocable thereto) is corrected before the close of the first 2½ months of the following plan year (6 months in the case of a plan that includes an eligible automatic contribution arrangement within the meaning of section 414(w)). The extension to 6 months applies to a distribution of excess contributions or excess aggregate contributions for a plan year beginning on or after January 1, 2010, only where all the eligible NHCEs and eligible HCEs (both as defined in §1.401(k)–6 of this Chapter) are covered employees under an eligible automatic contribution arrangement within the meaning of section 414(w) for the entire plan year (or the portion of the plan year that the eligible NHCEs and eligible HCEs are eligible employees under the plan)). Qualified nonelective contributions and qualified matching contributions taken into account under §1.401(k)–2(a)(6) of this Chapter or qualified nonelective contributions or

elective contributions taken into account under §1.401(m)–2(a)(6) of this Chapter for a plan year may permit a plan to avoid excess contributions or excess aggregate contributions, respectively, even if made after the close of the 2½ month (or 6 month) period for distributing excess contributions or excess aggregate contributions without the excise tax. See §1.401(k)–2(b)(1)(i) and (5)(i) of this Chapter for methods to avoid excess contributions, and §1.401(m)–2(b)(1)(i) of the Chapter for methods to avoid excess aggregate contributions.

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

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

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

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

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

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

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

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

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

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

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

§ 54.4980B–0 Table of contents.

This section contains first a list of the section headings and then a list of

the questions in each section in §§ 54.4980B–1 through 54.4980B–10.

LIST OF SECTIONS

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§ 54.4980B–2 Plans that must comply.

§ 54.4980B–3 Qualified beneficiaries.

§ 54.4980B–4 Qualifying events.

§ 54.4980B–5 COBRA continuation coverage.

§ 54.4980B–6 Electing COBRA continuation coverage.

§ 54.4980B–7 Duration of COBRA continuation coverage.

§ 54.4980B–8 Paying for COBRA continuation coverage.

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

§ 54.4980B–10 Interaction of FMLA and COBRA.

LIST OF QUESTIONS

§ 54.4980B–1 COBRA in general.

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§ 54.4980B–2 Plans that must comply.

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

§ 54.4980B–3 Qualified beneficiaries.

Q–1: Who is a qualified beneficiary?

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§ 54.4980B–4 Qualifying events.

Q–1: What is a qualifying event?

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§ 54.4980B–5 COBRA continuation coverage.

Q–1: What is COBRA continuation coverage?

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

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

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

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

§ 54.4980B–6 Electing COBRA continuation coverage.

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

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

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

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

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

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

§ 54.4980B–7 Duration of COBRA continuation coverage.

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

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

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

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

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

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

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

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

§ 54.4980B–8 Paying for COBRA continuation coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

§ 54.4980B–10 Interaction of FMLA and COBRA.

Q–1: In what circumstances does a qualifying event occur if an employee does not return from leave taken under FMLA?

Q–2: If a qualifying event described in Q&A–1 of this section occurs, when does it occur, and how is the maximum coverage period measured?

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

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

Q–5: May COBRA continuation coverage be conditioned upon reimbursement of the premiums paid by the employer for coverage

under a group health plan during FMLA leave?

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

§ 54.4980B–1 COBRA in general.

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

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

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

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

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

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

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

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

§ 54.4980B–2 Plans that must comply.

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

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

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

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

(c) Whether a benefit provided to employees constitutes health care is not affected by whether the benefit is excludable from income under section 132 (relating to certain fringe benefits). For example, if a department store provides its employees discounted prices on all merchandise, including health

care items such as drugs or eyeglasses, the mere fact that the discounted prices also apply to health care items will not cause the program to be a plan providing health care, so long as the discount program would normally be accessible to and used by employees without regard to health needs or physical condition. If, however, the employer maintaining the discount program is a health clinic, so that the program is used exclusively by employees with health or medical needs, the program is considered to be a plan providing health care and so is considered to be a group health plan.

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

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

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

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

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

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

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

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

(1) A person for whom services are performed;

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

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

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

Q–3: What is a multiemployer plan?

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

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

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

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

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

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

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

(c) The COBRA continuation coverage requirements generally do not apply to group health plans that are

excepted from COBRA. However, a small-employer plan otherwise excepted from COBRA is nonetheless subject to COBRA with respect to qualified beneficiaries who experience a qualifying event during a period when the plan is not a small-employer plan (see paragraph (g) of Q&A–5 of this section).

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

Q–5: What is a small-employer plan?

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

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

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

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

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

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

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

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

(d) In determining the number of the employees of an employer, each full-time employee is counted as one employee and each part-time employee is counted as a fraction of an employee, determined in accordance with paragraph (e) of this Q&A–5.

(e) An employer may determine the number of its employees on a daily basis or a pay period basis. The basis used by the employer must be used with respect to all employees of the employer and must be used for the entire year for which the number of employees is being determined. If an employer determines the number of its employees on a daily basis, it must determine the actual number of full-time employees on each typical business day and the actual number of part-time employees and the hours worked by each of those part-time employees on each typical business day. Each full-

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

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

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

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

Example 2. The facts are the same as in *Example 1*. The employer continues to employ 19 employees throughout 2003 and 2004 and consequently the plan continues to be excepted from COBRA during 2004 and 2005. Spouse *S* is covered under the plan because *S* is married to one of the employer's employees. On April 1, 2002, *S* is divorced from that employee and ceases to be eligible for coverage under the plan. The plan is subject to COBRA during 2002 because *X* normally employed 20 employees during 2001. *S* timely notifies the plan administrator of the divorce and timely elects and pays for COBRA continuation coverage. Even though the plan is generally excepted from COBRA during 2003, 2004, and 2005, it must nevertheless continue to make COBRA continuation coverage available to *S* during those years until the obligation to make COBRA continuation coverage available ceases under the rules of § 54.4980B–7. The obligation could continue until April 1, 2005, the date that is 36 months after the date of *S*'s qualifying event.

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

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

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

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

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

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

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

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

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

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

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

Q–7: What is the plan year?

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

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

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

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

(3) If the plan does not impose deductibles or limits on an annual basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, then the plan year is the employer's taxable year.

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

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

A–8: (a)(1) The provision of health care benefits does not fail to be a group

health plan merely because those benefits are offered under a cafeteria plan (as defined in section 125) or under any other arrangement under which an employee is offered a choice between health care benefits and other taxable or nontaxable benefits. However, the COBRA continuation coverage requirements apply only to the type and level of coverage under the cafeteria plan or other flexible benefit arrangement that a qualified beneficiary is actually receiving on the day before the qualifying event. See paragraphs (b) through (e) of this Q&A–8 for rules limiting the obligations of certain health flexible spending arrangements.

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

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

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

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

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

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

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

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

(e) If the conditions in paragraph (c) of this Q&A–8 are satisfied for a plan year, the health FSA is not obligated to make COBRA continuation coverage available for that plan year to any qualified beneficiary who experiences a qualifying event during that plan year unless, as of the date of the qualifying event, the qualified beneficiary can become entitled to receive during the remainder of the plan year a benefit that exceeds the maximum amount that the health FSA is permitted to require to be paid for COBRA continuation coverage for the remainder of the plan year. In determining the amount of the benefit that a qualified beneficiary can become entitled to receive during the remainder of the plan year, the health FSA may deduct from the maximum benefit available to that qualified beneficiary for the year (based on the election made under the health FSA for that qualified beneficiary before the date of the qualifying event) any reimbursable claims submitted to the

health FSA for that plan year before the date of the qualifying event.

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

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

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

(iii) Whether the health FSA is obligated to make COBRA continuation coverage available in 2002 to a qualified beneficiary with respect to a qualifying event that occurs in 2002 depends upon the maximum benefit that would be available to the qualified beneficiary under COBRA continuation coverage for that plan year. *Case 1:* Employee *B* has elected to reduce *B*'s salary by $1200 for 2002. Thus, the maximum benefit that *B* can become entitled to receive under the health FSA during the entire year is $2400. *B* experiences a qualifying event that is the termination of *B*'s employment on May 31, 2002. As of that date, *B* had submitted $300 of reimbursable expenses under the health FSA. Thus, the maximum benefit that *B* could become entitled to receive for the remainder of 2002 is $2100. The maximum amount that the health FSA can require to be paid for COBRA continuation coverage for the remainder of 2002 is 102 percent times 1/12 of the applicable premium for 2002 times the number of months remaining in 2002 after the date of the qualifying event. In *B*'s case, the maximum amount that the health FSA can require to be paid for COBRA continuation coverage for 2002 is 2.04 times $1200, or $2448. One-twelfth of $2448 is $204. Because seven months remain in the plan year, the maximum amount that the health FSA can require to be paid for *B*'s coverage for the remainder of the year is seven times $204, or $1428. Because $1428 is less than the maximum benefit that *B* could become entitled to receive for the remainder of the year ($2100), the health FSA is required to make COBRA continuation coverage available to *B* for the remainder of 2002 (but not for any subsequent year).

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

benefit available for each qualified beneficiary for the remainder of the plan year.)

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

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

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

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

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

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

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

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

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

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

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

§ 54.4980B–3 Qualified beneficiaries.

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

Q–1: Who is a qualified beneficiary?

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

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

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

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

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

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

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

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

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

(e) An individual is not a qualified beneficiary if the individual's status as a covered employee is attributable to a period in which the individual was a nonresident alien who received from the individual's employer no earned income (within the meaning of section 911(d)(2)) that constituted income from sources within the United States (within the meaning of section 861(a)(3)). If, pursuant to the preceding sentence, an individual is not a qualified beneficiary, then a spouse or dependent child of the individual is not considered a qualified beneficiary by virtue of the relationship to the individual.

(f) A qualified beneficiary who does not elect COBRA continuation coverage in connection with a qualifying

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

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

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

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

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

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

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

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

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

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

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

Example 5. (i) The facts are the same as in *Example 4*, except that, under the terms of the plan, the divorce or death does not cause *E* to lose coverage so that *E* continues to be covered for the balance of the original 12-month period.

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

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

A–2: (a)(1) For purposes of §§ 54.4980B–1 through 54.4980B–10 (except for purposes of Q&A–5 in § 54.4980B–2, relating

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

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

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

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

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

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

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

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

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

§ 54.4980B–4 Qualifying events.

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

Q–1: What is a qualifying event?

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

in the case of leave taken under the Family and Medical Leave Act of 1993 (29 U.S.C. 2601–2619).

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

(1) The death of a covered employee;

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

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

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

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

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

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

(d) An event satisfies this paragraph (d) if it occurs while the plan is subject to COBRA. Thus, an event will not satisfy this paragraph (d) if it occurs while the plan is excepted from COBRA (see Q&A–4 of § 54.4980B–2). Even if the plan later becomes subject to COBRA, it is not required to make COBRA continuation coverage available to anyone whose coverage ends as a result of an event during a year in which the plan is excepted from COBRA. For example, if a group health plan is excepted from COBRA as a small-employer plan during the year 2001 (see Q&A–5 of § 54.4980B–2) and an employee terminates employment on December 31, 2001, the termination is not a qualifying event and the plan is not required to permit the employee to elect COBRA continuation coverage. This is the case even if the plan ceases to be a small-employer plan as of January 1, 2002. Also, the same result will follow even if the employee is given three months of coverage beyond December 31 (that is, through March of 2002), because there will be no qualifying event as of the termination of coverage in March. However, if the employee's spouse is initially provided with the three-month coverage through March 2002, but the spouse divorces the employee before the end of the three months and loses coverage as a result

of the divorce, the divorce will constitute a qualifying event during 2002 and so entitle the spouse to elect COBRA continuation coverage. See Q&A–7 of §54.4980B–7 regarding the maximum coverage period in such a case.

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

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

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

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

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

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

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

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

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

Example 4. (i) *F* is a covered employee who is married to *G*, and both are covered under a group health plan maintained by *F*'s employer. *F* and *G* are divorced. Under the terms of the plan, the divorce causes *G* to lose coverage. The divorce is a qualifying event, and *G* elects COBRA continuation coverage, remarries during the period of COBRA continuation coverage, and *G*'s new spouse becomes covered under the plan. (See Q&A–5 in §54.4980B–5, paragraph (c) in Q&A–4 of §54.4980B–5, and section 9801(f)(2).) *G* dies. Under the terms of the plan, the death causes *G*'s new spouse to lose coverage under the plan.

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

Example 5. (i) An employer maintains a group health plan for both active employees and retired employees (and their families). The coverage for active employees and retired employees is identical, and the employer does not require retirees to pay more for coverage than active employees. The plan does not make COBRA continuation coverage available when an employee retires (and is not required to because the retired employee has not lost coverage under the plan). The employer amends the plan to

eliminate coverage for retired employees effective January 1, 2002. On that date, several retired employees (and their spouses and dependent children) have been covered under the plan since their retirement for less than the maximum coverage period that would apply to them in connection with their retirement.

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

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

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

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

§ 54.4980B–5 COBRA continuation coverage.

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

Q–1: What is COBRA continuation coverage?

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

(b) In the case of a qualified beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the child is generally entitled to elect immediately to have the same coverage that dependent children of active employees receive under the benefit packages under which the covered employee has coverage at the time of the birth or placement for adoption. Such a child would be entitled to elect coverage different from that elected by the covered employee during the next available open enrollment period under the plan. See Q&A–4 of this section.

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

A–2: (a) Qualified beneficiaries electing COBRA continuation coverage generally are subject to the same deductibles as similarly situated nonCOBRA beneficiaries. If a qualified beneficiary's COBRA continuation coverage begins before the end of a period prescribed for accumulating amounts

toward deductibles, the qualified beneficiary must retain credit for expenses incurred toward those deductibles before the beginning of COBRA continuation coverage as though the qualifying event had not occurred. The specific application of this rule depends on the type of deductible, as set forth in paragraphs (b) through (d) of this Q&A–2. Special rules are set forth in paragraph (e) of this Q&A–2, and examples appear in paragraph (f) of this Q&A–2.

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

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

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

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

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

Example 1. (i) A group health plan applies a separate $100 annual deductible to each individual it covers. The plan provides that the spouse and dependent children of a covered employee will lose coverage on the last day of the month after the month of the covered employee's death. A covered employee dies on June 11, 2001. The spouse and the two dependent children elect COBRA continuation coverage, which will begin on August 1, 2001. As of July 31, 2001, the spouse has incurred $80 of covered expenses, the older child has incurred no covered expenses, and the younger one has incurred $120 of covered expenses (and therefore has already satisfied the deductible).

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

Example 2. (i) A group health plan applies a separate $200 annual deductible to each individual it covers, except that each family member is treated as having satisfied the individual deductible once the family has incurred $500 of covered expenses during the year. The plan provides that upon the divorce of a covered employee, coverage will end immediately for the employee's spouse and any children who do not remain in the employee's custody. A covered employee with four dependent children is divorced, the

spouse obtains custody of the two oldest children, and the spouse and those children all elect COBRA continuation coverage to begin immediately. The family had accumulated $420 of covered expenses before the divorce, as follows: $70 by each parent, $200 by the oldest child, $80 by the youngest child, and none by the other two children.

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

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

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

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

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

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

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

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

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

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

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

Example 3. (i) A group health plan pays for 80 percent of covered expenses after satisfaction of a $100-per-individual deductible, and the plan pays for 100 percent of covered expenses after a family has incurred out-of-pocket costs of $2,000. The plan provides that upon the divorce of a covered employee, coverage will end immediately for the employee's spouse and any children who do not remain in the employee's custody. An employee and spouse with three dependent children divorce on June 1, 2001, and one of the children remains with the employee. The spouse elects COBRA continuation coverage as of that date for the spouse and the other two children. During January through May of 2001, the spouse incurred $600 of covered expenses and each of the two children in the spouse's custody after the divorce incurred covered expenses of $1,100. This resulted in total out-of-pocket costs for these three individuals of $800 ($300 total for the three deductibles, plus $500 for 20 percent of the other $2,500 in incurred expenses [$600 + $1,100 + $1,100 = $2,800; $2,800 − $300 = $2,500]).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) The right to add new family members under this Q&A–5 is in addition to the rights that newborn and adopted children of covered employees may have as qualified beneficiaries; see Q&A–1 in § 54.4980B–3.

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

§ 54.4980B–6 Electing COBRA continuation coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) The date of the qualifying event; or

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

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

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

A–3: (a) In general, each qualified beneficiary has until 60 days after the later of the date the qualifying event would cause her or him to lose coverage or the date notice is provided to the qualified beneficiary of her or his right to elect COBRA continuation

coverage to decide whether to elect COBRA continuation coverage. If the election is made during that period, coverage must be provided from the date that coverage would otherwise have been lost (but see Q&A–4 of this section). This can be accomplished as described in paragraph (b) or (c) of this Q&A–3.

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

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

(i) Electing and paying for the coverage; or

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

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

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

A–4: If, during the election period, a qualified beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver of COBRA continuation coverage is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the employer, employee organization, or plan administrator, as applicable.

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

A–5: No. An employer, and an employee organization, must not withhold

anything to which a qualified beneficiary is otherwise entitled (by operation of law or other agreement) in order to compel payment for COBRA continuation coverage or to coerce the qualified beneficiary to give up rights to COBRA continuation coverage (including the right to use the full election period to decide whether to elect such coverage). Such a withholding constitutes a failure to comply with the COBRA continuation coverage requirements. Furthermore, any purported waiver obtained by means of such a withholding is invalid.

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

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

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

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

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

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

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

§ 54.4980B–7 Duration of COBRA continuation coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A–2: (a) If a qualified beneficiary first becomes covered under another group health plan (including for this purpose any group health plan of a governmental employer or employee organization) after the date on which COBRA continuation coverage is elected for the qualified beneficiary and the other coverage satisfies the requirements of paragraphs (b), (c), and (d) of this Q&A–2, then the plan may terminate the qualified beneficiary's COBRA continuation coverage upon the date on which the qualified beneficiary first becomes covered under the other group health plan (even if the other coverage is less valuable to the qualified beneficiary). By contrast, if a qualified beneficiary first becomes covered under another group health plan on or before the date on which COBRA continuation coverage is elected, then the other coverage cannot be a basis for terminating the qualified beneficiary's COBRA continuation coverage.

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

(c) The requirement of this paragraph (c) is satisfied if the other group health plan is a plan that is not maintained

by the employer or employee organization that maintains the plan under which COBRA continuation coverage must otherwise be made available.

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

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

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

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

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

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

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

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

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

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

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

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

A–4: (a) Except as otherwise provided in this Q&A–4, the maximum coverage period ends 36 months after the qualifying event. The maximum coverage period for a qualified beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage is the maximum coverage period for the qualifying event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption. Paragraph (b) of this Q&A–4 describes the starting point from which the end of the maximum coverage period is measured. The date that the maximum coverage period ends is described in paragraph (c) of this Q&A–4 in a case where the qualifying event is a termination of employment or reduction of hours of employment, in paragraph (d) of this Q&A–4 in a case where a covered employee becomes entitled to Medicare benefits under title XVIII of the Social Security

Act (42 U.S.C. 1395–1395ggg) before experiencing a qualifying event that is a termination of employment or reduction of hours of employment, and in paragraph (e) of this Q&A–4 in the case of a qualifying event that is the bankruptcy of the employer. See Q&A–8 of § 54.4980B–2 for limitations that apply to certain health flexible spending arrangements. See also Q&A–6 of this section in the case of multiple qualifying events. Nothing in §§ 54.4980B–1 through 54.4980B–10 prohibits a group health plan from providing coverage that continues beyond the end of the maximum coverage period.

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

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

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

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

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

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

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

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

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

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

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

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

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

A–5: (a) A qualified beneficiary becomes entitled to a disability extension if the requirements of paragraphs

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

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

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

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

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

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

(b) The requirements of this paragraph (b) are satisfied if a qualifying event that gives rise to an 18-month maximum coverage period (or a 29-month maximum coverage period in the case of a disability extension) is followed, within that 18-month period (or within that 29-month period, in the case of a disability extension), by a second qualifying event (for example, a death or a divorce) that gives rise to a 36-month maximum coverage period. (Thus, a termination of employment following a qualifying event that is a reduction of hours of employment cannot be a second qualifying event that expands the maximum coverage period; the bankruptcy of an employer also cannot be a second qualifying event that expands the maximum coverage period.) In such a case, the original 18-month period (or 29-month period, in the case of a disability extension) is expanded to 36 months, but only for those individuals who were qualified beneficiaries under the group health plan in connection with the first qualifying event and who are still qualified beneficiaries at the time of the second

qualifying event. No qualifying event (other than a qualifying event that is the bankruptcy of the employer) can give rise to a maximum coverage period that ends more than 36 months after the date of the first qualifying event (or more than 36 months after the date of the loss of coverage, in the case of a plan that provides for the extension of the required periods; see paragraph (b) in Q&A–4 of this section). For example, if an employee covered by a group health plan that is subject to COBRA terminates employment (for reasons other than gross misconduct) on December 31, 2000, the termination is a qualifying event giving rise to a maximum coverage period that extends for 18 months to June 30, 2002. If the employee dies after the employee and the employee's spouse and dependent children have elected COBRA continuation coverage and on or before June 30, 2002, the spouse and dependent children (except anyone among them whose COBRA continuation coverage had already ended for some other reason) will be able to receive COBRA continuation coverage through December 31, 2003. See Q&A–8(b) of § 54.4980B–2 for a special rule that applies to certain health flexible spending arrangements.

