

HIGHLIGHTS OF THIS ISSUE

These synopses are intended only as aids to the reader in identifying the subject matter covered. They may not be relied upon as authoritative interpretations.

INCOME TAX

REG-120391-10, page 1005.

Proposed regulations would amend the rules regarding coverage for certain preventive services without cost sharing under the Patient Protection and Affordable Care Act. The proposed rules would amend the authorization to provide an exemption for group health plans established or maintained by certain religious employers (and group health insurance coverage provided in connection with such plans) with respect to the requirement to cover contraceptive services. The proposed rules would also establish accommodations for group health plans established or maintained by eligible organizations (and group health insurance coverage offered in connection with such plans), including student health insurance coverage arranged by eligible organizations that are religious institutions of higher education.

Notice 2013-27, page 985.

This notice provides the maximum vehicle values for use with the special valuation rules under regulation section 1.61-21(d) and (e) for 2013. These values are adjusted for inflation and must be adjusted annually by reference to the Consumer Price Index.

EMPLOYEE PLANS

Rev. Proc. 2013-22, page 985.

This revenue procedure sets forth the procedures of the Internal Revenue Service for issuing opinion and advisory letters for § 403(b) pre-approved plans (that is, § 403(b) prototype plans and § 403(b) volume submitter plans). Under the program established by this revenue procedure, the Service will accept

applications for opinion and advisory letters regarding the acceptability under § 403(b) of the Code of the form of prototype plans and volume submitter plans. Rev. Procs. 2013-4 and 2013-8 modified.

EMPLOYMENT TAX

Announcement 2013-29, page 1024.

In Announcement 2012-25, 2012-26 I.R.B. 1054, the IRS foreshadowed that it planned to solicit public comments on possible changes to the existing Tip Rate Determination and Education Program (TRDEP). In this Announcement, the IRS is seeking comments on the manner to incorporate items the public believes would increase tip reporting compliance and ease taxpayer burden into the potential re-engineering of its voluntary tip agreements. The IRS welcomes comments on all aspects of the Tip Rate Determination Agreement and Tip Reporting Alternative Commitment products, but is particularly interested in suggestions regarding processes, computational methodologies, agreement language, and suggested topics for "Frequently Asked Questions."

EXCISE TAX

Notice 2013-26, page 984.

On January 2, 2013, the American Taxpayer Relief Act of 2012, Pub. L. 112-240, (ATRA) retroactively extended various fuel tax credits that expired on December 31, 2011. The due date for filing certain claims for payments related to biodiesel mixtures and alternative fuel had already passed by the date that ATRA was enacted. This Notice allows additional time for claimants to file these claims for payments.

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Finding Lists begin on page ii.
Index for January through April begins on page iv.

ADMINISTRATIVE

Notice 2013-27, page 985.

This notice provides the maximum vehicle values for use with the special valuation rules under regulation section 1.61-21(d) and (e) for 2013. These values are adjusted for inflation and must be adjusted annually by reference to the Consumer Price Index.

The IRS Mission

Provide America's taxpayers top-quality service by helping them understand and meet their tax responsibilities and en-

force the law with integrity and fairness to all.

Introduction

The Internal Revenue Bulletin is the authoritative instrument of the Commissioner of Internal Revenue for announcing official rulings and procedures of the Internal Revenue Service and for publishing Treasury Decisions, Executive Orders, Tax Conventions, legislation, court decisions, and other items of general interest. It is published weekly.

It is the policy of the Service to publish in the Bulletin all substantive rulings necessary to promote a uniform application of the tax laws, including all rulings that supersede, revoke, modify, or amend any of those previously published in the Bulletin. All published rulings apply retroactively unless otherwise indicated. Procedures relating solely to matters of internal management are not published; however, statements of internal practices and procedures that affect the rights and duties of taxpayers are published.

Revenue rulings represent the conclusions of the Service on the application of the law to the pivotal facts stated in the revenue ruling. In those based on positions taken in rulings to taxpayers or technical advice to Service field offices, identifying details and information of a confidential nature are deleted to prevent unwarranted invasions of privacy and to comply with statutory requirements.

Rulings and procedures reported in the Bulletin do not have the force and effect of Treasury Department Regulations, but they may be used as precedents. Unpublished rulings will not be relied on, used, or cited as precedents by Service personnel in the disposition of other cases. In applying published rulings and procedures, the effect of subsequent legislation, regulations, court decisions, rulings, and procedures must be considered,

and Service personnel and others concerned are cautioned against reaching the same conclusions in other cases unless the facts and circumstances are substantially the same.