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

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

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

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

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

A–8: If a qualified beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the maximum coverage period, the group health plan must, during the 180-day period that ends on that expiration date, provide the qualified beneficiary the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated nonCOBRA beneficiaries under the group health plan. If such a conversion option is not otherwise generally available, it need not be made available to qualified beneficiaries.

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

§ 54.4980B–8 Paying for COBRA continuation coverage.

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

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

A–1: (a) Yes. For any period of COBRA continuation coverage, a group

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

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

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

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

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

(ii) Even though the employee's disabled spouse does not elect or pay for COBRA continuation coverage, the employee satisfies the requirements for the disability extension to apply with respect to the employee's qualifying event. Under these facts, the plan may not require the payment of more than 102 percent of the applicable premium for individual coverage for the entire period of the employee's COBRA continuation coverage, including the period from the 19th month through the 29th month. If COBRA continuation coverage had been elected and paid for with respect to other nondisabled members of the employee's family, then the plan could not require the payment of more than 102 percent of the applicable premium for family

coverage (or for any other appropriate category of coverage that might apply to that group of qualified beneficiaries under the plan, such as employee-plus-one-dependent or employee-plus-two-or-more-dependents) for those family members to continue their coverage from the 19th month through the 29th month.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) If timely payment is made to the plan in an amount that is not significantly less than the amount the plan requires to be paid for a period of coverage, then the amount paid is deemed to satisfy the plan's requirement for the amount that must be paid, unless the plan notifies the qualified beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. For this purpose, as a safe harbor, 30 days after the date the notice is provided is deemed to be a reasonable period of time. An amount is not significantly less than the amount the plan requires to be paid for a period of coverage if and only if the shortfall is no greater than the lesser of the following two amounts:

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

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

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

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

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

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

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

A–1: For purposes of this section:

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

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

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

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

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

A–2: In the case of a stock sale—

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

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

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

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

A–3: In the case of an asset sale—

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

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

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

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

(b) Stock sales: In the case of a stock sale, an individual is an M&A qualified beneficiary if the individual is a qualified beneficiary whose qualifying event occurred prior to or in connection with the sale and who is, or whose qualifying event occurred in connection with, a covered employee whose last employment prior to the qualifying event was with the acquired organization.

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

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

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

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

A–6: (a) Yes, unless—

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

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

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

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

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

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

A–8: (a) In the case of a business reorganization (whether a stock sale or an asset sale), so long as the selling group maintains a group health plan after the sale, a group health plan maintained by the selling group has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to that sale. This Q&A–8 prescribes rules for cases in which the selling group ceases to provide any group health plan to any employee in connection with the sale. Paragraph (b) of this Q&A–8 contains these rules for stock sales, and paragraph (c) of this Q&A–8 contains these rules for asset sales. Neither a stock sale nor an asset sale has any effect on the COBRA continuation coverage requirements applicable to any group health plan for any period before the sale.

(b)(1) In the case of a stock sale, if the selling group ceases to provide any group health plan to any employee in

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

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

(ii) The date of the stock sale.

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

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

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

(ii) The date of the asset sale.

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

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

Stock Sale Examples

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

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

Example 2. (i) Selling Group *S* consists of three corporations, *A*, *B*, and *C*. Each of *A*, *B*, and *C* maintains a group health plan for its employees (and their families). Buying

Group *P* consists of two corporations, *D* and *E*. *P* enters into a contract to purchase all of the stock of *C* from *S* effective July 1, 2002. As of June 30, 2002, there are 14 qualified beneficiaries receiving COBRA continuation coverage under *C*'s plan. *C* continues to employ all of its employees and continues to maintain its group health plan after being acquired by *P* on July 1, 2002.

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

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

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

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

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

Asset Sale Examples

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

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

Example 6. (i) Selling Group *S* provides group health plan coverage to employees at each of its operating divisions. *S* sells substantially all of the assets of all of its divisions to Buying Group *P*, and *S* ceases to provide any group health plan to any employee

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

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

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

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

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

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

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

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

Example 8. (i) Selling Group *S* provides group health plan coverage to employees at each of its operating divisions. *S* sells substantially all of the assets of all of its divisions to Buying Group *P*. *P* hires most of *S*'s employees on the date of the purchase of *S*'s assets, retains those employees in the same positions that they had with *S* before the purchase, and continues the business operations of those divisions without substantial change or interruption. *P* provides these employees with coverage under a group health plan. *S* continues to employ a few employees for the principal purpose of winding up the affairs of *S* in preparation for liquidation. *S* continues to provide coverage under a group health plan to these few remaining employees for several weeks after the date of the sale and then ceases to provide any group health plan to any employee.

(ii) Under these facts, the cessation by *S* to provide any group health plan to any employee is in connection with the asset sale to *P*. Because of this, and because *P* continued

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) Under these facts, *M* has the obligation to make COBRA continuation coverage available from July 1, 2001 until August 31, 2001, and the group health plan established by *X* has the obligation to make COBRA continuation coverage available from September 1, 2001 until the obligation ends (see Q&A–1 of §54.4980B–7) to any qualified beneficiary who experienced a qualifying event that preceded or coincided with the cessation of contributions to *M* and whose coverage under *M* on the day before the qualifying event was due to an employment affiliation with *X*. The loss of coverage under *M* for those employees of *X* who continue in employment (and the loss of coverage for their spouses and dependent children) does not constitute a qualifying event.

Example 5. (i) Employer *W* employs a class of employees covered by a collective bargaining agreement and participating in multiemployer group health plan *M*. As required by the collective bargaining agreement, *W* has been making contributions to *M*. The employees covered by the collective bargaining agreement vote to decertify their current employee representative effective January 1, 2002 and vote to certify a new employee representative effective the same date. As a consequence, on January 1, 2002 they cease to be covered under *M* and commence to be covered under multiemployer group health plan *N*.

(ii) Effective January 1, 2002, *N* has the obligation to make COBRA continuation coverage available to any qualified beneficiary who experienced a qualifying event that preceded or coincided with the cessation of contributions to *M* and whose coverage under *M* on the day before the qualifying event was due to an employment affiliation with W. The loss of coverage under *M* for those employees of W who continue in employment (and the loss of coverage for their spouses and dependent children) does not constitute a qualifying event.

[T.D. 8928, 66 FR 1855, Jan. 10, 2001]

§ 54.4980B–10 Interaction of FMLA and COBRA.

The following questions-and-answers address how the taking of leave under the Family and Medical Leave Act of 1993 (FMLA) (29 U.S.C. 2601–2619) affects the COBRA continuation coverage requirements:

Q–1: In what circumstances does a qualifying event occur if an employee does not return from leave taken under FMLA?

A–1: (a) The taking of leave under FMLA does not constitute a qualifying event. A qualifying event under Q&A–1 of §54.4980B–4 occurs, however, if—

(1) An employee (or the spouse or a dependent child of the employee) is covered on the day before the first day of FMLA leave (or becomes covered

during the FMLA leave) under a group health plan of the employee's employer;

(2) The employee does not return to employment with the employer at the end of the FMLA leave; and

(3) The employee (or the spouse or a dependent child of the employee) would, in the absence of COBRA continuation coverage, lose coverage under the group health plan before the end of the maximum coverage period.

(b) However, the satisfaction of the three conditions in paragraph (a) of this Q&A–1 does not constitute a qualifying event if the employer eliminates, on or before the last day of the employee's FMLA leave, coverage under a group health plan for the class of employees (while continuing to employ that class of employees) to which the employee would have belonged if the employee had not taken FMLA leave.

Q–2: If a qualifying event described in Q&A–1 of this section occurs, when does it occur, and how is the maximum coverage period measured?

A–2: A qualifying event described in Q&A–1 of this section occurs on the last day of FMLA leave. (The determination of when FMLA leave ends is not made under the rules of this section. See the FMLA regulations, 29 CFR Part 825 (§§825.100–825.800).) The maximum coverage period (see Q&A–4 of §54.4980B–7) is measured from the date of the qualifying event (that is, the last day of FMLA leave). If, however, coverage under the group health plan is lost at a later date and the plan provides for the extension of the required periods (see paragraph (b) of Q&A–4 of §54.4980B–7), then the maximum coverage period is measured from the date when coverage is lost. The rules of this Q&A–2 are illustrated by the following examples:

Example 1. (i) Employee *B* is covered under the group health plan of Employer *X* on January 31, 2001. *B* takes FMLA leave beginning February 1, 2001. *B*'s last day of FMLA leave is 12 weeks later, on April 25, 2001, and *B* does not return to work with *X* at the end of the FMLA leave. If *B* does not elect COBRA continuation coverage, *B* will not be covered under the group health plan of *X* as of April 26, 2001.

(ii) *B* experiences a qualifying event on April 25, 2001, and the maximum coverage period is measured from that date. (This is the case even if, for part or all of the FMLA leave, *B* fails to pay the employee portion of premiums for coverage under the group health plan of *X* and is not covered under *X*'s plan. See Q&A–3 of this section.)

Example 2. (i) Employee *C* and *C*'s spouse are covered under the group health plan of Employer *Y* on August 15, 2001. *C* takes FMLA leave beginning August 16, 2001. *C* informs *Y* less than 12 weeks later, on September 28, 2001, that *C* will not be returning to work. Under the FMLA regulations, 29 CFR Part 825 (§§825.100–825.800), *C*'s last day of FMLA leave is September 28, 2001. *C* does not return to work with *Y* at the end of the FMLA leave. If *C* and *C*'s spouse do not elect COBRA continuation coverage, they will not be covered under the group health plan of *Y* as of September 29, 2001.

(ii) *C* and *C*'s spouse experience a qualifying event on September 28, 2001, and the maximum coverage period (generally 18 months) is measured from that date. (This is the case even if, for part or all of the FMLA leave, *C* fails to pay the employee portion of premiums for coverage under the group health plan of *Y* and *C* or *C*'s spouse is not covered under *Y*'s plan. See Q&A–3 of this section.)

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

A–3: No. Any lapse of coverage under a group health plan during FMLA leave is irrelevant in determining whether a set of circumstances constitutes a qualifying event under Q&A–1 of this section or when such a qualifying event occurs under Q&A–2 of this section.

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

A–4: No. Any state or local law that requires coverage under a group health plan to be maintained during a leave of absence for a period longer than that required under FMLA (for example, for 16 weeks of leave rather than for the 12 weeks required under FMLA) is disregarded for purposes of determining when a qualifying event occurs under Q&A–1 through Q&A–3 of this section.

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

A–5: No. The U.S. Department of Labor has published rules describing the circumstances in which an employer may recover premiums it pays to maintain coverage, including family coverage, under a group health plan during FMLA leave from an employee who fails to return from leave. See 29 CFR 825.213. Even if recovery of premiums is permitted under 29 CFR 825.213, the right to COBRA continuation coverage cannot be conditioned upon the employee's reimbursement of the employer for premiums the employer paid to maintain coverage under a group health plan during FMLA leave.

[T.D. 8928, 66 FR 1855, Jan. 10, 2001]

§ 54.4980D–1 Requirement of return and time for filing of the excise tax under section 4980D.

Q–1: If a person is liable for the excise tax under section 4980D, what form must the person file and what is the due date for the filing and payment of the excise tax?

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

(b) *Due date for filing of return by employers. See* § 54.6071–1(b)(1).

(c) *Due date for filing of return by multiemployer plans or multiple employer health plans. See* § 54.6071–1(b)(2).

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

[T.D. 9457, 74 FR 45997, Sept. 8, 2009]

§ 54.4980E–1 Requirement of return and time for filing of the excise tax under section 4980E.

Q–1: If a person is liable for the excise tax under section 4980E, what form must the person file and what is the due date for the filing and payment of the excise tax?

A–1: (a) *In general. See* §§ 54.6011–2, 54.6151–1 and 54.6071–1(c).

(b) *Effective/applicability date.* The rules in this Q & A–1 are effective for plan years beginning on or after January 1, 2010.

[T.D. 9457, 74 FR 45997, Sept. 8, 2009]

§ 54.4980F–1 Notice requirements for certain pension plan amendments significantly reducing the rate of future benefit accrual.

The following questions and answers concern the notification requirements imposed by 4980F of the Internal Revenue Code and section 204(h) of ERISA relating to a plan amendment of an applicable pension plan that significantly reduces the rate of future benefit accrual or that eliminates or significantly reduces an early retirement benefit or retirement-type subsidy.

LIST OF QUESTIONS

Q–1. What are the notice requirements of section 4980F(e) of the Internal Revenue Code and section 204(h) of ERISA?
Q–2. What are the differences between section 4980F and section 204(h)?
Q–3. What is an ''applicable pension plan'' to which section 4980F and section 204(h) apply?
Q–4. What is ''section 204(h) notice'' and what is a ''section 204(h) amendment''?
Q–5. For which amendments is section 204(h) notice required?
Q–6. What is an amendment that reduces the rate of future benefit accrual or reduces an early retirement benefit or retirement-type subsidy for purposes of determining whether section 204(h) notice is required?
Q–7. What plan provisions are taken into account in determining whether an amendment is a section 204(h) amendment?
Q–8. What is the basic principle used in determining whether a reduction in the rate of future benefit accrual or a reduction in an early retirement benefit or retirement-type subsidy is significant for purposes of section 4980F and section 204(h)?
Q–9. When must section 204(h) notice be provided?
Q–10. To whom must section 204(h) notice be provided?
Q–11. What information is required to be provided in a section 204(h) notice?
Q–12. What special rules apply if participants can choose between the old and new benefit formulas?
Q–13. How may section 204(h) notice be provided?

Q–14. What are the consequences if a plan administrator fails to provide section 204(h) notice?
Q–15. What are some of the rules that apply with respect to the excise tax under section 4980F?
Q–16. How do section 4980F and section 204(h) apply when a business is sold?
Q–17. How are amendments to cease accruals and terminate a plan treated under section 4980F and section 204(h)?
Q–18. What are the effective dates of section 4980F, section 204(h), as amended by EGTRRA, and these regulations?

QUESTIONS AND ANSWERS

Q–1. What are the notice requirements of section 4980F(e) of the Internal Revenue Code and section 204(h) of ERISA?

A–1. (a) *Requirements of Internal Revenue Code section 4980F(e) and ERISA section 204(h).* Section 4980F of the Internal Revenue Code (section 4980F) and section 204(h) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), 29 U.S.C. 1054(h) (section 204(h)) each generally requires notice of an amendment to an applicable pension plan that either provides for a significant reduction in the rate of future benefit accrual or that eliminates or significantly reduces an early retirement benefit or retirement-type subsidy. The notice is required to be provided to plan participants and alternate payees who are applicable individuals (as defined in Q&A–10 of this section), to certain employee organizations, and to contributing employers under a multiemployer plan (as described in Q&A–10(a) of this section). The plan administrator must generally provide the notice before the effective date of the plan amendment. Q&A–9 of this section sets forth the time frames for providing notice, Q&A–11 of this section sets forth the content requirements for the notice, and Q&A–12 of this section contains special rules for cases in which participants can choose between the old and new benefit formulas.

(b) *Other notice requirements.* Other provisions of law may require that certain parties be notified of a plan amendment. See, for example, sections 102 and 104 of ERISA, and the regulations thereunder, for requirements relating to summary plan descriptions and summaries of material modifications.

Q–2. What are the differences between section 4980F and section 204(h)?

A–2. The notice requirements of section 4980F generally are parallel to the notice requirements of section 204(h), as amended by the Economic Growth and Tax Relief Reconciliation Act of 2001, Public Law 107–16 (115 Stat. 38) (2001) (EGTRRA). However, the consequences of the failure to satisfy the requirements of the two provisions differ: Section 4980F imposes an excise tax on a failure to satisfy the notice requirements, while section 204(h)(6), as amended by EGTRRA, contains a special rule with respect to an egregious failure to satisfy the notice requirements. See Q&A–14 and Q&A–15 of this section. Except to the extent specifically indicated, these regulations apply both to section 4980F and to section 204(h).

Q–3. What is an ''applicable pension plan'' to which section 4980F and section 204(h) apply?

A–3. (a) *In general.* Section 4980F and section 204(h) apply to an applicable pension plan. For purposes of section 4980F, an *applicable pension plan* means a defined benefit plan qualifying under section 401(a) or 403(a) of the Internal Revenue Code, or an individual account plan that is subject to the funding standards of section 412 of the Internal Revenue Code. For purposes of section 204(h), an *applicable pension plan* means a defined benefit plan that is subject to part 2 of subtitle B of title I of ERISA, or an individual account plan that is subject to such part 2 and to the funding standards of section 412 of the Internal Revenue Code. Accordingly, individual account plans that are not subject to the funding standards of section 412 of the Internal Revenue Code, such as profit-sharing and stock bonus plans and contracts under section 403(b) of the Internal Revenue Code, are not applicable pension plans to which section 4980F or section 204(h) apply. Similarly, a defined benefit plan that neither qualifies under section 401(a) or 403(a) of the Internal Revenue Code nor is subject to part 2 of subtitle B of title I of ERISA is not an applicable pension plan. Further, neither a governmental plan (within the meaning of section

414(d) of the Internal Revenue Code), nor a church plan (within the meaning of section 414(e) of the Internal Revenue Code) with respect to which no election has been made under section 410(d) of the Internal Revenue Code is an applicable pension plan.

(b) *Section 204(h) notice not required for small plans covering no employees.* Section 204(h) notice is not required for a plan under which no employees are participants covered under the plan, as described in §2510.3–3(b) of the Department of Labor regulations, and which has fewer than 100 participants.

Q–4. What is ''section 204(h) notice'' and what is a ''section 204(h) amendment''?

A–4. (a) *Section 204(h) notice* is notice that complies with section 4980F(e) of the Internal Revenue Code, section 204(h)(1) of ERISA, and this section.

(b) A *section 204(h) amendment* is an amendment for which section 204(h) notice is required under this section.

Q–5. For which amendments is section 204(h) notice required?

A–5. (a) *Significant reduction in the rate of future benefit accrual.* Section 204(h) notice is required for an amendment to an applicable pension plan that provides for a significant reduction in the rate of future benefit accrual.

(b) *Early retirement benefits and retirement-type subsidies.* Section 204(h) notice is also required for an amendment to an applicable pension plan that provides for the significant reduction of an early retirement benefit or retirement-type subsidy. For purposes of this section, *early retirement benefit* and *retirement-type subsidy* mean early retirement benefits and retirement-type subsidies within the meaning of section 411(d)(6)(B)(i).

(c) *Elimination or cessation of benefits.* For purposes of this section, the terms *reduce* or *reduction* include eliminate or cease or elimination or cessation.

(d) *Delegation of authority to Commissioner.* The Commissioner may provide in revenue rulings, notices, or other guidance published in the Internal Revenue Bulletin (*see* §601.601(d)(2) of this chapter) that section 204(h) notice need not be provided for plan amendments otherwise described in paragraph (a) or (b) of this Q&A–5 that the Commissioner determines to be necessary or appropriate, as a result of changes in the law, to maintain compliance with the requirements of the Internal Revenue Code (including requirements for tax qualification), ERISA, or other applicable federal law.

Q–6. What is an amendment that reduces the rate of future benefit accrual or reduces an early retirement benefit or retirement-type subsidy for purposes of determining whether section 204(h) notice is required?

A–6. (a) *In general.* For purposes of determining whether section 204(h) notice is required, an amendment reduces the rate of future benefit accrual or reduces an early retirement benefit or retirement-type subsidy only as provided in paragraph (b) or (c) of this Q&A–6.