The Bulletin is divided into four parts as follows:

Part I.—1986 Code.

This part includes rulings and decisions based on provisions of the Internal Revenue Code of 1986.

Part II.—Treaties and Tax Legislation.

This part is divided into two subparts as follows: Subpart A, Tax Conventions and Other Related Items, and Subpart B, Legislation and Related Committee Reports.

Part III.—Administrative, Procedural, and Miscellaneous.

To the extent practicable, pertinent cross references to these subjects are contained in the other Parts and Subparts. Also included in this part are Bank Secrecy Act Administrative Rulings. Bank Secrecy Act Administrative Rulings are issued by the Department of the Treasury's Office of the Assistant Secretary (Enforcement).

Part IV.—Items of General Interest.

This part includes notices of proposed rulemakings, disbarment and suspension lists, and announcements.

The last Bulletin for each month includes a cumulative index for the matters published during the preceding months. These monthly indexes are cumulated on a semiannual basis, and are published in the last Bulletin of each semiannual period.

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Part III. Administrative, Procedural, and Miscellaneous

Biodiesel and Alternative Fuels; Claims for 2012; Excise Tax

Notice 2013-26

Section 1. PURPOSE

(a) On January 2, 2013, the American Taxpayer Relief Act of 2012, Pub. L. 112-240, (ATRA) retroactively extended the following fuel tax credits that expired on December 31, 2011: the biodiesel (including renewable diesel) mixture credit, biodiesel credit, alternative fuel credit, and the alternative fuel mixture credit. These credits are now scheduled to expire on December 31, 2013.

(b) The due date for filing certain claims for payments related to biodiesel mixtures and alternative fuel had already passed by the date that ATRA was enacted, and the due date for other claims will expire before or shortly after this Notice is released. This Notice allows additional time for claimants to file these claims for payments.

Section 2. BACKGROUND

(a) *Excise tax credits*—(1) *In general.* Sections 6426(a) and (c) of the Internal Revenue Code allow a person producing a biodiesel (including renewable diesel) mixture to claim a \$1.00-per-gallon credit against its tax liability under section 4081 (relating to the tax imposed on taxable fuel). Similar rules under section 6426(d) apply to a person that sells or uses alternative fuel as a fuel in a motor vehicle or a motorboat and in aviation, except that the credit amount is \$0.50 per gallon, and the credit for alternative fuel is taken against the claimant's tax liability under section 4041 (relating to the tax imposed on diesel fuel and alternative fuel).

(2) *Form and timing.* The taxes imposed by sections 4041 and 4081 are reported on Form 720, *Quarterly Federal Excise Tax Return*, and the section 6426 claims are made on Schedule C (Form 720), *Claims*. Claims allowed by section 6426 that were not made by a claimant on the claimant's Form 720 for a particular quarter may be claimed on Form 720X,

Amended Quarterly Federal Excise Tax Return. Generally, these claims must be made within three years from the time the return was filed or two years from the time the tax was paid, whichever is later.

(b) *Claims for payment*—(1) *In general.* A person allowed the biodiesel mixture credit or alternative fuel credit whose claims exceed its tax liability may claim this excess as a payment under section 6427(e).

(2) *Form and timing.* A claimant must first apply the biodiesel mixture credit and alternative fuel credit against its tax liability by making the claim on Form 720 or Form 720X. To the extent the claim exceeds its tax liability, the claimant may file a claim for payment of that excess amount on Form 8849, *Claim for Refund of Excise Taxes*, and attach Schedule 3 (Form 8849), *Certain Fuel Mixtures and the Alternative Fuel Credit*. Section 6427(i)(3)(C) requires claims for payment under section 6427(e) to be filed on or before the last day of the first quarter following the earliest quarter of the claimant's income tax year included in the claim. For example, a calendar-year claimant's claim for a biodiesel mixture sold or used during June and July must be filed by September 30 of the same calendar year.

(c) *Refundable income tax claims*—(1) *In general.* If a claimant does not timely file an allowable claim for a payment under section 6427(e), then section 34 allows the claimant to file the claim as a refundable income tax credit.

(2) *Form and timing.* Claims under section 34 must be filed on Form 4136, *Credit for Federal Tax Paid on Fuels*, as an attachment to the claimant's income tax return. Generally, these claims must be made within three years from the time the claimant's income tax return was filed or two years from the time the income tax was paid, whichever is later.