(b) *Reduction in rate of future benefit accrual*—(1) *Defined benefit plans.* For purposes of section 4980F and section 204(h), an amendment to a defined benefit plan reduces the rate of future benefit accrual only if it is reasonably expected that the amendment will reduce the amount of the future annual benefit commencing at normal retirement age (or at actual retirement age, if later) for benefits accruing for a year. For this purpose, the annual benefit commencing at normal retirement age is the benefit payable in the form in which the terms of the plan express the accrued benefit (or, in the case of a plan in which the accrued benefit is not expressed in the form of an annual benefit commencing at normal retirement age, the benefit payable in the form of a single life annuity commencing at normal retirement age that is the actuarial equivalent of the accrued benefit expressed under the terms of the plan, as determined in accordance with section 411(c)(3) of the Internal Revenue Code).

(2) *Individual account plans.* For purposes of section 4980F and section 204(h), an amendment to an individual account plan reduces the rate of future benefit accrual only if it is reasonably expected that the amendment will reduce the amount of contributions or forfeitures allocated for any future year. Changes in the investments or investment options under an individual account plan are not taken into account for this purpose.

(3) *Determination of rate of future benefit accrual.* The rate of future benefit accrual for purposes of this paragraph (b) is determined without regard to optional forms of benefit within the meaning of §1.411(d)–4, Q&A–1(b) of this chapter (other than the annual benefit described in paragraph (b)(1) of this Q&A–6). The rate of future benefit accrual is also determined without regard to ancillary benefits and other rights or features as defined in §1.401(a)(4)–4(e) of this chapter.

(c) *Reduction of early retirement benefits or retirement-type subsidies.* For purposes of section 4980F and section 204(h), an amendment reduces an early retirement benefit or retirement-type subsidy only if it is reasonably expected that the amendment will eliminate or reduce an early retirement benefit or retirement-type subsidy.

Q–7. What plan provisions are taken into account in determining whether an amendment is a section 204(h) amendment?

A–7. (a) *Plan provisions taken into account*—-(1) *In general.* All plan provisions that may affect the rate of future benefit accrual, early retirement benefits, or retirement-type subsidies of participants or alternate payees must be taken into account in determining whether an amendment is a section 204(h) amendment. For example, plan provisions that may affect the rate of future benefit accrual include the dollar amount or percentage of compensation on which benefit accruals are based; the definition of service or compensation taken into account in determining an employee's benefit accrual; the method of determining average compensation for calculating benefit accruals; the definition of normal retirement age in a defined benefit plan; the exclusion of current participants from future participation; benefit offset provisions; minimum benefit provisions; the formula for determining the amount of contributions and forfeitures allocated to participants' accounts in an individual account plan; in the case of a plan using permitted disparity under section 401(l) of the Internal Revenue Code, the amount of disparity between the excess benefit percentage or excess contribution percentage and the base benefit percentage or base contribution percentage (all as defined in section 401(l) of the Internal Revenue Code); and the actuarial assumptions used to determine contributions under a target benefit plan (as defined in §1.401(a)(4)–8(b)(3)(i) of this chapter). Plan provisions that may affect early retirement benefits or retirement-type subsidies include the right to receive payment of benefits after severance from employment and before normal retirement age and actuarial factors used in determining optional forms for distribution of retirement benefits.

(2) *Provisions incorporated by reference in plan.* If all or a part of a plan's rate of future benefit accrual, or an early retirement benefit or retirement-type subsidy provided under the plan, depends on provisions in another document that are referenced in the plan document, a change in the provisions of the other document is an amendment of the plan.

(b) *Plan provisions not taken into account*—(1) *In general.* Plan provisions that do not affect the rate of future benefit accrual of participants or alternate payees are not taken into account in determining whether there has been a reduction in the rate of future benefit accrual.

(2) *Interaction with section 411(d)(6).* Any benefit that is not a section 411(d)(6) protected benefit as described in §§1.411(d)–3(g)(14) and 1.411(d)–4, Q&A–1(d) of this chapter, or that is a section 411(d)(6) protected benefit that may be eliminated or reduced as permitted under §1.411(d)–3(c), (d), or (f), or under §1.411(d)–4, Q&A–2(a)(2), (a)(3), (b)(1), or (b)(2)(ii) through (b)(2)(xi) of this chapter, is not taken into account in determining whether an amendment is a section 204(h) amendment. Thus, for example, provisions relating to the right to make after-tax deferrals are not taken into account.

(c) *Examples.* The following examples illustrate the rules in this Q&A–7:

Example 1. (i) *Facts.* A defined benefit plan provides a normal retirement benefit equal to 50% of highest 5-year average pay multiplied by a fraction (not in excess of one), the numerator of which equals the number of years of participation in the plan and the denominator of which is 20. A plan amendment is adopted that changes the numerator or denominator of that fraction.

(ii) *Conclusion.* The plan amendment must be taken into account in determining whether there has been a reduction in the rate of future benefit accrual.

Example 2. (i) *Facts.* Plan C is a multiemployer defined benefit plan subject to several collective bargaining agreements. The specific benefit formula under Plan C that applies to an employee depends on the hourly rate of contribution of the employee's employer, which is set forth in the provisions of the collective bargaining agreements that are referenced in the Plan C document. Collective Bargaining Agreement A between Employer B and the union representing employees of Employer B is renegotiated to provide that the hourly contribution rate for an employee of B who is subject to the Collective Bargaining Agreement A will decrease. That decrease will result in a decrease in the rate of future benefit accrual for employees of B.

(ii) *Conclusion.* Under paragraph (a)(2) of this Q&A–7, the change to Collective Bargaining Agreement A is a plan amendment that is a section 204(h) amendment if the reduction in the rate of future benefit accrual is significant.

Q–8. What is the basic principle used in determining whether a reduction in the rate of future benefit accrual or a reduction in an early retirement benefit or retirement-type subsidy is significant for purposes of section 4980F and section 204(h)?

A–8. (a) *General rule.* Whether an amendment reducing the rate of future benefit accrual or eliminating or reducing an early retirement benefit or retirement-type subsidy provides for a reduction that is significant for purposes of section 4980F (and section 204(h) of ERISA) is determined based on reasonable expectations taking into account the relevant facts and circumstances at the time the amendment is adopted, or, if earlier, at the effective date of the amendment.

(b) *Application for determining significant reduction in the rate of future benefit accrual.* For a defined benefit plan, the determination of whether an amendment provides for a significant reduction in the rate of future benefit accrual is made by comparing the amount of the annual benefit commencing at normal retirement age (or at actual retirement age, if later), as determined under Q&A–6(b)(1) of this section, under the terms of the plan as amended with the amount of the annual benefit commencing at normal retirement age (or at actual retirement age, if later), as determined under Q&A–6(b)(1) of this section, under the terms of the plan prior to amendment. For an individual account plan, the determination of whether an amendment provides for a significant reduction in the rate of future benefit accrual is made in accordance with Q&A–6(b)(2) of this section by comparing the amounts to be allocated in the future to participants' accounts under the terms of the plan as amended with the amounts to be allocated in the future to participants' accounts under the terms of the plan prior to amendment. An amendment to convert a money purchase pension plan to a profit-sharing or other individual account plan that is not subject to section 412 of the Internal Revenue Code is, in all cases, deemed to be an amendment that provides for a significant reduction in the rate of future benefit accrual.

(c) *Application to certain amendments reducing early retirement benefits or retirement-type subsidies.* Section 204(h) notice is not required for an amendment that reduces an early retirement benefit or retirement-type subsidy if the amendment is permitted under the third sentence of section 411(d)(6)(B) of the Internal Revenue Code and paragraphs (c), (d), and (f) of §1.411(d)–3 of this chapter (relating to the elimination or reduction of benefits or subsidies which create significant burdens or complexities for the plan and plan participants unless the amendment adversely affects the rights of any participant in a more than *de minimis* manner). However, in determining whether an amendment reducing a retirement-type subsidy constitutes a significant reduction because it reduces a retirement-type subsidy as permitted under §1.411(d)–3(e)(6) of this chapter, the amendment is treated in the same manner as an amendment that limits the retirement-type subsidy to benefits that accrue before the applicable amendment date (as defined at §1.411(d)–3(g)(4) of this chapter) with respect to each participant or alternate payee to whom the reduction is reasonably expected to apply.

(d) *Plan amendments reflecting a change in statutorily mandated minimum present value rules.* If a defined benefit

plan offers a distribution to which the minimum present value rules of section 417(e)(3) apply (other than a payment to which section 411(a)(13)(A) applies) and the plan is amended to reflect the changes to the applicable interest rate and applicable mortality table in section 417(e)(3) made by the Pension Protection Act of 2006, Public Law 109–780 (120 Stat. 780) (PPA '06) (and no change is made in the dates on which the payment will be made), no section 204(h) notice is required to be provided.

(e) *Examples.* The following examples illustrate the rules in this Q&A–8:

Example 1. (i) *Facts.* Pension Plan A is a defined benefit plan that provides a rate of benefit accrual of 1% of highest-5 years pay multiplied by years of service, payable annually for life commencing at normal retirement age (or at actual retirement age, if later). An amendment to Plan A is adopted on August 1, 2009, effective January 1, 2010, to provide that any participant who separates from service after December 31, 2009, and before January 1, 2015, will have the same number of years of service he or she would have had if his or her service continued to December 31, 2014.

(ii) *Conclusion.* In this example, the effective date of the plan amendment is January 1, 2010. While the amendment will result in a reduction in the annual rate of future benefit accrual from 2011 through 2014 (because, under the amendment, benefits based upon an additional 5 years of service accrue on January 1, 2010, and no additional service is credited after January 1, 2010 until January 1, 2015), the amendment does not result in a reduction that is significant because the amount of the annual benefit commencing at normal retirement age (or at actual retirement age, if later) under the terms of the plan as amended is not under any conditions less than the amount of the annual benefit commencing at normal retirement age (or at actual retirement age, if later) to which any participant would have been entitled under the terms of the plan had the amendment not been made.

Example 2. (i) *Facts.* The facts are the same as in *Example 1*, except that the 2009 amendment does not alter the plan provisions relating to a participant's number of years of service, but instead amends the plan's provisions relating to early retirement benefits. Before the amendment, the plan provides for distributions before normal retirement age to be actuarially reduced, but, if a participant retires after attainment of age 55 and completion of 10 years of service, the applicable early retirement reduction factor is 3% per year for the years between the ages 65 and 62 and 6% per year for the ages from 62 to 55. The amendment changes these provisions so that an actuarial reduction applies in all cases, but, in accordance with section 411(d)(6)(B), provides that no participant's early retirement benefit will be less than the amount provided under the plan as in effect on December 31, 2009 with respect to service before January 1, 2010. For participant X, the reduction is significant.

(ii) *Conclusion.* The amendment will result in a reduction in a retirement-type subsidy provided under Plan A (*i.e.*, Plan A's early retirement subsidy). Section 204(h) notice must be provided to participant X and any other participant for whom the reduction is significant and the notice must be provided at least 45 days before January 1, 2010 (or by such other date as may apply under Q&A–9 of this section).

Example 3. (i) *Facts.* The facts are the same as in *Example 2*, except that, for participant X, the change does not go into effect for any annuity commencement date before January 1, 2011. Participant X continues employment through January 1, 2011.

(ii) *Conclusion.* The conclusion is the same as in *Example 2*. Taking into account the rule in the second sentence of Q&A–8(c) of this section, the reduction that occurs for participant X on January 1, 2011, is treated as the same reduction that occurs under *Example 2*. Accordingly, assuming that the reduction is significant, section 204(h) notice must be provided to participant X at least 45 days before the January 1, 2010 effective date of the amendment (or by such other date as may apply under Q&A–9 of this section).

Q–9. When must section 204(h) notice be provided?

A–9. (a) *45-day general rule.* Except as otherwise provided in this Q&A–9, section 204(h) notice must be provided at least 45 days before the effective date of any section 204(h) amendment. See paragraph (e) of this Q&A–9 for special rules for amendments permitting participant choice.

(b) *15-day rule for small plans.* Except for amendments described in paragraphs (d)(2) and (g) of this Q&A–9, section 204(h) notice must be provided at least 15 days before the effective date of any section 204(h) amendment in the case of a small plan. For purposes of this section, a small plan is a plan that the plan administrator reasonably expects to have, on the effective date of the section 204(h) amendment, fewer than 100 participants who have an accrued benefit under the plan.

(c) *15-day rule for multiemployer plans.* Except for amendments described in

paragraphs (d)(2) and (g) of this Q&A–9, section 204(h) notice must be provided at least 15 days before the effective date of any section 204(h) amendment in the case of a multiemployer plan. For purposes of this section, a multiemployer plan means a multiemployer plan as defined in section 414(f) of the Internal Revenue Code.

(d) *Special timing rule for business transactions*—(1) *15-day rule for section 204(h) amendment in connection with an acquisition or disposition.* Except for amendments described in paragraphs (d)(2) and (g) of this Q&A–9, if a section 204(h) amendment is adopted in connection with an acquisition or disposition, section 204(h) notice must be provided at least 15 days before the effective date of the section 204(h) amendment.

(2) *Later notice permitted for a section 204(h) amendment significantly reducing early retirement benefit or retirement-type subsidies in connection with certain plan transfers, mergers, or consolidations.* If a section 204(h) amendment is adopted with respect to liabilities that are transferred to another plan in connection with a transfer, merger, or consolidation of assets or liabilities as described in section 414(l) of the Internal Revenue Code and §1.414(l)–1 of this chapter, the amendment is adopted in connection with an acquisition or disposition, and the amendment significantly reduces an early retirement benefit or retirement-type subsidy, but does not significantly reduce the rate of future benefit accrual, then section 204(h) notice must be provided no later than 30 days after the effective date of the section 204(h) amendment.

(3) *Definition of acquisition or disposition.* For purposes of this paragraph (d), see §1.410(b)–2(f) of this chapter for the definition of acquisition or disposition.

(e) *Timing rule for amendments permitting participant choice.* In general, section 204(h) notice of a section 204(h) amendment that provides applicable individuals with a choice between the old and the new benefit formulas (as described in Q&A–12 of this section) must be provided in accordance with the time period applicable under paragraphs (a) through (d) of this Q&A–9. See Q&A–12 of this section for additional guidance regarding section 204(h) notice in connection with participant choice.

(f) *Special timing rule for certain plans maintained by commercial airlines. See* section 402 of PPA '06 for a special rule that applies to certain plans maintained by an employer that is a commercial passenger airline or the principal business of which is providing catering services to a commercial passenger airline. Under this special rule, section 204(h) notice must be provided at least 15 days before the effective date of the amendment.

(g) *Special timing rules relating to certain section 204(h) amendments that reduce section 411(d)(6) protected benefits*—(1) *Plan amendments permitted to reduce prior accruals.* This paragraph (g) generally provides special rules with respect to a plan amendment that would not violate section 411(d)(6) even if the amendment were to reduce section 411(d)(6) protected benefits, which are limited to accrued benefits that are attributable to service before the applicable amendment date. For example, this paragraph (g) applies to amendments that are permitted to be effective retroactively under section 412(d)(2) of the Code (section 412(c)(8) for plan years beginning before January 1, 2008), section 418D of the Code, section 418E of the Code, section 4281 of ERISA, or section 1107 of PPA '06. *See,* generally, §1.411(d)–3(a)(1).

(2) *General timing rule for amendments to which this paragraph (g) applies.* For an amendment to which this paragraph (g) applies, the amendment is effective on the first date on which the plan is operated as if the amendment were in effect. Thus, except as otherwise provided in this paragraph (g), a section 204(h) notice for an amendment to which paragraph (a) of this section applies that is adopted after the effective date of the amendment must be provided, with respect to any applicable individual, at least 45 days before (or such other date as may apply under paragraph (b), (c), (d), or (f) of this Q&A–9) the date the amendment is put into operational effect.

(3) *Special rules for section 204(h) notices provided in connection with other disclosure requirements*—(i) *In general.* Notwithstanding the requirements in this Q&A–9 and Q&A–11 of this section,

if a plan provides one of the notices in paragraph (g)(3)(ii) of this Q&A–9, in accordance with the applicable timing and content rules for such notice, the plan is treated as timely providing a section 204(h) notice with respect to a section 204(h) amendment.

(ii) *Notice requirements.* The notices in this paragraph (g)(3)(ii) are—

(A) A notice required under any revenue ruling, notice, or other guidance published under the authority of the Commissioner in the Internal Revenue Bulletin to affected parties in connection with a retroactive plan amendment described in section 412(d)(2) (section 412(c)(8) for plan years beginning before January 1, 2008);

(B) A notice required under section 101(j) of ERISA if an amendment is adopted to comply with the benefit limitation requirements of section 206(g) of ERISA (section 436 of the Code);

(C) A notice required under section 432(b)(3)(D) of the Code for an amendment adopted to comply with the benefit restrictions under section 432(f)(2);

(D) A notice required under section 418D, or section 4244A(b) of ERISA, for an amendment that reduces or eliminates accrued benefits attributable to employer contributions with respect to a multiemployer plan in reorganization;

(E) A notice required under section 418E, or section 4245(e) of ERISA, relating to the effects of the insolvency status for a multiemployer plan; and

(F) A notice required under section 4281 of ERISA for an amendment of a multiemployer plan reducing benefits pursuant to section 4281(c) of ERISA.

(4) *Delegation of authority to Commissioner.* The Commissioner may provide special rules under section 4980F, in revenue rulings, notices, or other guidance published in the Internal Revenue Bulletin (*see* § 601.601(d)(2)(ii)(*b*) of this chapter), that the Commissioner determines to be necessary or appropriate with respect to a section 204(h) amendment—

(A) That applies to benefits accrued before the applicable amendment date but that does not violate section 411(d)(6); or

(B) For which there is a required notice relating to a reduction in benefits and such notice has timing and content requirements similar to a section 204(h) notice with respect to a significant reduction in the rate of future benefit accruals.

Q–10. To whom must section 204(h) notice be provided?

A–10. (a) *In general.* Section 204(h) notice must be provided to each applicable individual, to each employee organization representing participants who are applicable individuals, and, for plan years beginning after December 31, 2007, to each employer that has an obligation to contribute (within the meaning of section 4212(a) of ERISA) to a multiemployer plan. A special rule is provided in paragraph (d) of this Q&A–10.

(b) *Applicable individual.* Applicable individual means each participant in the plan, and any alternate payee, whose rate of future benefit accrual under the plan is reasonably expected to be significantly reduced, or for whom an early retirement benefit or retirement-type subsidy under the plan may reasonably be expected to be significantly reduced, by the section 204(h) amendment. The determination is made with respect to individuals who are reasonably expected to be participants or alternate payees in the plan at the effective date of the section 204(h) amendment.

(c) *Alternate payee.* Alternate payee means a beneficiary who is an alternate payee (within the meaning of section 414(p)(8) of the Internal Revenue Code) under an applicable qualified domestic relations order (within the meaning of section 414(p)(1)(A) of the Internal Revenue Code).

(d) *Designees.* Section 204(h) notice may be provided to a person designated in writing by an applicable individual or by an employee organization representing participants who are applicable individuals, instead of being provided to that applicable individual or employee organization. Any designation of a representative made through an electronic method that satisfies standards similar to those of Q&A–13(c)(1) of this section satisfies the requirement that a designation be in writing.

(e) *Facts and circumstances test.* Whether a participant or alternate

payee is an applicable individual is determined on a typical business day that is reasonably proximate to the time the section 204(h) notice is provided (or at the latest date for providing section 204(h) notice, if earlier), based on all relevant facts and circumstances.

(f) *Examples.* The following examples illustrate the rules in this Q&A–10:

Example 1. (i) *Facts.* A defined benefit plan requires an individual to complete 1 year of service to become a participant who can accrue benefits, and participants cease to accrue benefits under the plan at severance from employment with the employer. There are no alternate payees and employees are not represented by an employee organization. On November 18, 2004, the plan is amended effective as of January 1, 2005 to reduce significantly the rate of future benefit accrual. Section 204(h) notice is provided on November 1, 2004.

(ii) *Conclusion.* Section 204(h) notice is only required to be provided to individuals who, based on the facts and circumstances on November 1, 2004, are reasonably expected to have completed at least 1 year of service and to be employed by the employer on January 1, 2005.

Example 2. (i) *Facts.* The facts are the same as in *Example 1,* except that the sole effect of the plan amendment is to alter the preamendment 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 wearaway 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)?

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§ 54.4980G–2 Employer contribution defined.

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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.

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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?

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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?

Q–12: If an employer's contributions to an employee's HSA result in non-comparable contributions, may the employer recoup the excess amount from the employee's HSA?

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Q–14: How does an employer comply with the comparability rules if an employee has not established an HSA by December 31st?

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Q–16: What is the effective date for the rules in Q & A–14 and Q & A–15 of this section?

§ 54.4980G–5 HSA comparability rules and cafeteria plans and waiver of excise tax.

Q–1: If an employer makes contributions through a section 125 cafeteria plan to the HSA of each employee who is an eligible individual, are the contributions subject to the comparability rules?

Q–2: If an employer makes contributions through a cafeteria plan to the HSA of each employee who is an eligible individual in an amount equal to the amount of the employee's HSA contribution or a percentage of the amount of the employee's HSA contribution (*i.e.*, matching contributions), are the contributions subject to the section 4980G comparability rules?

Q–3: If under the employer's cafeteria plan, employees who are eligible individuals and who participate in health assessments, disease management programs or wellness programs receive an employer contribution to an HSA and the employees have the right to elect to make pre-tax salary reduction contributions to their HSAs, are the contributions subject to the comparability rules?

Q–4: May all or part of the excise tax imposed under section 4980G be waived?

[T.D. 9277, 71 FR 43058, July 31, 2006; 71 FR 53967, Sept. 13, 2006, as amended by T.D. 9393, 73 FR 20795, Apr. 17, 2008]

§ 54.4980G–1 Failure of employer to make comparable health savings account contributions.

Q–1: What are the comparability rules that apply to employer contributions to Health Savings Accounts (HSAs)?

A–1: If an employer makes contributions to any employee's HSA, the employer must make comparable contributions to the HSAs of all comparable participating employees. See Q & A–1 in § 54.4980G–4 for the definition of comparable contributions. Comparable participating employees are eligible individuals (as defined in section 223(c)(1)) who are in the same category of employees and who have the same category of high deductible health plan (HDHP) coverage. See sections 4980G(b) and 4980E(d)(3). See section 223(c)(2) and (g) for the definition of an HDHP. See also Q & A–5 in § 54.4980G–3 for the categories of employees and Q & A–2 of this section for the categories of HDHP coverage. But *see* Q & A–6 in § 54.4980G–3 for treatment of collectively bargained employees and Q & A–1 in § 54.4980G–6 for the rules allowing larger comparable contributions to nonhighly compensated employees.

Q–2: What are the categories of HDHP coverage for purposes of applying the comparability rules?

A–2: (a) *In general.* Generally, the categories of coverage are self-only HDHP coverage and family HDHP coverage. Family HDHP coverage means any coverage other than self-only HDHP coverage. The comparability rules apply separately to self-only HDHP coverage and family HDHP coverage. In addition, if an HDHP has family coverage options meeting the descriptions listed in paragraph (b) of this Q & A–2, each such coverage option may be treated as a separate category of coverage and the comparability rules may be applied separately to each category. However, if the HDHP has more than one category that provides coverage for the same number of individuals, all such categories are treated as a single category for purposes of the comparability rules. Thus, the categories of ''employee plus spouse'' and ''employee plus dependent,'' each providing coverage for two individuals, are treated as the single category ''self plus one'' for comparability purposes. See, however, the final sentence of paragraph (a) of Q & A–1 of § 54.4980G–4 for a special rule that applies if different amounts are contributed for different categories of family coverage. *See also* § 54.4980G–6 for the rules allowing larger comparable contributions to nonhighly compensated employees.

(b) *HDHP Family coverage categories.* The coverage categories are—

(1) Self plus one;

(2) Self plus two; and

(3) Self plus three or more.

(c) *Examples.* The rules of this Q & A–2 are illustrated by the following examples:

Example 1. Employer A maintains an HDHP and contributes to the HSAs of eligible employees who elect coverage under the HDHP. The HDHP has self-only coverage and family coverage. Thus, the categories of coverage are self-only and family coverage. Employer A contributes $750 to the HSA of each eligible employee with self-only HDHP coverage and $1,000 to the HSA of each eligible employee with family HDHP coverage. Employer A's contributions satisfy the comparability rules.

Example 2. (i) Employer B maintains an HDHP and contributes to the HSAs of eligible employees who elect coverage under the HDHP. The HDHP has the following coverage options:

(A) Self-only;

(B) Self plus spouse;

(C) Self plus dependent;

(D) Self plus spouse plus one dependent;

(E) Self plus two dependents; and

(F) Self plus spouse and two or more dependents.

(ii) The self plus spouse category and the self plus dependent category constitute the same category of HDHP coverage (self plus one) and Employer B must make the same comparable contributions to the HSAs of all eligible individuals who are in either the self plus spouse category of HDHP coverage or the self plus dependent category of HDHP coverage. Likewise, the self plus spouse plus one dependent category and the self plus two dependents category constitute the same category of HDHP coverage (self plus two) and Employer B must make the same comparable contributions to the HSAs of all eligible individuals who are in either the self plus spouse plus one dependent category of HDHP coverage or the self plus two dependents category of HDHP coverage.

Example 3. (i) Employer C maintains an HDHP and contributes to the HSAs of eligible employees who elect coverage under the HDHP. The HDHP has the following coverage options:

(A) Self-only;

(B) Self plus one;

(C) Self plus two; and

(D) Self plus three or more.

(ii) Employer C contributes $500 to the HSA of each eligible employee with self-only HDHP coverage, $750 to the HSA of each eligible employee with self plus one HDHP coverage, $900 to the HSA of each eligible employee with self plus two HDHP coverage and $1,000 to the HSA of each eligible employee with self plus three or more HDHP coverage. Employer C's contributions satisfy the comparability rules.

Q–3: What is the testing period for making comparable contributions to employees' HSAs?

A–3: To satisfy the comparability rules, an employer must make comparable contributions for the calendar year to the HSAs of employees who are comparable participating employees. See section 4980G(a). See Q & A–3 and Q & A–4 in § 54.4980G–4 for a discussion of HSA contribution methods.

Q–4: How is the excise tax computed if employer contributions do not satisfy the comparability rules for a calendar year?

A–4: (a) *Computation of tax.* If employer contributions do not satisfy the comparability rules for a calendar

year, the employer is subject to an excise tax equal to 35% of the aggregate amount contributed by the employer to HSAs for that period.

(b) *Example.* The following example illustrates the rules in paragraph (a) of this Q & A–4:

Example. During the 2007 calendar year, Employer D has 8 employees who are eligible individuals with self-only coverage under an HDHP provided by Employer D. The deductible for the HDHP is $2,000. For the 2007 calendar year, Employer D contributes $2,000 each to the HSAs of two employees and $1,000 each to the HSAs of the other six employees, for total HSA contributions of $10,000. Employer D's contributions do not satisfy the comparability rules. Therefore, Employer D is subject to an excise tax of $3,500 (35% of $10,000) for its failure to make comparable contributions to its employees' HSAs.

Q–5: If a person is liable for the excise tax under section 4980G, what form must the person file and what is the due date for the filing and payment of the excise tax?

A–5: (a) *In general.* §§ 54.6011–2, 54.6151–1 and 54.6071–1(d).

(b) *Effective/applicability date.* The rules in this Q & A–5 are effective for employer contributions made for calendar years beginning on or after January 1, 2010.

[T.D. 9277, 71 FR 43058, July 31, 2006, as amended by T.D. 9457, 74 FR 45997, Sept. 8, 2009]

§ 54.4980G–2 Employer contribution defined.

Q–1: Do the comparability rules apply to amounts rolled over from an employee's HSA or Archer Medical Savings Account (Archer MSA)?

A–1: No. The comparability rules do not apply to amounts rolled over from an employee's HSA or Archer MSA.

Q–2: If an employee requests that his or her employer deduct after-tax amounts from the employee's compensation and forward these amounts as employee contributions to the employee's HSA, do the comparability rules apply to these amounts?

A–2: No. Section 106(d) provides that amounts contributed by an employer to an eligible employee's HSA shall be treated as employer-provided coverage for medical expenses and are excludible from the employee's gross income up to the limit in section 223(b). After-tax employee contributions to an HSA are not subject to the comparability rules because they are not employer contributions under section 106(d).

[T.D. 9277, 71 FR 43058, July 31, 2006]

§ 54.4980G–3 Failure of employer to make comparable health savings account contributions.

Q–1: Do the comparability rules apply to contributions that an employer makes to the HSAs of independent contractors or self-employed individuals?

A–1: No. The comparability rules apply only to contributions that an employer makes to the HSAs of employees.

Q–2: May a sole proprietor who is an eligible individual contribute to his or her own HSA without contributing to the HSAs of his or her employees who are eligible individuals?

A–2: (a) *Sole proprietor not an employee.* Yes. The comparability rules apply only to contributions made by an employer to the HSAs of employees. Because a sole proprietor is not an employee, the comparability rules do not apply to contributions the sole proprietor makes to his or her own HSA. However, if a sole proprietor contributes to any employee's HSA, the sole proprietor must make comparable contributions to the HSAs of all comparable participating employees. In determining whether the comparability rules are satisfied, contributions that a sole proprietor makes to his or her own HSA are not taken into account.

(b) *Example.* The following example illustrates the rules in paragraph (a) of this Q & A–2:

Example. In a calendar year, B, a sole proprietor is an eligible individual and contributes $1,000 to B's own HSA. B also contributes $500 for the same calendar year to the HSA of each employee who is an eligible individual. The comparability rules are not violated by B's $1,000 contribution to B's own HSA.

Q–3: Do the comparability rules apply to contributions by a partnership to a partner's HSA?

A–3: (a) *Partner not an employee.* No. Contributions by a partnership to a bona fide partner's HSA are not subject to the comparability rules because the contributions are not contributions by

an employer to the HSA of an employee. The contributions are treated as either guaranteed payments under section 707(c) or distributions under section 731. However, if a partnership contributes to the HSAs of any employee who is not a partner, the partnership must make comparable contributions to the HSAs of all comparable participating employees.

(b) *Example.* The following example illustrates the rules in paragraph (a) of this Q & A–3:

Example. (i) Partnership X is a limited partnership with three equal individual partners, A (a general partner), B (a limited partner), and C (a limited partner). C is to be paid $300 annually for services rendered to Partnership X in her capacity as a partner without regard to partnership income (a section 707(c) guaranteed payment). D and E are the only employees of Partnership X and are not partners in Partnership X. A, B, C, D, and E are eligible individuals and each has an HSA. During Partnership X's Year 1 taxable year, which is also a calendar year, Partnership X makes the following contributions—

(A) A $300 contribution to each of A's and B's HSAs which are treated as section 731 distributions to A and B;

(B) A $300 contribution to C's HSA in lieu of paying C the guaranteed payment directly; and

(C) A $200 contribution to each of D's and E's HSAs, who are comparable participating employees.

(ii) Partnership X's contributions to A's and B's HSAs are section 731 distributions, which are treated as cash distributions. Partnership X's contribution to C's HSA is treated as a guaranteed payment under section 707(c). The contribution is not excludible from C's gross income under section 106(d) because the contribution is treated as a distributive share of partnership income for purposes of all Code sections other than sections 61(a) and 162(a), and a guaranteed payment to a partner is not treated as compensation to an employee. Thus, Partnership X's contributions to the HSAs of A, B, and C are not subject to the comparability rules. Partnership X's contributions to D's and E's HSAs are subject to the comparability rules because D and E are employees of Partnership X and are not partners in Partnership X. Partnership X's contributions satisfy the comparability rules.

Q–4: How are members of controlled groups treated when applying the comparability rules?

A–4: All persons or entities treated as a single employer under section 414 (b), (c), (m), or (o) are treated as one employer. See sections 4980G(b) and 4980E(e).

Q–5: What are the categories of employees for comparability testing?

A–5: (a) *Categories.* The categories of employees for comparability testing are as follows (but *see* Q & A–6 of this section for the treatment of collectively bargained employees and Q & A–1 of § 54.4980G–6 for a special rule for contributions made to the HSAs of nonhighly compensated employees)—

(1) Current full-time employees;

(2) Current part-time employees; and

(3) Former employees (except for former employees with coverage under the employer's HDHP because of an election under a COBRA continuation provision (as defined in section 9832(d)(1)).

(b) *Part-time and full-time employees.* For purposes of section 4980G, part-time employees are customarily employed for fewer than 30 hours per week and full-time employees are customarily employed for 30 or more hours per week. See sections 4980G(b) and 4980E(d)(4)(A) and (B).

(c) *In general.* Except as provided in Q & A–6 of this section, the categories of employees in paragraph (a) of this Q & A–5 are the exclusive categories of employees for comparability testing. An employer must make comparable contributions to the HSAs of all comparable participating employees (eligible individuals who are in the same category of employees with the same category of HDHP coverage) during the calendar year without regard to any classification other than these categories. For example, full-time eligible employees with self-only HDHP coverage and part-time eligible employees with self-only HDHP coverage are separate categories of employees and different amounts can be contributed to the HSAs for each of these categories. But *see* § 54.4980G–6 for a special rule for contributions made to the HSAs of nonhighly compensated employees.

Q–6: Are employees who are included in a unit of employees covered by a collective bargaining agreement comparable participating employees?

A–6: (a) *In general.* No. Collectively bargained employees who are covered by a bona fide collective bargaining

agreement between employee representatives and one or more employers are not comparable participating employees, if health benefits were the subject of good faith bargaining between such employee representatives and such employer or employers. Former employees covered by a collective bargaining agreement also are not comparable participating employees.

(b) *Examples.* The following examples illustrate the rules in paragraph (a) of this Q & A–6. The examples read as follows:

Example 1. Employer A offers its employees an HDHP with a $1,500 deductible for self-only coverage. Employer A has collectively bargained and non-collectively bargained employees. The collectively bargained employees are covered by a collective bargaining agreement under which health benefits were bargained in good faith. In the 2007 calendar year, Employer A contributes $500 to the HSAs of all eligible non-collectively bargained employees with self-only coverage under Employer A's HDHP. Employer A does not contribute to the HSAs of the collectively bargained employees. Employer A's contributions to the HSAs of non-collectively bargained employees satisfy the comparability rules. The comparability rules do not apply to collectively bargained employees.

Example 2. Employer B offers its employees an HDHP with a $1,500 deductible for self-only coverage. Employer B has collectively bargained and non-collectively bargained employees. The collectively bargained employees are covered by a collective bargaining agreement under which health benefits were bargained in good faith. In the 2007 calendar year and in accordance with the terms of the collective bargaining agreement, Employer B contributes to the HSAs of all eligible collectively bargained employees. Employer B does not contribute to the HSAs of the non-collectively bargained employees. Employer B's contributions to the HSAs of collectively bargained employees are not subject to the comparability rules because the comparability rules do not apply to collectively bargained employees. Accordingly, Employer B's failure to contribute to the HSAs of the non-collectively bargained employees does not violate the comparability rules.

Example 3. Employer C has two units of collectively bargained employees—unit Q and unit R—each covered by a collective bargaining agreement under which health benefits were bargained in good faith. In the 2007 calendar year and in accordance with the terms of the collective bargaining agreement, Employer C contributes to the HSAs of all eligible collectively bargained employees in unit Q. In accordance with the terms of the collective bargaining agreement, Employer C makes no HSA contributions for collectively bargained employees in unit R. Employer C's contributions to the HSAs of collectively bargained employees are not subject to the comparability rules because the comparability rules do not apply to collectively bargained employees.

Example 4. Employer D has a unit of collectively bargained employees that are covered by a collective bargaining agreement under which health benefits were bargained in good faith. In accordance with the terms of the collective bargaining agreement, Employer D contributes an amount equal to a specified number of cents per hour for each hour worked to the HSAs of all eligible collectively bargained employees. Employer D's contributions to the HSAs of collectively bargained employees are not subject to the comparability rules because the comparability rules do not apply to collectively bargained employees.

Q–7: Is an employer permitted to make comparable contributions only to the HSAs of comparable participating employees who have coverage under the employer's HDHP?

A–7: (a) *Employer-provided HDHP coverage.* If during a calendar year, an employer contributes to the HSA of any employee who is an eligible individual covered under an HDHP provided by the employer, the employer is required to make comparable contributions to the HSAs of all comparable participating employees with coverage under any HDHP provided by the employer. An employer that contributes only to the HSAs of employees who are eligible individuals with coverage under the employer's HDHP is not required to make comparable contributions to HSAs of employees who are eligible individuals but are not covered under the employer's HDHP.

(b) *Non-employer provided HDHP coverage.* An employer that contributes to the HSA of any employee who is an eligible individual with coverage under any HDHP that is not an HDHP provided by the employer, must make comparable contributions to the HSAs of all comparable participating employees whether or not covered under the employer's HDHP. An employer that makes a reasonable good faith effort to identify all comparable participating employees with non-employer provided HDHP coverage and makes

comparable contributions to the HSAs of such employees satisfies the requirements in paragraph (b) of this Q & A–7.

(c) *Examples.* The following examples illustrate the rules in this Q & A–7. None of the employees in the following examples are covered by a collective bargaining agreement. The examples read as follows:

Example 1. In a calendar year, Employer E offers an HDHP to its full-time employees. Most full-time employees are covered under Employer E's HDHP and Employer E makes comparable contributions only to these employees' HSAs. Employee W, a full-time employee of Employer E and an eligible individual, is covered under an HDHP provided by the employer of W's spouse and not under Employer E's HDHP. Employer E is not required to make comparable contributions to W's HSA.

Example 2. In a calendar year, Employer F does not offer an HDHP. Several full-time employees of Employer F, who are eligible individuals, have HSAs. Employer F contributes to these employees' HSAs. Employer F must make comparable contributions to the HSAs of all full-time employees who are eligible individuals.

Example 3. In a calendar year, Employer G offers an HDHP to its full-time employees. Most full-time employees are covered under Employer G's HDHP and Employer G makes comparable contributions to these employees' HSAs and also to the HSAs of full-time employees who are eligible individuals and who are not covered under Employer G's HDHP. Employee S, a full-time employee of Employer G and a comparable participating employee, is covered under an HDHP provided by the employer of S's spouse and not under Employer G's HDHP. Employer G must make comparable contributions to S's HSA.

Q–8: If an employee and his or her spouse are eligible individuals who work for the same employer and one employee-spouse has family coverage for both employees under the employer's HDHP, must the employer make comparable contributions to the HSAs of both employees?

A–8: (a) *In general.* If the employer makes contributions only to the HSAs of employees who are eligible individuals covered under its HDHP where only one employee-spouse has family coverage for both employees under the employer's HDHP, the employer is not required to contribute to the HSAs of both employee-spouses. The employer is required to contribute to the HSA of the employee-spouse with coverage under the employer's HDHP, but is not required to contribute to the HSA of the employee-spouse covered under the employer's HDHP by virtue of his or her spouse's coverage. However, if the employer contributes to the HSA of any employee who is an eligible individual with coverage under an HDHP that is not an HDHP provided by the employer, the employer must make comparable contributions to the HSAs of both employee-spouses if they are both eligible individuals. If an employer is required to contribute to the HSAs of both employee-spouses, the employer is not required to contribute amounts in excess of the annual contribution limits in section 223(b).

(b) *Examples.* The following examples illustrate the rules in paragraph (a) of this Q & A–8. None of the employees in the following examples are covered by a collective bargaining agreement. The examples read as follows:

Example 1. In a calendar year, Employer H offers an HDHP to its full-time employees. Most full-time employees are covered under Employer H's HDHP and Employer H makes comparable contributions only to these employees' HSAs. T and U are a married couple. Employee T, who is a full-time employee of Employer H and an eligible individual, has family coverage under Employer H's HDHP for T and T's spouse. Employee U, who is also a full-time employee of Employer H and an eligible individual, does not have coverage under Employer H's HDHP except as the spouse of Employee T. Employer H is required to make comparable contributions to T's HSA, but is not required to make comparable contributions to U's HSA.

Example 2. In a calendar year, Employer J offers an HDHP to its full-time employees. Most full-time employees are covered under Employer J's HDHP and Employer J makes comparable contributions to these employees' HSAs and to the HSAs of full-time employees who are eligible individuals but are not covered under Employer J's HDHP. R and S are a married couple. Employee S, who is a full-time employee of Employer J and an eligible individual, has family coverage under Employer J's HDHP for S and S's spouse. Employee R, who is also a full-time employee of Employer J and an eligible individual, does not have coverage under Employer J's HDHP except as the spouse of Employee S. Employer J must make comparable contributions to S's HSA and to R's HSA.