Section 3. TRANSITION RELIEF

(a) *In general.* When ATRA was enacted on January 2, 2013, the time had already passed for filing some claims for payment under section 6427(i)(3)(C). The time for filing certain other claims for payment will expire before or shortly after this

Notice is released. This Notice extends the time allowed to file these claims. These claims may be combined on a single form with claims for an excise tax credit under section 6426. This Notice does not affect the time for filing claims under section 34 (relating to refundable income tax credits) or section 6426 (relating to excise tax credits). Further, this Notice does not affect a claimant's ability to amend a previously-filed income tax return on which the claimant claimed a section 34 credit so that a section 6427(e) claim may be made pursuant to this Notice. For example, if before April 3, 2013, a claimant filed a claim for an income tax credit under section 34 for 2012, the claimant may amend its income tax return to remove that claim under section 34 and instead file a claim for payment under section 6427(e) pursuant to the procedures in section 3(b) of this Notice.

(b) *Allowable claims.* The IRS will consider a claim as timely filed if—

(1) The claim relates to sales or uses of biodiesel mixtures or alternative fuel in 2012 for which either a credit under section 6426 or a payment under section 6427 is allowed;

(2) The claim is filed on Form 8849 in accordance with the instructions for that form (as modified by this paragraph 3(b));

(3) The claimant has not made, and will not make, this claim on any other form or at any other time except for a claim that—

(i) Had previously been rejected by the IRS solely because the claim was untimely; or

(ii) Has been repaid by the claimant on an amended income tax return as described in paragraph (a) of this section; and

(4) The claim is filed by July 1, 2013.

Section 4. DRAFTING INFORMATION

The principal author of this Notice is Frank Boland of the Office of Associate Chief Counsel (Passthroughs and Special Industries). Mr. Boland may be reached at (202) 622-3130 (not a toll-free call). For questions about filing claims described in this Notice, please contact Ron Sass at (919) 850-1136 (not a toll-free call).

Maximum Vehicle Values for 2013 for Use of Vehicle Cents-Per-Mile and Fleet-Average Valuation Rules

Notice 2013-27

PURPOSE

This notice provides the maximum vehicle values for 2013 that taxpayers need to determine the value of personal use of employer-provided vehicles under the special valuation rules provided under section 1.61-21(d) and (e) of the Income Tax Regulations.

BACKGROUND

If an employer provides an employee with a vehicle that is available to the employee for personal use, the value of the personal use must generally be included in the employee's income and wages. Internal Revenue Code § 61; Regulation section 1.61-21. If the employer meets certain requirements, the employer may elect to determine the value of the personal use using certain special valuation rules, including the vehicle cents-per-mile rule and the fleet-average value rule set forth in Regulation section 1.61-21(d) and (e), respectively. Both the vehicle cents-per-mile rule

and the fleet-average value rule provide that those rules may not be used to value personal use of vehicles that have fair market values exceeding specified maximum vehicle values on the first day the vehicles are made available to employees. These maximum vehicle values are indexed for inflation and must be adjusted annually by referring to the Consumer Price Index. In previous years these maximum vehicle values and guidance on their calculation and application have been provided by Revenue Procedure. For example, the maximum vehicle values for vehicles first placed into service in 2012 were published in Revenue Procedure 2012-13 I.R.B. 2012-3 (January 17, 2012). Guidance on the calculation and application of these maximum vehicle values is set forth in section 1.61-21(d) and (e) of the Regulations and does not change from year-to-year. Accordingly, beginning this year, only the maximum vehicle values as adjusted for inflation will be published annually in a shorter notice.

MAXIMUM VEHICLE VALUES

The maximum value of employer-provided vehicles first made available to employees for personal use in calendar year 2013 for which the vehicle cents-per-mile valuation rule provided under Regulation

section 1.61-21(e) may be applicable is \$16,000 for a passenger automobile and \$17,000 for a truck or van.

The maximum value of employer-provided vehicles first made available to employees for personal use in calendar year 2013 for which the fleet-average valuation rule provided under Regulation section 1.61-21(d) may be applicable is \$21,200 for a passenger automobile and \$22,300 for a truck or van.

EFFECTIVE DATE

This notice applies to employer provided passenger automobiles first made available to employees for personal use in calendar year 2013.

DRAFTING INFORMATION

The principal author of this notice is Don M. Parkinson of the Office of the Division Counsel/Associate Chief Counsel (Tax Exempt & Government Entities). For further information on this notice contact Don Parkinson on (202) 622-6040 (not a toll-free call).

Rev. Proc. 2013-22

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SECTION 1. PURPOSE

This revenue procedure sets forth the procedures of the Internal Revenue Service for issuing opinion and advisory letters for § 403(b) pre-approved plans (that is, § 403(b) prototype plans and § 403(b) volume submitter plans). Under the program established by this revenue procedure, the Service will accept applications for opinion and advisory letters regarding the acceptability under § 403(b) of the Internal Revenue Code of the form of prototype plans and volume submitter plans, respectively, starting June 28, 2013.

SECTION 2. BACKGROUND

.01 Contributions for an annuity contract purchased for an employee by an eligible employer are generally excluded from the employee's gross income if the requirements described in § 403(b) are met. Amounts paid by an eligible employer to a custodial account which satisfies the requirements of § 401(f)(2) are treated as contributed to an annuity contract for an employee if the requirements of § 403(b)(7)(A)(i) and (ii) are met. A retirement income account, within the meaning of § 403(b)(9)(B), for employees of a Church-related organization, within the meaning of § 1.403(b)-2(b)(6) of the Treasury regulations, is treated as an annuity contract. For purposes of this

revenue procedure, and except as otherwise indicated, an eligible employer is a public school, an employer described in § 501(c)(3) that is exempt from tax under § 501(a), an employer of a minister described in § 414(e)(5)(A) with respect to the minister, or a minister described in § 414(e)(5)(A) with respect to a retirement income account established for the minister.

.02 The 2007 regulations (as defined in section 3.01) were generally effective as of January 1, 2009.

.03 Sections 1.403(b)-3(b)(3) and 1.403(b)-9(a)(2)(ii) of the 2007 regulations provide that an annuity contract, custodial account, or retirement income account generally does not satisfy the requirements of § 403(b) unless it is maintained pursuant to a plan. A plan means a written defined contribution plan that, in both form and operation, satisfies the requirements of the 2007 regulations. Subsequent references in this revenue procedure to the requirements of § 403(b) include the requirements of the 2007 regulations.

.04 The Service has not heretofore maintained a program for the issuance of opinion and advisory letters regarding the acceptability of the form of a plan under § 403(b). However, the Service has on occasion issued private letter rulings regarding the excludability of contributions for a contract or account under § 403(b).

.05 The Service has received comments from the public recommending ways to assist eligible employers in complying with the written plan requirement of the 2007 regulations. Among the recommendations have been the publication of model plan language for § 403(b) plans of public schools and the expansion of the scope of the Service's master and prototype opinion letter program for the pre-approval of plans qualified under § 401(a) to include § 403(b) plans.

.06 Rev. Proc. 2007-71, 2007-2 C.B. 1184, provides guidance regarding compliance with the 2007 regulations and includes model plan language that may be used by public schools either to adopt a written plan to reflect the requirements of § 403(b) or to amend a plan to reflect those requirements. Rev. Proc. 2007-71 also provides that other eligible employers may use the model language as sample language to comply with one or more of the requirements imposed by the 2007 regulations. Rev. Proc. 2007-71, including its provisions regarding the extent to which the model plan language may be relied upon, is not modified by this revenue procedure. Accordingly, absent further notice, public schools and other eligible employers may continue to utilize the language in Rev. Proc. 2007-71 as model or sample language.

.07 Notice 2009-3, 2009-1 I.R.B. 250, provides transition relief during 2009 for

sponsors of § 403(b) plans with respect to the requirement to have a written § 403(b) plan in place by January 1, 2009. Notice 2009-3 provides that the Service will not treat a § 403(b) plan as failing to satisfy the requirements of § 403(b) during the 2009 calendar year, provided that:

(1) on or before December 31, 2009, the sponsor of the plan has adopted a written § 403(b) plan that is intended to satisfy the requirements of § 403(b) (including the 2007 regulations) effective as of January 1, 2009;

(2) during 2009, the sponsor operates the plan in accordance with a reasonable interpretation of § 403(b), taking into account the 2007 regulations; and

(3) before the end of 2009, the sponsor makes its best efforts to retroactively correct any operational failure during the 2009 calendar year to conform to the terms of the written § 403(b) plan, with such correction to be based on the general principles of correction set forth in the Service's Employee Plans Compliance Resolution System (EPCRS) at section 6 of Rev. Proc. 2008-50, 2008-35 I.R.B. 464.

The relief in Notice 2009-3 applies solely with respect to the 2009 calendar year and may not be relied on with respect to the operation of a § 403(b) plan or correction of operational defects in any prior or subsequent year.

.08 Announcement 2009-34, 2009-18 I.R.B. 916, asked for public comments on a draft revenue procedure for pre-approving the form of § 403(b) prototype plans and on draft sample plan language that can be used in writing these plans.