Q–9: Does an employer that makes HSA contributions only for one class of non-collectively bargained employees who are eligible individuals, but not for another class of non-collectively bargained employees who are eligible individuals (for example, management v. non-management) satisfy the requirement that the employer make comparable contributions?

A–9: (a) *Different classes of employees.* No. If the two classes of employees are comparable participating employees, the comparability rules are not satisfied. The only categories of employees for comparability purposes are current full-time employees, current part-time employees, and former employees. Collectively bargained employees are not comparable participating employees. But see Q & A–1 in 54.4980G–5 on contributions made through a cafeteria plan. *See* § 54.4980G–6 for a special rule for contributions made to the HSAs of nonhighly compensated employees.

(b) *Examples.* The following examples illustrate the rules in paragraph (a) of this Q & A–9. None of the employees in the following examples are covered by a collective bargaining agreement. The examples read as follows:

Example 1. In a calendar year, Employer K maintains an HDHP covering all management and non-management employees. Employer K contributes to the HSAs of non-management employees who are eligible individuals covered under its HDHP. Employer K does not contribute to the HSAs of its management employees who are eligible individuals covered under its HDHP. The comparability rules are not satisfied.

Example 2. All of Employer L's employees are located in city X and city Y. In a calendar year, Employer L maintains an HDHP for all employees working in city X only. Employer L does not maintain an HDHP for its employees working in city Y. Employer L contributes $500 to the HSAs of city X employees who are eligible individuals with coverage under its HDHP. Employer L does not contribute to the HSAs of any of its city Y employees. The comparability rules are satisfied because none of the employees in city Y are covered under an HDHP of Employer L. (However, if any employees in city Y were covered by an HDHP of Employer L, Employer L could not fail to contribute to their HSAs merely because they work in a different city.)

Example 3. Employer M has two divisions—division N and division O. In a calendar year, Employer M maintains an HDHP for employees working in division N and division O. Employer M contributes to the HSAs of division N employees who are eligible individuals with coverage under its HDHP. Employer M does not contribute to the HSAs of division O employees who are eligible individuals covered under its HDHP. The comparability rules are not satisfied.

Q–10: If an employer contributes to the HSAs of former employees who are eligible individuals, do the comparability rules apply to these contributions?

A–10: (a) *Former employees.* Yes. The comparability rules apply to contributions an employer makes to former employees' HSAs. Therefore, if an employer contributes to any former employee's HSA, it must make comparable contributions to the HSAs of all comparable participating former employees (former employees who are eligible individuals with the same category of HDHP coverage). However, an employer is not required to make comparable contributions to the HSAs of former employees with coverage under the employer's HDHP because of an election under a COBRA continuation provision (as defined in section 9832(d)(1)). See Q & A–5 and Q & A–12 of this section. The comparability rules apply separately to former employees because they are a separate category of covered employee. See Q & A–5 of this section. Also, former employees who were covered by a collective bargaining agreement immediately before termination of employment are not comparable participating employees. See Q & A–6 of this section.

(b) *Locating former employees.* An employer making comparable contributions to former employees must take reasonable actions to locate any missing comparable participating former employees. In general, such actions include the use of certified mail, the Internal Revenue Service Letter Forwarding Program or the Social Security Administration's Letter Forwarding Service.

(c) *Examples.* The following examples illustrate the rules in paragraph (a) of this Q & A–10. None of the employees in the following examples are covered by a collective bargaining agreement. The examples read as follows:

Example 1. In a calendar year, Employer N contributes $1,000 for the calendar year to

the HSA of each current employee who is an eligible individual with coverage under any HDHP. Employer N does not contribute to the HSA of any former employee who is an eligible individual. Employer N's contributions satisfy the comparability rules.

Example 2. In a calendar year, Employer O contributes to the HSAs of current employees and former employees who are eligible individuals covered under any HDHP. Employer O contributes $750 to the HSA of each current employee with self-only HDHP coverage and $1,000 to the HSA of each current employee with family HDHP coverage. Employer O also contributes $300 to the HSA of each former employee with self-only HDHP coverage and $400 to the HSA of each former employee with family HDHP coverage. Employer O's contributions satisfy the comparability rules.

Q–11: Is an employer permitted to make comparable contributions only to the HSAs of comparable participating former employees who have coverage under the employer's HDHP?

A–11: If during a calendar year, an employer contributes to the HSA of any former employee who is an eligible individual covered under an HDHP provided by the employer, the employer is required to make comparable contributions to the HSAs of all former employees who are comparable participating former employees with coverage under any HDHP provided by the employer. An employer that contributes only to the HSAs of former employees who are eligible individuals with coverage under the employer's HDHP is not required to make comparable contributions to the HSAs of former employees who are eligible individuals and who are not covered under the employer's HDHP. However, an employer that contributes to the HSA of any former employee who is an eligible individual with coverage under an HDHP that is not an HDHP of the employer, must make comparable contributions to the HSAs of all former employees who are eligible individuals whether or not covered under an HDHP of the employer.

Q–12: If an employer contributes only to the HSAs of former employees who are eligible individuals with coverage under the employer's HDHP, must the employer make comparable contributions to the HSAs of former employees who are eligible individuals with coverage under the employer's HDHP because of an election under a COBRA continuation provision (as defined in section 9832(d)(1))?

A–12: No. An employer that contributes only to the HSAs of former employees who are eligible individuals with coverage under the employer's HDHP is not required to make comparable contributions to the HSAs of former employees who are eligible individuals with coverage under the employer's HDHP because of an election under a COBRA continuation provision (as defined in section 9832(d)(1)).

Q–13: How do the comparability rules apply if some employees have HSAs and other employees have Archer MSAs?

A–13: (a) *HSAs and Archer MSAs.* The comparability rules apply separately to employees who have HSAs and employees who have Archer MSAs. However, if an employee has both an HSA and an Archer MSA, the employer may contribute to either the HSA or the Archer MSA, but not to both.

(b) *Example.* The following example illustrates the rules in paragraph (a) of this Q & A–13:

Example. In a calendar year, Employer P contributes $600 to the Archer MSA of each employee who is an eligible individual and who has an Archer MSA. Employer P contributes $500 for the calendar year to the HSA of each employee who is an eligible individual and who has an HSA. If an employee has both an Archer MSA and an HSA, Employer P contributes to the employee's Archer MSA and not to the employee's HSA. Employee X has an Archer MSA and an HSA. Employer P contributes $600 for the calendar year to X's Archer MSA but does not contribute to X's HSA. Employer P's contributions satisfy the comparability rules.

[T.D. 9277, 71 FR 43058, July 31, 2006, as amended by T.D. 9457, 74 FR 45998, Sept. 8, 2009]

§ 54.4980G–4 Calculating comparable contributions.

Q–1: What are comparable contributions?

A–1: (a) *Definition.* Contributions are comparable if, for each month in a calendar year, the contributions are either the same amount or the same percentage of the deductible under the HDHP for employees who are eligible individuals with the same category of coverage on the first day of that month. Employees with self-only

HDHP coverage are tested separately from employees with family HDHP coverage. Similarly, employees with different categories of family HDHP coverage may be tested separately. See Q & A–2 in § 54.4980G–1. An employer is not required to contribute the same amount or the same percentage of the deductible for employees who are eligible individuals with one category of HDHP coverage that it contributes for employees who are eligible individuals with a different category of HDHP coverage. For example, an employer that satisfies the comparability rules by contributing the same amount to the HSAs of all employees who are eligible individuals with family HDHP coverage is not required to contribute any amount to the HSAs of employees who are eligible individuals with self-only HDHP coverage, or to contribute the same percentage of the self-only HDHP deductible as the amount contributed with respect to family HDHP coverage. However, the contribution with respect to the self plus two category may not be less than the contribution with respect to the self plus one category and the contribution with respect to the self plus three or more category may not be less than the contribution with respect to the self plus two category. But *see* Q & A–1 of § 54.4980G–6 for a special rule for contributions made to the HSAs of nonhighly compensated employees.

(b) *Examples.* The following examples illustrate the rules in paragraph (a) of this Q & A–1. None of the employees in the following examples are covered by a collective bargaining agreement. The examples read as follows:

Example 1. In the 2007 calendar year, Employer A offers its full-time employees three health plans, including an HDHP with self-only coverage and a $2,000 deductible. Employer A contributes $1,000 for the calendar year to the HSA of each employee who is an eligible individual electing the self-only HDHP coverage. Employer A makes no HSA contributions for employees with family HDHP coverage or for employees who do not elect the employer's self-only HDHP. Employer A's HSA contributions satisfy the comparability rules.

Example 2. In the 2007 calendar year, Employer B offers its employees an HDHP with a $3,000 deductible for self-only coverage and a $4,000 deductible for family coverage. Employer B contributes $1,000 for the calendar year to the HSA of each employee who is an eligible individual electing the self-only HDHP coverage. Employer B contributes $2,000 for the calendar year to the HSA of each employee who is an eligible individual electing the family HDHP coverage. Employer B's HSA contributions satisfy the comparability rules.

Example 3. In the 2007 calendar year, Employer C offers its employees an HDHP with a $1,500 deductible for self-only coverage and a $3,000 deductible for family coverage. Employer C contributes $1,000 for the calendar year to the HSA of each employee who is an eligible individual electing the self-only HDHP coverage. Employer C contributes $1,000 for the calendar year to the HSA of each employee who is an eligible individual electing the family HDHP coverage. Employer C's HSA contributions satisfy the comparability rules.

Example 4. In the 2007 calendar year, Employer D offers its employees an HDHP with a $1,500 deductible for self-only coverage and a $3,000 deductible for family coverage. Employer D contributes $1,500 for the calendar year to the HSA of each employee who is an eligible individual electing the self-only HDHP coverage. Employer D contributes $1,000 for the calendar year to the HSA of each employee who is an eligible individual electing the family HDHP coverage. Employer D's HSA contributions satisfy the comparability rules.

Example 5. (i) In the 2007 calendar year, Employer E maintains two HDHPs. Plan A has a $2,000 deductible for self-only coverage and a $4,000 deductible for family coverage. Plan B has a $2,500 deductible for self-only coverage and a $4,500 deductible for family coverage. For the calendar year, Employer E makes contributions to the HSA of each full-time employee who is an eligible individual covered under Plan A of $600 for self-only coverage and $1,000 for family coverage. Employer E satisfies the comparability rules, if it makes either of the following contributions for the 2007 calendar year to the HSA of each full-time employee who is an eligible individual covered under Plan B—

(A) $600 for each full-time employee with self-only coverage and $1,000 for each full-time employee with family coverage; or

(B) $750 for each employee with self-only coverage and $1,125 for each employee with family coverage (the same percentage of the deductible Employer E contributes for full-time employees covered under Plan A, 30% of the deductible for self-only coverage and 25% of the deductible for family coverage).

(ii) Employer E also makes contributions to the HSA of each part-time employee who is an eligible individual covered under Plan A of $300 for self-only coverage and $500 for family coverage. Employer E satisfies the comparability rules, if it makes either of the following contributions for the 2007 calendar

year to the HSA of each part-time employee who is an eligible individual covered under Plan B—

(A) $300 for each part-time employee with self-only coverage and $500 for each part-time employee with family coverage; or

(B) $375 for each part-time employee with self-only coverage and $563 for each part-time employee with family coverage (the same percentage of the deductible Employer E contributes for part-time employees covered under Plan A, 15% of the deductible for self-only coverage and 12.5% of the deductible for family coverage).

Example 6. (i) In the 2007 calendar year, Employer F maintains an HDHP. The HDHP has the following coverage options—

(A) A $2,500 deductible for self-only coverage;

(B) A $3,500 deductible for self plus one dependent (self plus one);

(C) A $3,500 deductible for self plus spouse (self plus one);

(D) A $3,500 deductible for self plus spouse and one dependent (self plus two); and

(E) A $3,500 deductible for self plus spouse and two or more dependents (self plus three or more).

(ii) Employer F makes the following contributions for the calendar year to the HSA of each full-time employee who is an eligible individual covered under the HDHP—

(A) $750 for self-only coverage;

(B) $1,000 for self plus one dependent;

(C) $1,000 for self plus spouse;

(D) $1,500 for self plus spouse and one dependent; and

(E) $2,000 for self plus spouse and two or more dependents.

(iii) Employer F's HSA contributions satisfy the comparability rules.

Example 7. (i) In a calendar year, Employer G offers its employees an HDHP and a health flexible spending arrangement (health FSA). The health FSA reimburses employees for medical expenses as defined in section 213(d). Some of Employer G's employees have coverage under the HDHP and the health FSA, some have coverage under the HDHP and their spouse's FSA, and some have coverage under the HDHP and are enrolled in Medicare. For the calendar year, Employer G contributes $500 to the HSA of each employee who is an eligible individual. No contributions are made to the HSAs of employees who have coverage under Employer G's health FSA or under a spouse's health FSA or who are enrolled in Medicare.

(ii) The employees who have coverage under a health FSA (whether Employer H's or their spouse's FSA) or who are covered under Medicare are not eligible individuals. Specifically, the employees who have coverage under the health FSA or under a spouse's health FSA are not comparable participating employees because they are not eligible individuals under section 223(c)(1). Similarly, the employees who are enrolled in Medicare are not comparable participating employees because they are not eligible individuals under section 223(b)(7) and (c)(1). Therefore, employees who have coverage under the health FSA or under a spouse's health FSA and employees who are enrolled in Medicare are excluded from comparability testing. See sections 4980G(b) and 4980E. Employer G's contributions satisfy the comparability rules.

Q–2: How does an employer comply with the comparability rules when some non-collectively bargained employees who are eligible individuals do not work for the employer during the entire calendar year?

A–2: (a) *In general.* In determining whether the comparability rules are satisfied, an employer must take into account all full-time and part-time employees who were employees and eligible individuals for any month during the calendar year. (Full-time and part-time employees are tested separately. See Q & A–5 in § 54.4980G–3.) There are two methods to comply with the comparability rules when some employees who are eligible individuals do not work for the employer during the entire calendar year; contributions may be made on a pay-as-you-go basis or on a look-back basis. See Q & A–9 through Q & A–11 in § 54.4980G–3 for the rules regarding comparable contributions to the HSAs of former employees.

(b) *Contributions on a pay-as-you-go basis.* An employer may comply with the comparability rules by contributing amounts at one or more dates during the calendar year to the HSAs of employees who are eligible individuals as of the first day of the month, if contributions are the same amount or the same percentage of the HDHP deductible for employees who are eligible individuals as of the first day of the month with the same category of coverage and are made at the same time. Contributions made at the employer's usual payroll interval for different groups of employees are considered to be made at the same time. For example, if salaried employees are paid monthly and hourly employees are paid bi-weekly, an employer may contribute to the HSAs of hourly employees on a bi-weekly basis and to the HSAs of salaried employees on a monthly basis. An employer may change the amount

that it contributes to the HSAs of employees at any point. However, the changed contribution amounts must satisfy the comparability rules.

(c) *Examples.* The following examples illustrate the rules in paragraph (b) of this Q & A–2: The examples read as follows:

Example 1. (i) Beginning on January 1st, Employer H contributes $50 per month on the first day of each month to the HSA of each employee who is an eligible individual on that date. Employer H does not contribute to the HSAs of former employees. In mid-March of the same year, Employee X, an eligible individual, terminates employment after Employer H has contributed $150 to X's HSA. After X terminates employment, Employer H does not contribute additional amounts to X's HSA. In mid-April of the same year, Employer H hires Employee Y, an eligible individual, and contributes $50 to Y's HSA in May and $50 in June. Effective in July of the same year, Employer H stops contributing to the HSAs of all employees and makes no contributions to the HSA of any employee for the months of July through December. In August, Employer H hires Employee Z, an eligible individual. Employer H does not contribute to Z's HSA. After Z is hired, Employer H does not hire additional employees. As of the end of the calendar year, Employer H has made the following HSA contributions to its employees' HSAs—

(A) Employer H contributed $150 to X's HSA;

(B) Employer H contributed $100 to Y's HSA;

(C) Employer H did not contribute to Z's HSA; and

(D) Employer H contributed $300 to the HSA of each employee who was an eligible individual and employed by Employer J from January through June.

(ii) Employer H's contributions satisfy the comparability rules.

Example 2. In a calendar year, Employer J offers its employees an HDHP and contributes on a monthly pay-as-you-go basis to the HSAs of employees who are eligible individuals with coverage under Employer J's HDHP. In the calendar year, Employer J contributes $50 per month to the HSA of each employee with self-only HDHP coverage and $100 per month to the HSA of each employee with family HDHP coverage. From January 1st through March 31st of the calendar year, Employee X is an eligible individual with self-only HDHP coverage. From April 1st through December 31st of the calendar year, X is an eligible individual with family HDHP coverage. For the months of January, February and March of the calendar year, Employer J contributes $50 per month to X's HSA. For the remaining months of the calendar year, Employer J contributes $100 per month to X's HSA. Employer J's contributions to X's HSA satisfy the comparibility rules.

(d) *Contributions on a look-back basis.* An employer may also satisfy the comparability rules by determining comparable contributions for the calendar year at the end of the calendar year, taking into account all employees who were eligible individuals for any month during the calendar year and contributing the same percentage of the HDHP deductible or the same dollar amount to the HSAs of all employees with the same category of coverage for that month.

(e) *Examples.* The following examples illustrate the rules in paragraph (d) of this Q & A–2. The examples read as follows:

Example 1. In a calendar year, Employer K offers its employees an HDHP and contributes on a look-back basis to the HSAs of employees who are eligible individuals with coverage under Employer K's HDHP. Employer K contributes $600 ($50 per month) for the calendar year to the HSA of each employee with self-only HDHP coverage and $1,200 ($100 per month) for the calendar year to the HSA of each employee with family HDHP coverage. From January 1st through June 30th of the calendar year, Employee Y is an eligible individual with family HDHP coverage. From July 1st through December 31st, Y is an eligible individual with self-only HDHP coverage. Employer K contributes $900 on a look-back basis for the calendar year to Y's HSA ($100) per month for the months of January through June and $50 per month for the months of July through December. Employer K's contributions to Y's HSA satisfy the comparability rules.

Example 2. On December 31st, Employer L contributes $50 per month on a look-back basis to each employee's HSA for each month in the calendar year that the employee was an eligible individual. In mid-March of the same year, Employee T, an eligible individual, terminated employment. In mid-April of the same year, Employer L hired Employee U, who becomes an eligible individual as of May 1st and works for Employer L through December 31st. On December 31st, Employer L contributes $150 to Employee T's HSA and $400 to Employee U's HSA. Employer L's contributions satisfy the comparability rules.

(f) *Periods and dates for making contributions.* With both the pay-as-you-go method and the look-back method, an

employer may establish, on a reasonable and consistent basis, periods for which contributions will be made (for example, a quarterly period covering three consecutive months in a calendar year) and the dates on which such contributions will be made for that designated period (for example, the first day of the quarter or the last day of the quarter in the case of an employer who has established a quarterly period for making contributions). An employer that makes contributions on a pay-as-you-go basis for a period covering more than one month will not fail to satisfy the comparability rules because an employee who terminates employment prior to the end of the period for which contributions were made has received more contributions on a monthly basis than employees who have worked the entire period. In addition, an employer that makes contributions on a pay-as-you-go basis for a period covering more than one month must make HSA contributions for any comparable participating employees hired after the date of initial funding for that period.

(g) *Example.* The following example illustrates the rules in paragraph (f) of this Q & A–2:

Example. Employer M has established, on a reasonable and consistent basis, a quarterly period for making contributions to the HSAs of eligible employees on a pay-as-you-go basis. Beginning on January 1st, Employer M contributes $150 for the first three months of the calendar year to the HSA of each employee who is an eligible individual on that date. On January 15th, Employee V, an eligible individual, terminated employment after Employer M has contributed $150 to V's HSA. On January 15th, Employer M hired Employee W, who becomes an eligible individual as of February 1st. On April 1st, Employer M has contributed $100 to W's HSA for the two months (February and March) in the quarter period that Employee W was an eligible employee. Employer M's contributions satisfy the comparability rules.