.09 Announcement 2009-89, 2009-52 I.R.B. 1009, provides that if a plan sponsor adopts a written § 403(b) plan on or before December 31, 2009, that is intended to satisfy the requirements of § 403(b), the sponsor will have a remedial amendment period in which to correct defects in the form of the plan, retroactive to January 1, 2010, provided that the plan sponsor timely adopts a pre-approved § 403(b) plan with an opinion letter or timely applies for an individual determination letter.

.10 Rev. Rul. 2011-7, 2011-10 I.R.B. 534, provides guidance clarifying how the 2007 regulations apply when a § 403(b) plan is terminated.

.11 Announcement 2011-82, 2011-52 I.R.B. 1052, describes changes to the de-

termination letter program for plans qualified under § 401(a) that were first effective in 2012. Rev. Proc. 2013-6, 2013-1 I.R.B. 198, which sets forth the procedures for issuing determination letters for qualified plans, reflects the changes described in Announcement 2011-82. These changes resulted from the Service's reevaluation of how best to allocate its limited resources to help taxpayers understand and comply with the law. These changes eliminate features of the determination letter program that are of limited utility (*i.e.*, elective demonstrations of a plan's satisfaction of nondiscrimination requirements) and limit the types of pre-approved qualified plans that may obtain individual determination letters. As a result of these changes, determination letters for qualified plans will no longer take into account, or provide reliance with respect to, certain issues, and determination letters for qualified plans that are based on the plan's pre-approved status will only be issued with respect to volume submitter plans that include minor modifications to the pre-approved volume submitter specimen plan. These resource allocation considerations are also reflected in the approach taken in this revenue procedure.

SECTION 3. DEFINITIONS

.01 *2007 regulations* means the final regulations under § 403(b) (§§ 1.403(b)-1 through 1.403(b)-11) that were published on July 26, 2007 (72 FR 41128).

.02 *Annuity contract* means a contract that includes payment in the form of an annuity and that is issued by an insurance company qualified to issue annuities in a State.

.03 *Church* means a church within the meaning of § 3121(w)(3)(A).

.04 *Church-related organization* means a church or a convention or association of churches, including an organization described in § 414(e)(3)(A).

.05 *Custodial account* means a plan or separate account under a plan in which an amount attributable to § 403(b) contributions or amounts rolled over to a § 403(b) contract is held by a bank or a person who satisfies the conditions in § 401(f)(2), if:

(1) all amounts in the account are invested in stock of a regulated investment company, as defined in § 851(a);

(2) the requirements of § 1.403(b)-6(c) restricting distributions are satisfied with respect to amounts in the account;

(3) the assets in the account cannot be used for, or diverted to, purposes other than the exclusive benefit of plan participants and their beneficiaries; and

(4) the account is not part of a retirement income account.

.06 *Eligible employer* means an employer described in § 403(b)(1)(A).

.07 *Governmental plan* means a governmental plan within the meaning of § 414(d).

.08 *Investment arrangement* means the funding arrangement(s) under a § 403(b) plan and includes an *annuity contract*, *custodial account*, and, in the case of a § 403(b) plan for the employees of a Church-related organization, a *retirement income account*.

.09 The term *mass submitter* has the meaning given in section 11.03.

.10 The term *minor modifier* has the meaning given in section 11.03.

.11 *Non-qualified church-controlled organization* or *Non-QCCO* means a church-controlled tax-exempt organization described in § 501(c)(3) that is not a qualified church-controlled organization within the meaning of § 3121(w)(3)(B).

.12 The term *nonstandardized plan* has the meaning given in section 6.03.

.13 *Prototype sponsor* means a person meeting the eligibility requirements of section 11.01 or section 11.03 that submits an application for an opinion letter for a § 403(b) prototype plan under this revenue procedure.

.14 *Qualified church-controlled organization* or *QCCO* means a church-controlled tax-exempt organization described in § 501(c)(3) that is a qualified church-controlled organization within the meaning of § 3121(w)(3)(B).

.15 *Retirement income account* means a defined contribution program established or maintained by a Church-related organization to provide benefits under § 403(b) for its employees or their beneficiaries as described in § 1.403(b)-9.

.16 *Section 403(b) pre-approved plan* means a plan that is either a § 403(b) prototype plan or a § 403(b) volume submitter plan.

.17 The term *§ 403(b) prototype plan* has the meaning given in section 5.

.18 The terms *§ 403(b) volume submitter plan* and *§ 403(b) volume submitter specimen plan* have the meaning given in section 7.

.19 The term *standardized plan* has the meaning given in section 6.

.20 *Volume submitter practitioner* means a person meeting the eligibility requirements of section 11.02 or section 11.03 that submits an application for an advisory letter for a § 403(b) volume submitter specimen plan under this revenue procedure.

SECTION 4. OVERVIEW AND PRINCIPAL CHANGES FROM THE DRAFT REVENUE PROCEDURE

.01 Overview.

(1) This revenue procedure establishes a program for the pre-approval of § 403(b) plans. This program offers employers that maintain a § 403(b) plan an alternative to adopting an individually designed plan in order to satisfy the written plan requirement of the 2007 regulations. Under this program, the Service will issue an opinion or advisory letter as to whether the form of a § 403(b) prototype plan or a § 403(b) volume submitter plan, respectively, meets the requirements of § 403(b). An employer may satisfy the written plan requirement and obtain assurance that its plan meets the requirements of § 403(b) by adopting a plan that has received an opinion or advisory letter under this program.

(2) The program described in this revenue procedure is similar in many respects to the Service's pre-approved plan program for plans qualified under § 401(a), which is described in Rev. Proc. 2011-49, 2011-44 I.R.B. 608. For example, two categories of pre-approved plans — prototype plans and volume submitter plans, which are described in section 5 and section 7 of this revenue procedure, respectively — are available under both programs.

(3) Although the program described in this revenue procedure is similar in many respects to the program described in Rev. Proc. 2011-49, there are differences between the two programs, beyond those that result from the differences in the Code requirements under § 401(a) and § 403(b). Under the pre-approved plan program for qualified plans, adopting employers may be able to obtain individual determination letters under certain circumstances. The

Service is not establishing a determination letter program for § 403(b) plans at this time and an employer who adopts a pre-approved § 403(b) plan will not be able to apply for an individual determination letter for the plan. The extent of the adopting employer's reliance on the opinion or advisory letter may be limited, based on the type of pre-approved § 403(b) plan the employer has adopted, as explained in sections 4.01(6) and 4.01(8). A § 401(a) volume submitter plan may provide that the volume submitter practitioner can amend the plan on behalf of adopting employers, but the plan is not required to include such a provision. Under this revenue procedure, a § 403(b) volume submitter plan must provide that the volume submitter practitioner can amend the plan on behalf of adopting employers so that changes in the Code, regulations, revenue rulings, or other guidance published by the Service, or corrections of prior approved plans, may be applied to all eligible employers that have adopted the plan.

(4) As more fully described in section 5, a § 403(b) prototype plan is a two-part plan document intended to satisfy the requirements of § 403(b) that a vendor or other entity (referred to as "the prototype sponsor") provides to eligible employers that wish to adopt a written § 403(b) plan. The prototype sponsor submits the document to the Service for approval that the form of the document meets the requirements of § 403(b). Approval is provided in the form of an opinion letter issued to the sponsor by the Service.

(5) The first part of a § 403(b) prototype plan document, called the basic plan document, contains provisions that apply to the plan of any eligible employer that uses the document to adopt a written § 403(b) plan. An eligible employer may not modify the provisions of a basic plan document. The second part of the document, called the adoption agreement, is the part of the plan document which is completed and signed by an eligible employer in order to establish a written plan. The adoption agreement gives the eligible employer elections and options from which to choose in order to customize particular features of its plan. Thus, different eligible employers can use the same § 403(b) prototype plan document to adopt a written § 403(b) plan, with the plans differentiated by the choices each eligible employer makes in its plan's

adoption agreement and the different investment arrangements offered under each plan. This revenue procedure does not impose any special restrictions on the types, number, or features of investment arrangements that may be offered under an eligible employer's § 403(b) prototype plan. However, the terms of the § 403(b) prototype plan must override any inconsistent provisions of investment arrangements under the plan.

(6) There are two forms of § 403(b) prototype plan under this revenue procedure: a "standardized plan" and a "nonstandardized plan." A § 403(b) prototype plan is a standardized plan if the only contributions the employer may choose to provide under the plan are elective deferrals or if the terms of the plan satisfy uniform coverage and nondiscrimination requirements with respect to any other contributions under the plan. For example, a standardized plan must satisfy one of the design-based safe harbors described in § 1.401(a)(4)-2(b)(2) with respect to any employer nonelective contributions (other than matching contributions) under the plan. A nonstandardized plan is a § 403(b) prototype plan that is not a standardized plan. An eligible employer that adopts a standardized plan generally can rely directly on the opinion letter for the plan. An eligible employer that adopts a nonstandardized plan generally can rely directly on the opinion letter for the plan if the plan is a governmental plan or the employer is a Church or QCCO. In all other cases, an eligible employer that adopts a nonstandardized plan generally can rely directly on the opinion letter for the plan except with respect to whether the plan satisfies the nondiscrimination requirements of §§ 401(a)(4) and 410(b) relating to contributions under the plan other than elective deferrals. An opinion letter may not be relied upon with respect to Title I of ERISA, although the Service may decline to issue an opinion letter on a plan that fails to satisfy a Code provision that is parallel to a provision of Part 2 of Subtitle B of Title I of ERISA. Standardized and nonstandardized plans are discussed in section 6, and reliance on an opinion letter for a § 403(b) prototype plan is discussed in section 14. Also see section 13 regarding the scope of an opinion or advisory letter.