(h) *Maximum contribution permitted for all employees who are eligible individuals during the last month of the taxable year.* An employer may contribute up to the maximum annual contribution amount for the calendar year (based on the employees' HDHP coverage) to the HSAs of all employees who are eligible individuals on the first day of the last month of the employees' taxable year, including employees who worked for the employer for less than the entire calendar year and employees who became eligible individuals after January 1st of the calendar year. For example, such contribution may be made on behalf of an eligible individual who is hired after January 1st or an employee who becomes an eligible individual after January 1st. Employers are not required to provide more than a pro-rata contribution based on the number of months that an individual was an eligible individual and employed by the employer during the year. However, if an employer contributes more than a pro-rata amount for the calendar year to the HSA of any eligible individual who is hired after January 1st of the calendar year or any employee who becomes an eligible individual any time after January 1st of the calendar year, the employer must contribute that same amount on an equal and uniform basis to the HSAs of all comparable participating employees (as defined in Q & A–1 in § 54.4980G–1) who are hired or become eligible individuals after January 1st of the calendar year. Likewise, if an employer contributes the maximum annual contribution amount for the calendar year to the HSA of any eligible individual who is hired after January 1st of the calendar year or any employee who becomes an eligible individual any time after January 1st of the calendar year, the employer must contribute the maximum annual contribution amount on an equal and uniform basis to the HSAs of all comparable participating employees (as defined in Q & A–1 in § 54.4980G–1) who are hired or become eligible individuals after January 1st of the calendar year. An employer who makes the maximum calendar year contribution or more than a pro-rata contribution to the HSAs of employees who become eligible individuals after the first day of the calendar year or eligible individuals who are hired after the first day of the calendar year will not fail to satisfy comparability merely because some employees will have received more contributions on a monthly basis than employees who worked the entire calendar year.

(i) *Examples.* The following examples illustrate the rules in paragraph (h) in this Q & A–2. In the following examples, no contributions are made through a section 125 cafeteria plan and none of the employees are covered by a collective bargaining agreement.

Example 1. On January 1, 2010, Employer Q contributes $1,000 for the calendar year to the HSAs of employees who are eligible individuals with family HDHP coverage. In mid-March of the same year, Employer Q hires Employee A, an eligible individual with family HDHP coverage. On April 1, 2010, Employer Q contributes $1,000 to the HSA of Employee A. In September of the same year, Employee B becomes an eligible individual with family HDHP coverage. On October 1, 2010, Employer G contributes $1,000 to the HSA of Employee B. Employer Q does not make any other contributions for the 2010 calendar year. Employer Q's contributions satisfy the comparability rules.

Example 2. For the 2010 calendar year, Employer R only has two employees, Employee C and Employee D. Employee C, an eligible individual with family HDHP coverage, works for Employer R for the entire calendar year. Employee D, an eligible individual with family HDHP coverage works for Employer R from July 1st through December 31st. Employer R contributes $1,200 for the calendar year to the HSA of Employee C and $600 to the HSA of Employee D. Employer R does not make any other contributions for the 2010 calendar year. Employer R's contributions satisfy the comparability rules.

(j) *Effective/applicability date.* The rules in paragraphs (h) and (i) of Q & A–2 are effective for employer contributions made for calendar years beginning on or after January 1, 2010.

Q–3: How do the comparability rules apply to employer contributions to employees' HSAs if some non-collectively bargained employees work full-time during the entire calendar year, and other non-collectively bargained employees work full-time for less than the entire calendar year?

A–3: Employer contributions to the HSAs of employees who work full-time for less than twelve months satisfy the comparability rules if the contribution amount is comparable when determined on a month-to-month basis. For example, if the employer contributes $240 to the HSA of each full-time employee who works the entire calendar year, the employer must contribute $60 to the HSA of each full-time employee who works on the first day of each three months of the calendar year. The rules set forth in this Q & A–2 apply to employer contributions made on a pay-as-you-go basis or on a look-back basis as described in Q & A–3 of this section. See sections 4980G(b) and 4980E(d)(2)(B).

Q–4: May an employer make contributions for the entire year to the HSAs of its employees who are eligible individuals at the beginning of the calendar year (on a pre-funded basis) instead of contributing on a pay-as-you-go or on a look-back basis?

A–4: (a) *Contributions on a pre-funded basis.* Yes. An employer may make contributions for the entire year to the HSAs of its employees who are eligible individuals at the beginning of the calendar year. An employer that pre-funds the HSAs of its employees will not fail to satisfy the comparability rules because an employee who terminates employment prior to the end of the calendar year has received more contributions on a monthly basis than employees who work the entire calendar year. See Q & A–12 of this section. Under section 223(d)(1)(E), an account beneficiary's interest in an HSA is nonforfeitable. An employer must make comparable contributions for all employees who are comparable participating employees for any month during the calendar year, including employees who are eligible individuals hired after the date of initial funding. An employer that makes HSA contributions on a pre-funded basis may also contribute on a pre-funded basis to the HSAs of employees who are eligible individuals hired after the date of initial funding. Alternatively, an employer that has pre-funded the HSAs of comparable participating employees may contribute to the HSAs of employees who are eligible individuals hired after the date of initial funding on a pay-as-you-go basis or on a look-back basis. An employer that makes HSA contributions on a pre-funded basis must use the same contribution method for all employees who are eligible individuals hired after the date of initial funding.

(b) *Example.* The following example illustrates the rules in paragraph (a) of this Q & A–4:

Example. (i) On January 1, Employer N contributes $1,200 for the calendar year on a pre-funded basis to the HSA of each employee who is an eligible individual. In mid-May, Employer N hires Employee B, who becomes an eligible individual as of June 1st. Therefore, Employer N is required to make comparable contributions to B's HSA beginning in June. Employer N satisfies the comparability rules with respect to contributions to B's HSA if it makes HSA contributions in any one of the following ways—

(A) Pre-funding B's HSA by contributing $700 to B's HSA;

(B) Contributing $100 per month on a pay-as-you-go basis to B's HSA; or

(C) Contributing to B's HSA at the end of the calendar year taking into account each month that B was an eligible individual and employed by Employer M.

(ii) If Employer M hires additional employees who are eligible individuals after initial funding, it must use the same contribution method for these employees that it used to contribute to B's HSA.

Q–5: Must an employer use the same contribution method as described in Q & A–2 and Q & A–4 of this section for all employees who were comparable participating employees for any month during the calendar year?

A–5: Yes. If an employer makes comparable HSA contributions on a pay-as-you-go basis, it must do so for each employee who is a comparable participating employee as of the first day of the month. If an employer makes comparable contributions on a look-back basis, it must do so for each employee who was a comparable participating employee for any month during the calendar year. If an employer makes HSA contributions on a pre-funded basis, it must do so for all employees who are comparable participating employees at the beginning of the calendar year and must make comparable HSA contributions for all employees who are comparable participating employees for any month during the calendar year, including employees who are eligible individuals hired after the date of initial funding. See Q & A–4 of this section for rules regarding contributions for employees hired after initial funding.

Q–6: How does an employer comply with the comparability rules if an employee has not established an HSA at the time the employer contributes to its employees' HSAs?

A–6: (a) *Employee has not established an HSA at the time the employer funds its employees' HSAs.* If an employee has not established an HSA at the time the employer funds its employees' HSAs, the employer complies with the comparability rules by contributing comparable amounts plus reasonable interest to the employee's HSA when the employee establishes the HSA, taking into account each month that the employee was a comparable participating employee. See Q & A–13 of this section for rules regarding reasonable interest.

(b) *Example.* The following example illustrates the rules in paragraph (a) of this Q & A–6:

Example. Beginning on January 1st, Employer O contributes $500 per calendar year on a pay-as-you-go basis to the HSA of each employee who is an eligible individual. Employee C is an eligible individual during the entire calendar year but does not establish an HSA until March. Notwithstanding C's delay in establishing an HSA, Employer O must make up the missed HSA contributions plus reasonable interest for January and February by April 15th of the following calendar year.

Q–7: If an employer bases its contributions on a percentage of the HDHP deductible, how is the correct percentage or dollar amount computed?

A–7: (a) *Computing HSA contributions.* The correct percentage is determined by rounding to the nearest 1/100th of a percentage point and the dollar amount is determined by rounding to the nearest whole dollar.

(b) *Example.* The following example illustrates the rules in paragraph (a) of this Q & A–7:

Example. In this *Example,* assume that each HDHP provided by Employer P satisfies the definition of an HDHP for the 2007 calendar year. In the 2007 calendar year, Employer P maintains two HDHPs. Plan A has a deductible of $3,000 for self-only coverage. Employer P contributes $1,000 for the calendar year to the HSA of each employee covered under Plan A. Plan B has a deductible of $3,500 for self-only coverage. Employer P satisfies the comparability rules if it makes either of the following contributions for the 2007 calendar year to the HSA of each employee who is an eligible individual with self-only coverage under Plan B—

(i) $1,000; or

(ii) $1,167 (33.33% of the deductible rounded to the nearest whole dollar amount).

Q–8: Does an employer that contributes to the HSA of each comparable participating employee in an amount equal to the employee's HSA contribution or a percentage of the employee's HSA contribution (matching contributions) satisfy the rule that all comparable participating employees receive comparable contributions?

A–8: No. If all comparable participating employees do not contribute the same amount to their HSAs and, consequently, do not receive comparable contributions to their HSAs, the comparability rules are not satisfied, notwithstanding that the employer offers to make available the same contribution amount to each comparable participating employee. But see Q & A–1 in § 54.4980G–5 on contributions to HSAs made through a cafeteria plan.

Q–9: If an employer conditions contributions by the employer to an employee's HSA on an employee's participation in health assessments, disease management programs or wellness programs and makes the same contributions available to all employees who participate in the programs, do the contributions satisfy the comparability rules?

A–9: No. If all comparable participating employees do not elect to participate in all the programs and consequently, all comparable participating employees do not receive comparable contributions to their HSAs, the employer contributions fail to satisfy the comparability rules. But see Q & A–1 in § 54.4980G–5 on contributions made to HSAs through a cafeteria plan.

Q–10: If an employer makes additional contributions to the HSAs of all comparable participating employees who have attained a specified age or who have worked for the employer for a specified number of years, do the contributions satisfy the comparability rules?

A–10: No. If all comparable participating employees do not meet the age or length of service requirement, all comparable participating employees do not receive comparable contributions to their HSAs and the employer contributions fail to satisfy the comparability rules.

Q–11: If an employer makes additional contributions to the HSAs of all comparable participating employees who are eligible to make the additional contributions (HSA catch-up contributions) under section 223(b)(3), do the contributions satisfy the comparability rules?

A–11: No. If all comparable participating employees are not eligible to make the additional HSA contributions under section 223(b)(3), all comparable participating employees do not receive comparable contributions to their HSAs, and the employer contributions fail to satisfy the comparability rules.

Q–12: If an employer's contributions to an employee's HSA result in non-comparable contributions, may the employer recoup the excess amount from the employee's HSA?

A–12: No. An employer may not recoup from an employee's HSA any portion of the employer's contribution to the employee's HSA. Under section 223(d)(1)(E), an account beneficiary's interest in an HSA is nonforfeitable. However, an employer may make additional HSA contributions to satisfy the comparability rules. An employer may contribute up until April 15th following the calendar year in which the non-comparable contributions were made. An employer that makes additional HSA contributions to correct non-comparable contributions must also contribute reasonable interest. However, an employer is not required to contribute amounts in excess of the annual contribution limits in section 223(b). See Q & A–13 of this section for rules regarding reasonable interest.

Q–13: What constitutes a reasonable interest rate for purposes of making comparable contributions?

A–13: The determination of whether a rate of interest used by an employer is reasonable will be based on all of the facts and circumstances. If an employer calculates interest using the Federal short-term rate as determined by the Secretary in accordance with section 1274(d), the employer is deemed to use a reasonable interest rate.

Q–14: Does an employer fail to satisfy the comparability rules for a calendar year if the employer fails to make contributions with respect to eligible employees because the employee has not

established an HSA or because the employer does not know that the employee has established an HSA?

A–14: (a) *In general.* An employer will not fail to satisfy the comparability rules for a calendar year (Year 1) merely because the employer fails to make contributions with respect to an eligible employee because the employee has not established an HSA or because the employer does not know that the employee has established an HSA, if—

(1) The employer provides timely written notice to all such eligible employees that it will make comparable contributions for Year 1 for eligible employees who, by the last day of February of the following calendar year (Year 2), both establish an HSA and notify the employer (in accordance with a procedure specified in the notice) that they have established an HSA; and

(2) For each such eligible employee who establishes an HSA and so notifies the employer on or before the last day of February of Year 2, the employer contributes to the HSA for Year 1 comparable amounts (taking into account each month that the employee was a comparable participating employee) plus reasonable interest by April 15th of Year 2.

(b) *Notice.* The notice described in paragraph (a) of this Q & A–14 must be provided to each eligible employee who has not established an HSA by December 31 of Year 1 or if the employer does not know if the employee established an HSA. The employer may provide the notice to other employees as well. However, if an employee has earlier notified the employer that he or she has established an HSA, or if the employer has previously made contributions to that employee's HSA, the employer may not condition making comparable contributions on receipt of any additional notice from that employee. For each calendar year, a notice is deemed to be timely if the employer provides the notice no earlier than 90 days before the first HSA employer contribution for that calendar year and no later than January 15 of the following calendar year.

(c) *Model notice.* Employers may use the following sample language as a basis in preparing their own notices.

Notice to Employees Regarding Employer Contributions to HSAs:

This notice explains how you may be eligible to receive contributions from [employer] if you are covered by a High Deductible Health Plan (HDHP). [Employer] provides contributions to the Health Savings Account (HSA) of each employee who is [insert employer's eligibility requirements for HSA contributions] (''eligible employee''). If you are an eligible employee, you must do the following in order to receive an employer contribution:

(1) Establish an HSA on or before the last day in February of [insert year after the year for which the contribution is being made] and;

(2) Notify [insert name and contact information for appropriate person to be contacted] of your HSA account information on or before the last day in February of [insert year after year for which the contribution is being made]. [Specify the HSA account information that the employee must provide (e.g., account number, name and address of trustee or custodian, etc.) and the method by which the employee must provide this account information (e.g., in writing, by e-mail, on a certain form, etc.)].

If you establish your HSA on or before the last day of February in [insert year after year for which the contribution is being made] and notify [employer] of your HSA account information, you will receive your HSA contributions, plus reasonable interest, for [insert year for which contribution is being made] by April 15 of [insert year after year for which contribution is being made]. If, however, you do not establish your HSA or you do not notify us of your HSA account information by the deadline, then we are not required to make any contributions to your HSA for [insert applicable year]. You may notify us that you have established an HSA by sending an [e-mail or] a written notice to [insert name, title and, if applicable, e-mail address]. If you have any questions about this notice, you can contact [insert name and title] at [insert telephone number or other contact information].

(d) [Reserved]

(e) *Electronic delivery.* An employer may furnish the notice required under this section electronically in accordance with § 1.401(a)-21 of this chapter.

(f) *Examples.* The following examples illustrate the rules in this Q & A–14:

Example 1. In a calendar year, Employer Q contributes to the HSAs of current employees who are eligible individuals covered under any HDHP. For the 2009 calendar year, Employer Q contributes $50 per month on the first day of each month, beginning January 1st, to the HSA of each employee who is an eligible employee on that date. For the 2009

calendar year, Employer Q provides written notice satisfying the content requirements of this Q & A–14 on October 16, 2008 to all employees regarding the availability of HSA contributions for eligible employees. For eligible employees who are hired after October 16, 2008, Employer Q provides such a notice no later than January 15, 2010. Employer Q's notice satisfies the notice timing requirements in paragraph (a)(1) of this Q & A–14.

Example 2. Employer R's written cafeteria plan permits employees to elect to make pre-tax salary reduction contributions to their HSAs. Employees making this election have the right to receive cash or other taxable benefits in lieu of their HSA pre-tax contribution. Employer R automatically contributes a non-elective matching contribution to the HSA of each employee who makes a pre-tax HSA contribution. Because Employer R's HSA contributions are made through the cafeteria plan, the comparability requirements do not apply to the HSA contributions made by Employer R. Consequently, Employer R is not required to provide written notice to its employees regarding the availability of this matching HSA contribution. See Q & A–1 in § 54.4980G–5 for treatment of HSA contributions made through a cafeteria plan.

Example 3. In a calendar year, Employer S maintains an HDHP and only contributes to the HSAs of eligible employees who elect coverage under its HDHP. For the 2009 calendar year, Employer S employs ten eligible employees and all ten employees have elected coverage under Employer S's HDHP and have established HSAs. For the 2009 calendar year, Employer S makes comparable contributions to the HSAs of all ten employees. Employer S satisfies the comparability rules. Thus, Employer S is not required to provide written notice to its employees regarding the availability of HSA contributions for eligible employees.

Example 4. In a calendar year, Employer T contributes to the HSAs of current full-time employees with family coverage under any HDHP. For the 2009 calendar year, Employer T provides timely written notice satisfying the content requirements of this section to all employees regardless of HDHP coverage. Employer T makes identical monthly contributions to all eligible employees (meaning full time employees with family HDHP coverage) that establish HSAs. Employer T contributes comparable amounts (taking into account each month that the employee was a comparable participating employee) plus reasonable interest to the HSAs of the eligible employees that establish HSAs and provide the necessary information after the end of the year but on or before the last day of February, 2010. Employer T makes no contribution to the HSAs of employees that do not establish an HSA or that do not provide the necessary information on or before the last day of February, 2010. Employer T satisfies the comparability requirements.

Example 5. For the 2009 calendar year, Employer V contributes to the HSAs of current full time employees with family coverage under any HDHP. Employer V has 500 current full time employees. As of the date for Employer V's first HSA contribution for the 2009 calendar year, 450 eligible employees have established HSAs. Employer V provides timely written notice satisfying the content requirements of this section only to those 50 eligible employees who have not established HSAs. Employer V makes identical quarterly contributions to the 450 eligible employees who established HSAs. By April 15, 2010, Employer V contributes comparable amounts to the other eligible employees who establish HSAs and provide the necessary information on or before the last day of February, 2010. Employer V makes no contribution to the HSAs of eligible employees that do not establish an HSA or that do not provide the necessary information on or before the last day of February, 2010. Employer V satisfies the comparability rules.

Q–15: For any calendar year, may an employer accelerate part or all of its contributions for the entire year to the HSAs of employees who have incurred, during the calendar year, qualified medical expenses (as defined in section 223(d)(2)) exceeding the employer's cumulative HSA contributions at that time?

A–15: (a) *In general.* Yes. For any calendar year, an employer may accelerate part or all of its contributions for the entire year to the HSAs of employees who have incurred, during the calendar year, qualified medical expenses exceeding the employer's cumulative HSA contributions at that time. If an employer accelerates contributions to the HSA of any such eligible employee, all accelerated contributions must be available throughout the calendar year on an equal and uniform basis to all such eligible employees. Employers must establish reasonable uniform methods and requirements for accelerated contributions and the determination of medical expenses.

(b) *Satisfying comparability.* An employer that accelerates contributions to the HSAs of its employees will not fail to satisfy the comparability rules because employees who incur qualifying medical expenses exceeding the employer's cumulative HSA contributions at that time have received more contributions in a given period than

comparable employees who do not incur such expenses, provided that all comparable employees receive the same amount or the same percentage for the calendar year. Also, an employer that accelerates contributions to the HSAs of its employees will not fail to satisfy the comparability rules because an employee who terminates employment prior to the end of the calendar year has received more contributions on a monthly basis than employees who work the entire calendar year. An employer is not required to contribute reasonable interest on either accelerated or non-accelerated HSA contributions. But see Q & A–6 and Q & A–12 of this section for when reasonable interest must be paid.

Q–16: What is the effective date for the rules in Q & A–14 and Q & A–15 of this section?

A–16: These regulations apply to employer contributions made for calendar years beginning on or after January 1, 2009.

[T.D. 9277, 71 FR 43058, July 31, 2006; 71 FR 53967, Sept. 13, 2006, as amended by T.D. 9393, 73 FR 20795, Apr. 17, 2008; T.D. 9457, 74 FR 45998, Sept. 8, 2009]

§ 54.4980G–5 HSA comparability rules and cafeteria plans and waiver of excise tax.

Q–1: If an employer makes contributions through a section 125 cafeteria plan to the HSA of each employee who is an eligible individual, are the contributions subject to the comparability rules?

A–1: (a) *In general.* No. The comparability rules do not apply to HSA contributions that an employer makes through a section 125 cafeteria plan. However, contributions to an HSA made through a cafeteria plan are subject to the section 125 nondiscrimination rules (eligibility rules, contributions and benefits tests and key employee concentration tests). See section 125(b), (c) and (g) and the regulations thereunder.

(b) *Contributions made through a section 125 cafeteria plan.* Employer contributions to employees' HSAs are made through a section 125 cafeteria plan and are subject to the section 125 cafeteria plan nondiscrimination rules and not the comparability rules if under the written cafeteria plan, the employees have the right to elect to receive cash or other taxable benefits in lieu of all or a portion of an HSA contribution (meaning that all or a portion of the HSA contributions are available as pre-tax salary reduction amounts), regardless of whether an employee actually elects to contribute any amount to the HSA by salary reduction.