(7) The second type of § 403(b) pre-approved plan is a § 403(b) volume submit-

ter plan, which is described in section 7. Under this component of the pre-approved plan program, a § 403(b) volume submitter practitioner may apply for an advisory letter that a § 403(b) volume submitter specimen plan (that is, a sample plan of the practitioner rather than an employer's plan) satisfies the requirements of § 403(b). A § 403(b) volume submitter plan is not required to have an adoption agreement, but may have one.

(8) An adopting employer of a § 403(b) volume submitter plan can rely directly on the advisory letter for the approved specimen plan, except to the extent that the employer's plan is not identical to the approved specimen plan, disregarding any differences attributable solely to the employer's choices of options provided under the specimen plan, and except with respect to the requirements of §§ 401(a)(4) and 410(b) (unless those requirements do not apply to the plan, for example, because the only contributions under the plan are elective deferrals). See section 15 regarding employer reliance on an advisory letter.

(9) Under the § 403(b) pre-approved plan program, the Service will review the basic plan document and adoption agreement, or the specimen plan, as applicable, but will not review any investment arrangements or any other documents that may form a part of an employer's plan. The terms of the pre-approved plan must therefore satisfy the requirements of § 403(b), independent of the terms of the investment arrangements under the plan. In addition, every § 403(b) pre-approved plan must provide that in the event of a conflict between the terms of the pre-approved plan and the terms of any investment arrangements under the plan, the terms of the plan will govern. Section 8 describes this and other provisions that must be included in every § 403(b) pre-approved plan. Sections 9 and 10 describe additional provisions that must be included in every § 403(b) prototype plan and in every § 403(b) plan intended to be a retirement income account under § 403(b)(9), respectively. Also see section 13 regarding the scope of an opinion or advisory letter.

(10) Some of the provisions described in section 8 that must be included in every § 403(b) pre-approved plan reflect procedural requirements of the § 403(b) pre-approved plan program. One of those re-

quirements is that each § 403(b) pre-approved plan allow the prototype sponsor or volume submitter practitioner, as applicable, to amend the § 403(b) pre-approved plan on behalf of each eligible employer that has adopted the plan. Under this revenue procedure, each pre-approved plan sponsor must carry out certain duties, among them to keep the document up to date for changes in law and to notify adopting employers of amendments to the document. See section 11 for eligibility to sponsor a § 403(b) pre-approved plan, section 17 for opinion and advisory letter application procedures, and sections 12 and 16 through 20 regarding the duties of sponsorship.

(11) As indicated in Notice 2009-3 and Announcement 2009-89, this revenue procedure, in section 21, includes a remedial amendment provision that allows eligible employers to retroactively correct defects in the form of their § 403(b) plans for certain years through the timely adoption of remedial amendments. This provision applies to eligible employers that timely adopt a § 403(b) pre-approved plan or that otherwise timely amend a § 403(b) plan. No inferences should be drawn from this provision regarding the application of § 401(b) to retroactive changes in plans qualified under § 401(a).

.02 Principal changes from the draft revenue procedure.

(1) This revenue procedure incorporates a number of changes to the program described in the draft revenue procedure. Some of the changes reflect the changes to the qualified plan determination letter program described in Announcement 2011-82 and the Service's need to more efficiently direct its limited resources. Others are based on the Service's consideration of the comments submitted in response to Announcement 2009-34. The following are the principal changes to the draft revenue procedure that are incorporated in this revenue procedure:

(2) Announcement 2009-34 stated the Service's intent to establish a program for the issuance of determination letters for individually designed § 403(b) plans following establishment of the prototype program described in the draft revenue procedure. The draft revenue procedure provided that adopters of prototype § 403(b) plans would also be able to obtain individual determination letters in certain cases.