Q–2: If an employer makes contributions through a cafeteria plan to the HSA of each employee who is an eligible individual in an amount equal to the amount of the employee's HSA contribution or a percentage of the amount of the employee's HSA contribution (matching contributions), are the contributions subject to the section 4980G comparability rules?

A–2: No. The comparability rules do not apply to HSA contributions that an employer makes through a section 125 cafeteria plan. Thus, where matching contributions are made by an employer through a cafeteria plan, the contributions are not subject to the comparability rules of section 4980G. However, contributions, including matching contributions, to an HSA made under a cafeteria plan are subject to the section 125 nondiscrimination rules (eligibility rules, contributions and benefits tests and key employee concentration tests). See Q & A–1 of this section.

Q–3: If under the employer's cafeteria plan, employees who are eligible individuals and who participate in health assessments, disease management programs or wellness programs receive an employer contribution to an HSA and the employees have the right to elect to make pre-tax salary reduction contributions to their HSAs, are the contributions subject to the comparability rules?

A–3: (a) *In general.* No. The comparability rules do not apply to employer contributions to an HSA made through a cafeteria plan. See Q & A–1 of this section.

(b) *Examples.* The following examples illustrate the rules in this § 54.4980G–5. The examples read as follows:

Example 1. Employer A's written cafeteria plan permits employees to elect to make pre-tax salary reduction contributions to their

HSAs. Employees making this election have the right to receive cash or other taxable benefits in lieu of their HSA pre-tax contribution. The section 125 cafeteria plan nondiscrimination rules and not the comparability rules apply because the HSA contributions are made through the cafeteria plan.

Example 2. Employer B's written cafeteria plan permits employees to elect to make pre-tax salary reduction contributions to their HSAs. Employees making this election have the right to receive cash or other taxable benefits in lieu of their HSA pre-tax contribution. Employer B automatically contributes a non-elective matching contribution or seed money to the HSA of each employee who makes a pre-tax HSA contribution. The section 125 cafeteria plan nondiscrimination rules and not the comparability rules apply to Employer B's HSA contributions because the HSA contributions are made through the cafeteria plan.

Example 3. Employer C's written cafeteria plan permits employees to elect to make pre-tax salary reduction contributions to their HSAs. Employees making this election have the right to receive cash or other taxable benefits in lieu of their HSA pre-tax contribution. Employer C makes a non-elective contribution to the HSAs of all employees who complete a health risk assessment and participate in Employer C's wellness program. Employees do not have the right to receive cash or other taxable benefits in lieu of Employer C's non-elective contribution. The section 125 cafeteria plan nondiscrimination rules and not the comparability rules apply to Employer C's HSA contributions because the HSA contributions are made through the cafeteria plan.

Example 4. Employer D's written cafeteria plan permits employees to elect to make pre-tax salary reduction contributions to their HSAs. Employees making this election have the right to receive cash or other taxable benefits in lieu of their HSA pre-tax contribution. Employees participating in the plan who are eligible individuals receive automatic employer contributions to their HSAs. Employees make no election with respect to Employer D's contribution and do not have the right to receive cash or other taxable benefits in lieu of Employer D's contribution but are permitted to make their own pre-tax salary reduction contributions to fund their HSAs. The section 125 cafeteria plan nondiscrimination rules and not the comparability rules apply to Employer D's HSA contributions because the HSA contributions are made through the cafeteria plan.

Q–4: May all or part of the excise tax imposed under section 4980G be waived?

A–4: In the case of a failure which is due to reasonable cause and not to willful neglect, all or a portion of the excise tax imposed under section 4980G may be waived to the extent that the payment of the tax would be excessive relative to the failure involved. See sections 4980G(b) and 4980E(c).

[T.D. 9277, 71 FR 43058, July 31, 2006]

§ 54.4980G–6 Special rule for contributions made to the HSAs of nonhighly compensated employees.

Q–1: May an employer make larger contributions to the HSAs of nonhighly compensated employees than to the HSAs of highly compensated employees?

A–1: Yes. Employers may make larger HSA contributions for nonhighly compensated employees who are comparable participating employees than for highly compensated employees who are comparable participating employees. *See* Q & A–1 in § 54.4980G–1 for the definition of comparable participating employee. For purposes of this section, highly compensated employee is defined under section 414(q). Nonhighly compensated employees are employees that are not highly compensated employees. The comparability rules continue to apply with respect to contributions to the HSAs of all nonhighly compensated employees. Employers must make comparable contributions for the calendar year to the HSA of each nonhighly compensated employee who is a comparable participating employee.

Q–2: May an employer make larger contributions to the HSAs of highly compensated employees than to the HSAs of nonhighly compensated employees?

A–2: (a) *In general.* No. Employer contributions to HSAs for highly compensated employees who are comparable participating employees may not be larger than employer HSA contributions for nonhighly compensated employees who are comparable participating employees. The comparability rules continue to apply with respect to contributions to the HSAs of all highly compensated employees. Employers must make comparable contributions for the calendar year to the HSA of each highly compensated comparable participating employee. *See* Q & A–1 in

§ 54.4980G–1 for the definition of comparable participating employee.

(b) *Examples.* The following examples illustrate the rules in Q & A–1 and Q & A–2 of this section. No contributions are made through a section 125 cafeteria plan and none of the employees in the following examples are covered by a collective bargaining agreement. All of the employees in the following examples have the same HDHP deductible for the same category of coverage.

Example 1. In 2010, Employer A contributes $1,000 for the calendar year to the HSA of each full-time nonhighly compensated employee who is an eligible individual with self-only HDHP coverage. Employer A makes no contribution to the HSA of any full-time highly compensated employee who is an eligible individual with self-only HDHP coverage. Employer A's HSA contributions for calendar year 2010 satisfy the comparability rules.

Example 2. In 2010, Employer B contributes $2,000 for the calendar year to the HSA of each full-time nonhighly compensated employee who is an eligible individual with self-only HDHP coverage. Employer B also contributes $1,000 for the calendar year to the HSA of each full-time highly compensated employee who is an eligible individual with self-only HDHP coverage. Employer B's HSA contributions for calendar year 2010 satisfy the comparability rules.

Example 3. In 2010, Employer C contributes $1,000 for the calendar year to the HSA of each full-time nonhighly compensated employee who is an eligible individual with self-only HDHP coverage. Employer C contributes $2,000 for the calendar year to the HSA of each full-time highly compensated employee who is an eligible individual with self-only HDHP coverage. Employer C's HSA contributions for calendar year 2010 do not satisfy the comparability rules.

Example 4. In 2010, Employer D contributes $1,000 for the calendar year to the HSA of each full-time nonhighly compensated employee who is an eligible individual with self-only HDHP coverage. Employer D also contributes $1,000 to the HSA of each full-time highly compensated employee who is an eligible individual with self-only HDHP coverage. In addition, the employer contributes an additional $500 to the HSA of each nonhighly compensated employee who participates in a wellness program. The nonhighly compensated employees did not receive comparable contributions, and, therefore, Employer D's HSA contributions for calendar year 2010 do not satisfy the comparability rules.

Example 5. In 2010, Employer E contributes $1,000 for the calendar year to the HSA of each full-time non-management nonhighly compensated employee who is an eligible individual with family HDHP coverage. Employer E also contributes $500 for the calendar year to the HSA of each full-time management nonhighly compensated employee who is an eligible individual with family HDHP coverage. The nonhighly compensated employees did not receive comparable contributions, and, therefore, Employer E's HSA contributions for calendar year 2010 do not satisfy the comparability rules.

Q–3: May an employer make larger HSA contributions for employees with self plus two HDHP coverage than employees with self plus one HDHP coverage even if the employees with self plus two are all highly compensated employees and the employees with self plus one are all nonhighly compensated employees?

A–3: (a) Yes. Q & A–1 in § 54.4980G–4 provides that an employer's contribution with respect to the self plus two category of HDHP coverage may not be less than the contribution with respect to the self plus one category and the contribution with respect to the self plus three or more category may not be less than the contribution with respect to the self plus two category. Therefore, the comparability rules are not violated if an employer makes a larger HSA contribution for the self plus two category of HDHP coverage than to self plus one coverage, even if the employees with self plus two coverage are all highly compensated employees and the employees with self plus one coverage are all nonhighly compensated employees. Likewise, the comparability rules are not violated if an employer makes a larger HSA contribution for the self plus three category of HDHP coverage than to self plus two coverage, even if the employees with self plus three coverage are all highly compensated employees and the employees with self plus two coverage are all nonhighly compensated employees.

(b) *Example.* The following example illustrates the rules in paragraph (a) of this Q & A–3. In the following example, no contributions are made through a section 125 cafeteria plan and none of the employees are covered by a collective bargaining agreement.

Example. In 2010, Employer F contributes $1,000 for the calendar year to the HSA of each full-time employee who is an eligible individual with self plus one HDHP coverage.

Employer F contributes $1,500 for the calendar year to the HSA of each employee who is an eligible individual with self plus two HDHP coverage. The deductible for both the self plus one HDHP and the self plus two HDHP is $2,000. Employee A, an eligible individual, is a nonhighly compensated employee with self plus one coverage. Employee B, an eligible individual, is a highly compensated employee with self plus two coverage. For the 2010 calendar year, Employer F contributes $1,000 to Employee A's HSA and $1,500 to Employee B's HSA. Employer F's HSA contributions satisfy the comparability rules.

Q–4:What is the effective date for the rules in this section?

A–4: The rules in this section are effective for employer contributions made for calendar years beginning on or after January 1, 2010.

[T.D. 9457, 74 FR 45998, Sept. 8, 2009]

§ 54.4980G–7 Special comparability rules for qualified HSA distributions contributed to HSAs on or after December 20, 2006 and before January 1, 2012.

Q–1 How do the comparability rules of section 4980G apply to qualified HSA distributions under section 106(e)(2)?

A–1:The comparability rules of section 4980G do not apply to amounts contributed to employee HSAs through qualified HSA distributions. However, in order to satisfy the comparability rules, if an employer offers qualified HSA distributions, as defined in section 106(e)(2), to any employee who is an eligible individual covered under any HDHP, the employer must offer qualified HSA distributions to all employees who are eligible individuals covered under any HDHP. However, if an employer offers qualified HSA distributions only to employees who are eligible individuals covered under the employer's HDHP, the employer is not required to offer qualified HSA distributions to employees who are eligible individuals but are not covered under the employer's HDHP.

Q–2: What is the effective date for the rules in this section?

A–2: The rules in this section are effective for are effective for employer contributions made for calendar years beginning on or after January 1, 2010.

[T.D. 9457, 74 FR 45999, Sept. 8, 2009]

§ 54.4980H–0 Table of contents.

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(15) Employee.
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(19) Federal poverty line.
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(48) United States.
(49) Variable hour employee.
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§ 54.4980H–2 Applicable large employer and applicable large employer member.

(a) In general.

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(2) Calculating the number of FTEs.
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(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.
(2) Special rule for certain employees to whom minimum value coverage has been continuously offered.
(g) Nonpayment or late payment of premiums.
(h) Additional guidance.
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§ 54.4980H–4 Assessable payments under section 4980H(a).

(a) In general.
(b) Offer of coverage.
(1) In general.
(2) Offer of coverage on behalf of another entity.
(c) Partial calendar month.
(d) Application to applicable large employer member.
(e) Allocated reduction of 30 full-time employees.
(f) Example.
(g) Additional guidance.
(h) Effective/applicability date.

§ 54.4980H–5 Assessable payments under section 4980H(b).

(a) In general.
(b) Offer of coverage.
(c) Partial calendar month.
(d) Applicability to applicable large employer member.
(e) Affordability.
(1) In general.
(2) Affordability safe harbors for section 4980H(b) purposes.
(f) Additional guidance.
(g) Effective/applicability date.

§ 54.4980H–6 Administration and procedure.

(a) In general.
(b) Effective/applicability date.

[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]

§ 54.6011–3 Required use of electronic form for the filing requirements for the return for certain excise taxes related to employee benefit plans.

(a) *Excise tax returns required in electronic form.* Any employer or individual required to file an excise tax return on Form 5330, *Return of Excise Taxes Related to Employee Benefit Plans,* under § 54.6011–1 of this chapter must file the excise tax return electronically if the filer is required by the Internal Revenue Code or regulations to file at least 10 returns of any type during the calendar year that the Form 5330 is due. The Commissioner may direct the type of electronic filing and may also exempt certain returns from the electronic-filing requirements of this section through revenue procedures, publications, forms, instructions, or other guidance, including postings on the *IRS.gov* website. Returns filed electronically must be made in accordance with the applicable revenue procedures, publications, forms, instructions, or other guidance.

(b) *Exclusions from electronic-filing requirements*—(1) *Waivers.* The Commissioner may grant waivers of the requirements of this section in cases of undue hardship. One principal factor in

determining hardship will be the amount, if any, by which the cost of filing the return electronically in accordance with this section exceeds the cost of filing the return on paper. A request for a waiver must be made in accordance with applicable IRS revenue procedures, publications, forms, instructions, or other guidance, including postings to the *IRS.gov* website. The waiver request will specify the type of filing (that is, a return required under § 54.6011–1 of this chapter) and the period to which it applies.

(2) *Exemptions.* The Commissioner may provide exemptions from the requirements of this section to promote effective and efficient tax administration. A submission claiming an exemption must be made in accordance with applicable IRS revenue procedures, publications, forms, instructions, or other guidance, including postings to the *IRS.gov* website.

(3) *Additional exclusion.* If the IRS's systems do not support electronic filing, taxpayers will not be required to file electronically.

(c) *Failure to file.* If a filer required to file the Form 5330 fails to file the report electronically when required to do so by this section, the filer has failed to file the report. See generally section 6651(a)(1) for the penalty for the failure to file a tax return or to pay tax. For general rules relating to the failure to file a tax return or to pay tax, see the regulations under 26 CFR 301.6651–1 (Regulations on Procedure and Administration).

(d) *Meaning of terms.* The following definitions apply for purposes of this section:

(1) *Magnetic media or electronic form.* The terms *magnetic media or electronic form* mean any media or form permitted under applicable regulations, revenue procedures, or publications. These generally include electronic filing, as well as magnetic tape, tape cartridge, diskette, and other media specifically permitted under the applicable regulations, procedures, publications, forms, instructions, or other guidance.

(2) *Calculating the number of returns a filer is required to file*—(i) *In general.* For purposes of this section, a filer is required to file at least 10 returns during a calendar year if the filer is required to file at least 10 returns of any type, including information returns (for example, Forms W–2 and Forms 1099), income tax returns, employment tax returns, and excise tax returns.

(ii) *Definition of filer.* For purposes of this section, the term *filer* means the person required to report the tax on the Form 5330. For general rules on who is required to report the tax on the Form 5330, see the Instructions to the Form 5330.

(e) *Example.* The following example illustrates the provisions of paragraph (d)(2) of this section:

(1) In 2023, Employer A (the plan sponsor and plan administrator of Plan B) is required to file Form 5330 for its nondeductible contribution under section 4972 to Plan B. During the 2024 calendar year, Employer A is required to file 20 returns (including 19 Forms 1099–R *Distributions From Pensions, Annuities, Retirement, Profit-Sharing Plans, IRAs, Insurance Contracts, etc.,* and one Form 5500 series, *Annual Return/Report of the Employee Benefit Plan*). Plan B's plan year is the calendar year. Because Employer A is required to file at least 10 returns during the 2024 calendar year, Employer A must file the 2023 Form 5330 for Plan B electronically.

(2) [Reserved]

(f) *Applicability date.* The rules of this section apply to any Form 5330 required to be filed for taxable years ending on or after December 31, 2023.

[T.D. 9972, 88 FR 11766, Feb. 23, 2023]

§ 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 nonconfinement, actively-at-work, and other service requirements), paragraph (f) of this section (relating to wellness programs), and paragraph (g) of this section (permitting favorable treatment of individuals with adverse health factors).

(ii) For purposes of this section, rules for eligibility include, but are not limited to, rules relating to—

(A) Enrollment;

(B) The effective date of coverage;

(C) Waiting (or affiliation) periods;

(D) Late and special enrollment;

(E) Eligibility for benefit packages (including rules for individuals to change their selection among benefit packages);

(F) Benefits (including rules relating to covered benefits, benefit restrictions, and cost-sharing mechanisms such as coinsurance, copayments, and deductibles), as described in paragraphs (b)(2) and (3) of this section;

(G) Continued eligibility; and

(H) Terminating coverage (including disenrollment) of any individual under the plan.

(iii) The rules of this paragraph (b)(1) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan that is available to all employees who enroll within the first 30 days

of their employment. However, employees who do not enroll within the first 30 days cannot enroll later unless they pass a physical examination.

(ii) *Conclusion.* In this *Example 1,* the requirement to pass a physical examination in order to enroll in the plan is a rule for eligibility that discriminates based on one or more health factors and thus violates this paragraph (b)(1).

Example 2. (i) *Facts.* Under an employer's group health plan, employees who enroll during the first 30 days of employment (and during special enrollment periods) may choose between two benefit packages: An indemnity option and an HMO option. However, employees who enroll during late enrollment are permitted to enroll only in the HMO option and only if they provide evidence of good health.

(ii) *Conclusion.* In this *Example 2,* the requirement to provide evidence of good health in order to be eligible for late enrollment in the HMO option is a rule for eligibility that discriminates based on one or more health factors and thus violates this paragraph (b)(1). However, if the plan did not require evidence of good health but limited late enrollees to the HMO option, the plan's rules for eligibility would not discriminate based on any health factor, and thus would not violate this paragraph (b)(1), because the time an individual chooses to enroll is not, itself, within the scope of any health factor.

Example 3. (i) *Facts.* Under an employer's group health plan, all employees generally may enroll within the first 30 days of employment. However, individuals who participate in certain recreational activities, including motorcycling, are excluded from coverage.

(ii) *Conclusion.* In this *Example 3*, excluding from the plan individuals who participate in recreational activities, such as motorcycling, is a rule for eligibility that discriminates based on one or more health factors and thus violates this paragraph (b)(1).

Example 4. (i) *Facts.* A group health plan applies for a group health policy offered by an issuer. As part of the application, the issuer receives health information about individuals to be covered under the plan. Individual *A* is an employee of the employer maintaining the plan. *A* and *A*'s dependents have a history of high health claims. Based on the information about *A* and *A*'s dependents, the issuer excludes *A* and *A*'s dependents from the group policy it offers to the employer.

(ii) *Conclusion.* See *Example 4* in 29 CFR 2590.702(b)(1) and 45 CFR 146.121(b)(1) for a conclusion that the exclusion by the issuer of *A* and *A*'s dependents from coverage is a rule for eligibility that discriminates based on one or more health factors and violates rules under 29 CFR 2590.702(b)(1) and 45 CFR 146.121(b)(1) similar to the rules under this paragraph (b)(1). (If the employer is a small employer under 45 CFR 144.103 (generally, an employer with 50 or fewer employees), the issuer also may violate 45 CFR 146.150, which requires issuers to offer all the policies they sell in the small group market on a guaranteed available basis to all small employers and to accept every eligible individual in every small employer group.) If the plan provides coverage through this policy and does not provide equivalent coverage for *A* and *A*'s dependents through other means, the plan violates this paragraph (b)(1).

(2) *Application to benefits*—(i) *General rule*—(A) Under this section, a group health plan is not required to provide coverage for any particular benefit to any group of similarly situated individuals.

(B) However, benefits provided under a plan must be uniformly available to all similarly situated individuals (as described in paragraph (d) of this section). Likewise, any restriction on a benefit or benefits must apply uniformly to all similarly situated individuals and must not be directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries (determined based on all the relevant facts and circumstances). Thus, for example, a plan may limit or exclude benefits in relation to a specific disease or condition, limit or exclude benefits for certain types of treatments or drugs, or limit or exclude benefits based on a determination of whether the benefits are experimental or not medically necessary, but only if the benefit limitation or exclusion applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. In addition, a plan 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 re-enrollment.* 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 re-enrollment.* 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, nonemergency services performed by nonparticipating 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 freestanding 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]

§ 54.9816–6 Methodology for calculating qualifying payment amount.

(a) For further guidance see § 54.9816–6T(a) introductory text through (a)(17).

(1)–(17) [Reserved]

(18) *Downcode* means the alteration by a plan or issuer of a service code to another service code, or the alteration, addition, or removal by a plan or issuer of a modifier, if the changed code or modifier is associated with a lower qualifying payment amount than the service code or modifier billed by the provider, facility, or provider of air ambulance services.

(b) For further guidance see § 54.9816–6T(b) and (c).

(c) For further guidance see § 54.9816–6T(b) and (c).

(d) For further guidance see § 54.9816–6T(d) introductory text through (d)(1)(i).

(1) [Reserved]

(i) [Reserved]

(ii) If the qualifying payment amount is based on a downcoded service code or modifier—

(A) A statement that the service code or modifier billed by the provider, facility, or provider of air ambulance services was downcoded;

(B) An explanation of why the claim was downcoded, which must include a description of which service codes were altered, if any, and a description of which modifiers were altered, added, or removed, if any; and

(C) The amount that would have been the qualifying payment amount had the service code or modifier not been downcoded.

(iii) For further guidance see § 54.9816–6T(d)(1)(iii) through (v).

(iv) For further guidance see § 54.9816–6T(d)(1)(iii) through (v).

(v) For further guidance see § 54.9816–6T(d)(1)(iii) through (v).

(2) For further guidance see § 54.9816–6T(d)(2).

(e) For further guidance see § 54.9816–6T(e) and (f).

(f) For further guidance see § 54.9816–6T(e) and (f).

(g) *Applicability date.* The provisions of this section are applicable for plan years beginning on or after January 1, 2022, except that paragraph (a)(18) of this section regarding the definition of the term ''downcode'' and paragraph (d)(1)(ii) of this section regarding additional information that must be provided if the qualifying payment amount is based on a downcoded service code or modifier are applicable with respect to items or services provided or furnished on or after October 25, 2022, for plan years beginning on or after January 1, 2022.

[T.D. 9965, 87 FR 52644, Aug. 26, 2022]

§ 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.

(18) For further guidance see § 54.9816–6(a)(18).

(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) For further guidance see § 54.9816–6(d)(1)(ii);

(iii) 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;

(iv) 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

(v) 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, as amended by T.D. 9965, 87 FR 52645, Aug. 26, 2022]

§ 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]

§ 54.9816–8 Independent dispute resolution process.

(a) For further guidance see § 54.9816–8T(a) and (b).

(b) For further guidance see § 54.9816–8T(a) and (b).

(c) For further guidance see § 54.9816–8T(c) introductory text through (c)(3).

(1)–(3) [Reserved]

(4) For further guidance see § 54.9816–8T(c)(4) introductory text through (c)(4)(ii) introductory text.

(i) [Reserved]

(ii) [Reserved]

(A) Select as the out-of-network rate for the qualified IDR item or service one of the offers submitted under § 54.9816–8T(c)(4)(i), weighing only the considerations specified in paragraph (c)(4)(iii) of this section (as applied to the information provided by the parties pursuant to § 54.9816–8T(c)(4)(i)). The certified IDR entity must select the offer that the certified IDR entity determines best represents the value of the qualified IDR item or service as the out-of-network rate.

(B) For further guidance see § 54.9816–8T(c)(4)(ii)(B).

(iii) *Considerations in determination.* In determining which offer to select:

(A) The certified IDR entity must consider the qualifying payment amount(s) for the applicable year for the same or similar item or service.

(B) The certified IDR entity must then consider information submitted by a party that relates to the following circumstances:

(*1*) The level of training, experience, and quality and outcomes measurements of theprovider 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 or issuer in thegeographic 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 or issuer to enter into network agreements with each other, and, if applicable,contracted rates between the provider or facility, as applicable, and the plan or issuer, as applicable, during the previous 4 plan years.

(C) The certified IDR entity must also consider information provided by a party in response to a request by the certified IDR entity under § 54.9816–8T(c)(4)(i)(A)(*2*) that relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination and that does not include information on factors described in § 54.9816–8T(c)(4)(v).

(D) The certified IDR entity must also consider additional information submitted by a party that relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination and that does not include information on factors described in § 54.9816–8T(c)(4)(v).

(E) In weighing the considerations described in paragraphs (c)(4)(iii)(B)

through (D) of this section, the certified IDR entity should evaluate whether the information is credible and relates to the offer submitted by either party for the payment amount for the qualified IDR item or service that is the subject of the payment determination. The certified IDR entity should not give weight to information to the extent it is not credible, it does not relate to either party's offer for the payment amount for the qualified IDR item or service, or it is already accounted for by the qualifying payment amount under paragraph (c)(4)(iii)(A) of this section or other credible information under paragraphs (c)(4)(iii)(B) through (D) of this section.

(iv) *Examples.* The rules of paragraph (c)(4)(iii) of this section are illustrated in the following paragraphs. Each example assumes that the Federal IDR process applies for purposes of determining the out-of-network rate, that both parties have submitted the information parties are required to submit as part of the Federal IDR process, and that the submitted information does not include information on factors described in paragraph (c)(4)(v) of this section:

(A) *Example 1—(1) Facts.* A level 1 trauma center that is a nonparticipating emergency facility and an issuer are parties to a payment determination in the Federal IDR process. The facility submits an offer that is higher than the qualifying payment amount. The facility also submits additional written information showing that the scope of services available at the facility was critical to the delivery of care for the qualified IDR item or service provided, given the particular patient's acuity. This information is determined to be credible by the certified IDR entity. Further, the facility submits additional information showing the contracted rates used to calculate the qualifying payment amount for the qualified IDR item or service were based on a level of service that is typical in cases in which the services are delivered by a facility that is not a level 1 trauma center and that does not have the capability to provide the scope of services provided by a level 1 trauma center. This information is also determined to be credible by the certified IDR entity. The issuer submits an offer equal to the qualifying payment amount. No additional information is submitted by either party. The certified IDR entity determines that all the information submitted by the nonparticipating emergency facility relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination.

(*2*) *Conclusion.* In this paragraph (c)(4)(iv)(A) (*Example 1*), the certified IDR entity must consider the qualifying payment amount. The certified IDR entity then must consider the additional information submitted by the nonparticipating emergency facility, provided the information relates to circumstances described in paragraphs (c)(4)(iii)(B) through (D) of this section and relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination. If the certified IDR entity determines that it is appropriate to give weight to the additional credible information submitted by the nonparticipating emergency facility and that the additional credible information submitted by the facility demonstrates that the facility's offer best represents the value of the qualified IDR item or service, the certified IDR entity should select the facility's offer.

(B) *Example 2—(1) Facts.* A nonparticipating provider and an issuer are parties to a payment determination in the Federal IDR process. The provider submits an offer that is higher than the qualifying payment amount. The provider also submits additional written information regarding the level of training and experience the provider possesses. This information is determined to be credible by the certified IDR entity, but the certified IDR entity finds that the information does not demonstrate that the provider's level of training and experience relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination (for example, the information does not show that the provider's level of training and experience was necessary for providing the qualified IDR

service that is the subject of the payment determination to the particular patient, or that the training or experience made an impact on the care that was provided). The nonparticipating provider does not submit any additional information. The issuer submits an offer equal to the qualifying payment amount, with no additional information.

(*2*) *Conclusion.* In this paragraph (c)(4)(iv)(B) (*Example 2*), the certified IDR entity must consider the qualifying payment amount. The certified IDR entity must then consider the additional information submitted by the nonparticipating provider, provided the information relates to circumstances described in paragraphs (c)(4)(iii)(B) through (D) of this section and relates to the offer for the payment amount for the qualified IDR item or service that is the subject of the payment determination. In addition, the certified IDR entity should not give weight to information to the extent it is already accounted for by the qualifying payment amount or other credible information under paragraphs (c)(4)(iii)(B) through (D) of this section. If the certified IDR entity determines that the additional information submitted by the provider is credible but does not relate to the offer for the payment amount for the qualified IDR service that is the subject of the payment determination, and determines that the issuer's offer best represents the value of the qualified IDR service, in the absence of any other credible information that relates to either party's offer, the certified IDR entity should select the issuer's offer.

(C) *Example 3—(1) Facts.* A nonparticipating provider and an issuer are parties to a payment determination in the Federal IDR process involving an emergency department visit for the evaluation and management of a patient. The provider submits an offer that is higher than the qualifying payment amount. The provider also submits additional written information showing that the acuity of the patient's condition and complexity of the qualified IDR service furnished required the taking of a comprehensive history, a comprehensive examination, and medical decision making of high complexity. This information is determined to be credible by the certified IDR entity. The issuer submits an offer equal to the qualifying payment amount for CPT code 99285, which is the CPT code for an emergency department visit for the evaluation and management of a patient requiring a comprehensive history, a comprehensive examination, and medical decision making of high complexity. The issuer also submits additional written information showing that this CPT code accounts for the acuity of the patient's condition. This information is determined to be credible by the certified IDR entity. The certified IDR entity determines that the information provided by the provider and issuer relates to the offer for the payment amount for the qualified IDR service that is the subject of the payment determination. Neither party submits any additional information.

(*2*) *Conclusion.* In this paragraph (c)(4)(iv)(C) (*Example 3*), the certified IDR entity must consider the qualifying payment amount. The certified IDR entity then must consider the additional information submitted by the parties, but the certified IDR entity should not give weight to information to the extent it is already accounted for by the qualifying payment amount or other credible information under paragraphs (c)(4)(iii)(B) through (D) of this section. If the certified IDR entity determines the additional information on the acuity of the patient and complexity of the service is already accounted for in the calculation of the qualifying payment amount, the certified IDR entity should not give weight to the additional information provided by the provider. If the certified IDR entity determines that the issuer's offer best represents the value of the qualified IDR service, the certified IDR entity should select the issuer's offer.

(D) *Example 4—(1) Facts.* A nonparticipating emergency facility and an issuer are parties to a payment determination in the Federal IDR process. Although the facility is not participating in the issuer's network during the relevant plan year, it was a participating facility in the issuer's network in the previous 4 plan years. The issuer submits an offer that is

higher than the qualifying payment amount and that is equal to the facility's contracted rate (adjusted for inflation) for the previous year with the issuer for the qualified IDR service. The issuer also submits additional written information showing that the contracted rates between the facility and the issuer during the previous 4 plan years were higher than the qualifying payment amount submitted by the issuer, and that these prior contracted rates account for the case mix and scope of services typically furnished at the nonparticipating facility. The certified IDR entity determines this information is credible and that it relates to the offer submitted by the issuer for the payment amount for the qualified IDR service that is the subject of the payment determination. The facility submits an offer that is higher than both the qualifying payment amount and the contracted rate (adjusted for inflation) for the previous year with the issuer for the qualified IDR service. The facility also submits additional written information, with the intent to show that the case mix and scope of services available at the facility were integral to the service provided. The certified IDR entity determines this information is credible and that it relates to the offer submitted by the facility for the payment amount for the qualified IDR service that is the subject of the payment determination. Neither party submits any additional information.

(*2*) *Conclusion.* In this paragraph (c)(4)(iv)(D) (*Example 4*), the certified IDR entity must consider the qualifying payment amount. The certified IDR entity then must consider the additional information submitted by the parties, but should not give weight to information to the extent it is already accounted for by the qualifying payment amount or other credible information under paragraphs (c)(4)(iii)(B) through (D) of this section. If the certified IDR entity determines that the information submitted by the facility regarding the case mix and scope of services available at the facility includes information that is also accounted for in the information the issuer submitted regarding prior contracted rates, then the certified IDR entity should give weight to that information only once. The certified IDR entity also should not give weight to the same information provided by the nonparticipating emergency facility in relation to any other factor. If the certified IDR entity determines that the issuer's offer best represents the value of the qualified IDR service, the certified IDR entity should select the issuer's offer.

(E) *Example 5*—(*1*) *Facts.* A nonparticipating provider and an issuer are parties to a payment determination in the Federal IDR process regarding a qualified IDR service for which the issuer downcoded the service code that the provider billed. The issuer submits an offer equal to the qualifying payment amount (which was calculated using the downcoded service code). The issuer also submits additional written information that includes the documentation disclosed to the nonparticipating provider under §54.9816–6(d)(1)(ii) at the time of the initial payment (which describes why the service code was downcoded). The certified IDR entity determines this information is credible and that it relates to the offer for the payment amount for the qualified IDR service that is the subject of the payment determination. The provider submits an offer equal to the amount that would have been the qualifying payment amount had the service code not been downcoded. The provider also submits additional written information that includes the documentation disclosed to the nonparticipating provider under §54.9816–6(d)(1)(ii) at the time of the initial payment. Further, the provider submits additional written information that explains why the billed service code was more appropriate than the downcoded service code, as evidence that the provider's offer, which is equal to the amount the qualifying payment amount would have been for the service code that the provider billed, best represents the value of the service furnished, given its complexity. The certified IDR entity determines this information to be credible and that it relates to the offer for the payment amount for the qualified IDR service that is the subject of the payment determination. Neither party submits any additional information.

(*2*) *Conclusion.* In this paragraph (c)(4)(iv)(E) (*Example 5*), the certified IDR entity must consider the qualifying payment amount, which is based on the downcoded service code. The certified IDR entity then must consider whether to give weight to additional information submitted by the parties. If the certified IDR entity determines that the additional credible information submitted by the provider demonstrates that the nonparticipating provider's offer, which is equal to the qualifying payment amount for the service code that the provider billed, best represents the value of the qualified IDR service, the certified IDR entity should select the nonparticipating provider's offer.

(v) For further guidance see § 54.9816–8T(c)(4)(v) through (c)(4)(vi)(A).

(vi) [Reserved]

(A) [Reserved]

(B) The certified IDR entity's written decision must include an explanation of their determination, including what information the certified IDR entity determined demonstrated that the offer selected as the out-of-network rate is the offer that best represents the value of the qualified IDR item or service, including the weight given to the qualifying payment amount and any additional credible information under paragraphs (c)(4)(iii)(B) through (D) of this section. If the certified IDR entity relies on information described under paragraphs (c)(4)(iii)(B) through (D) of this section in selecting an offer, the written decision must include an explanation of why the certified IDR entity concluded that this information was not already reflected in the qualifying payment amount.

(vii) For further guidance see § 54.9816–8T(c)(4)(vii) through (ix).

(viii) For further guidance see § 54.9816–8T(c)(4)(vii) through (ix).

(ix) For further guidance see § 54.9816–8T(c)(4)(vii) through (ix).

(d) For further guidance see § 54.9816–8T(d) through (e).

(e) For further guidance see § 54.9816–8T(d) through (e).

(f) For further guidance see § 54.9816–8T(f) introductory text through (f)(1)(iv).

(1) [Reserved]

(i)–(iv) [Reserved]

(v) For further guidance see § 54.9816–8T(f)(1)(v) introductory text through (f)(1)(v)(E).

(A)–(E) [Reserved]

(F) The rationale for the certified IDR entity's decision, including the extent to which the decision relied on the criteria in paragraphs (c)(4)(iii)(B) through (D) of this section.

(G) For further guidance see § 54.9816–8T(f)(1)(v)(G) through (I).

(H) For further guidance see § 54.9816–8T(f)(1)(v)(G) through (I).

(I) For further guidance see § 54.9816–8T(f)(1)(v)(G) through (I).

(vi) For further guidance see § 54.9816–8T(f)(1)(vi).

(2) [Reserved]

(g) For further guidance see § 54.9816–8T(g).

(h) *Applicability date.* The provisions of this section are applicable with respect to plan years beginning on or after January 1, 2022, except that paragraphs (c)(4)(ii) through (iv) of this section regarding payment determinations, paragraph (c)(4)(vi)(B) of this section regarding written decisions, and paragraph (f)(1)(v)(F) of this section regarding reporting of information relating to the Federal IDR process are applicable with respect to items or services provided or furnished on or after October 25, 2022, for plan years beginning on or after January 1, 2022.

[T.D. 9965, 87 FR 52645, Aug. 26, 2022]

§ 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 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.

(ix) *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.

(x) *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.

(xi) *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.

(xii) *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) For further guidance see §54.9816–8(c)(4)(ii)(A).

(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) For further guidance see §54.9816–8(c)(4)(iii).

(iv) For further guidance see §54.9816–8(c)(4)(iv).

(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) For further guidance see §54.9816–8(c)(4)(vi)(B).

(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 deidentified 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) For further guidance see § 54.9816–8(f)(1)(v)(F);

(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; and paragraphs (c)(4)(ii) through (iv) of this section regarding payment determinations, paragraph (c)(4)(vi)(B) of this section regarding written decisions, and paragraph (f)(1)(v)(F) of this section regarding reporting of information relating to the Federal IDR process are applicable with respect to items or services provided or furnished on or after October 25, 2022, for plan years beginning on or after January 1, 2022.

[T.D. 9955, 86 FR 56100, Oct. 7, 2021, as amended by T.D. 9965, 87 FR 52647, Aug. 26, 2022]

§ 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]

§ 54.9817–2 Independent dispute resolution process for air ambulance services.

(a) For further guidance see § 54.9817–2T(a).

(b) For further guidance see § 54.9817–2T(b) introductory text.

(1) *In general.* Except as provided in paragraphs (b)(2) and (3) of this section and § 54.9817–2T(b)(2) and (4), in determining the out-of-network rate to be paid by group health plans and health insurance issuers offering group health

insurance coverage for out-of-network air ambulance services, plans and issuers must comply with the requirements of §§ 54.9816–8T and 54.9816–8, except that references in §§ 54.9816–8T and 54.9816–8 to the additional circumstances in § 54.9816–8(c)(4)(iii)(B) shall be understood to refer to paragraph (b)(2) of this section and § 54.9817–2T(b)(2).

(2) *Considerations for air ambulance services.* In determining which offer to select, in addition to considering the applicable qualifying payment amount(s), the certified IDR entity must consider information submitted by a party that relates to the following circumstances:

(i) For further guidance see § 54.9817–2T(b)(2)(i) through (vi).

(ii) For further guidance see § 54.9817–2T(b)(2)(i) through (vi).

(iii) For further guidance see § 54.9817–2T(b)(2)(i) through (vi).

(vi) For further guidance see § 54.9817–2T(b)(2)(i) through (vi).

(3) *Weighing considerations.* In weighing the considerations described in paragraph (b)(2) of this section and § 54.9817–2T(b)(2), the certified IDR entity should evaluate whether the information is credible and relates to the offer submitted by either party for the payment amount for the qualified IDR service that is the subject of the payment determination. The certified IDR entity should not give weight to information to the extent it is not credible, it does not relate to either party's offer for the payment amount for the qualified IDR service, or it is already accounted for by the qualifying payment amount under § 54.9816–8(c)(4)(iii)(A) or other credible information under § 54.9816–8(c)(4)(iii)(B) through (D), except that the additional circumstances in § 54.9816–8(c)(4)(iii)(B) shall be understood to refer to paragraph (b)(2) of this section and § 54.9817–2T(b)(2).

(4) For further guidance see § 54.9817–2T(b)(4) introductory text through (b)(4)(iii).

(i)–(iii) [Reserved]

(iv) For further guidance see § 54.9817–2T(b)(4)(iv) introductory text through (b)(4)(iv)(E).

(A)–(E) [Reserved]

(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 and § 54.9816–8(c)(4)(iii)(C) and (D).

(G) For further guidance see § 54.9817–2T(b)(4)(iv)(G) through (I).

(H) For further guidance see § 54.9817–2T(b)(4)(iv)(G) through (I).

(I) For further guidance see § 54.9817–2T(b)(4)(iv)(G) through (I).

(c) *Applicability date.* The provisions of this section are applicable with respect to plan years beginning on or after January 1, 2022, except that paragraphs (b)(1), (2), and (3) and (b)(4)(iv)(F) of this section regarding payment determinations are applicable with respect to services provided or furnished on or after October 25, 2022, for plan years beginning on or after January 1, 2022.

[T.D. 9965, 87 FR 52648, Aug. 26, 2022]

§ 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) For further guidance see § 54.9817–2(b)(1).

(2) For further guidance see § 54.9817–2(b)(2).

(3) For further guidance see § 54.9817–2(b)(3).

(4) *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) For further guidance see § 54.9817–2(b)(4)(iv)(F);

(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, except that paragraphs (b)(1), (2), and (3) and (b)(4)(iv)(F) of this section regarding payment determinations are applicable with respect to services provided or furnished on or after October 25, 2022, for plan years beginning on or after January 1, 2022.

[T.D. 9955, 86 FR 56109, Oct. 7, 2021, as amended by T.D. 9965, 87 FR 52648, Aug. 26, 2022]

§ 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.