A program for the pre-approval of prototype and volume submitter plans is a practical way to help large numbers of adopters of § 403(b) plans understand and comply with the tax rules regarding their plans. A pre-approval program will utilize the Service's resources efficiently. A determination letter program for individually designed § 403(b) plans, on the other hand, is costly and less efficient. Given the Service's limited resources, it is not feasible for the Service to establish such a program at this time. Furthermore, issuing individual determination letters to adopters of pre-approved § 403(b) plans would greatly increase the Service's cost of administering the pre-approved plan program with minimal additional benefit to plan sponsors and plan participants. Therefore, this revenue procedure does not contemplate the issuance of individual determination letters to sponsors of § 403(b) plans. Thus, a sponsor of a § 403(b) plan will be able to obtain reliance as to the acceptability of the form of its plan only if the plan is a pre-approved plan as described in this revenue procedure or if the employer is a public school that has adopted the model plan language included in Rev. Proc. 2007-71 and is entitled to reliance under that revenue procedure. In addition, the extent of a plan sponsor's reliance on an opinion or advisory letter will depend in some cases on the type of pre-approved § 403(b) plan that the sponsor adopts. See sections 4.01(6) and 4.01(8).

(3) Announcement 2009-89 and the draft revenue procedure contained a remedial amendment provision that would allow sponsors of § 403(b) plans to amend their plans retroactively to satisfy § 403(b) and the 2007 regulations by either adopting a pre-approved plan or amending an individually-designed plan and applying for a determination letter. Although a determination letter program for § 403(b) plans is no longer contemplated, sponsors of both pre-approved § 403(b) plans and individually designed § 403(b) plans will be permitted to amend their plans retroactively to satisfy § 403(b) and the 2007 regulations. An individually-designed § 403(b) plan that is eligible for remedial amendment under this revenue procedure must be amended to the extent necessary to correct, retroactively, any defects in the form of the plan by the time described in section 21.05. Employers using individ-

ually designed plans will not be entitled to reliance that their plan terms comply with the requirements of § 403(b) unless they timely restate their plans in the form of a pre-approved plan. As a result, after the deadline described in section 21.05, the sponsor of an individually designed § 403(b) plan will not have reliance that the terms of the plan document meet the applicable requirements for favorable tax treatment.

(4) The scope of the § 403(b) pre-approved plan program has been expanded under this revenue procedure to provide for the issuance of advisory letters for § 403(b) volume submitter specimen plans, including mass submitter specimen plans, in addition to opinion letters for § 403(b) prototype plans. This change will provide eligible employers that choose not to use an adoption agreement format in their plans access to pre-approved § 403(b) plan documents.

(5) The provisions of the draft revenue procedure regarding mass submitter plans have been modified in this revenue procedure to provide for the issuance of opinion letters for § 403(b) prototype plans that are minor modifiers of a § 403(b) prototype plan of a mass submitter, regardless of the number of eligible employers expected to adopt the minor modifier plan.

(6) The scope of the program has been expanded under this revenue procedure to provide for the issuance of opinion and advisory letters for retirement income accounts.

(7) The definition of who is eligible to sponsor a § 403(b) pre-approved plan has been modified to include a Church-related organization that sponsors a retirement income account, regardless of the number of eligible employers expected to adopt the plan.

(8) This revenue procedure eliminates the provision of the draft revenue procedure that would have prohibited the issuance of opinion letters for plans that include provisions applicable only to Churches and QCCOs, Church-related organizations, or ministers described in § 414(e)(5)(A).

(9) This revenue procedure also eliminates the provision of the draft revenue procedure that would have prohibited the issuance of opinion letters for plans that include terms that are acceptable under § 403(b) only in a plan of a Church or

QCCO. Thus, for example, the Service will not decline to issue an opinion or advisory letter for a plan merely because the plan does not require universal availability of § 403(b) elective deferrals if the plan is available for adoption only by a Church or QCCO.

(10) This revenue procedure clarifies an adopting employer's ability to rely on an opinion or advisory letter for a § 403(b) pre-approved plan. The provisions of the revenue procedure regarding reliance take into account the following factors:

(a) Generally, a § 403(b) plan must satisfy both (i) the universal availability requirement of § 1.403(b)-5(b) with respect to elective deferral contributions and (ii) the rules of § 1.403(b)-5(a) that require any nonelective contributions under the plan to satisfy the nondiscrimination requirements of §§ 401(a)(4), 401(a)(17), 401(m), and 410(b) in the same manner as a qualified plan under § 401(a). However, pursuant to § 1.403(b)-5(d), the universal availability and nondiscrimination requirements of § 1.403(b)-5 do not apply to a § 403(b) contract purchased by a Church or QCCO. In addition, pursuant to § 1.403(b)-5(a)(5), a governmental § 403(b) plan must satisfy the universal availability requirement with respect to elective deferrals under § 1.403(b)-5(b), but such a plan is not required to satisfy the nondiscrimination rules for nonelective contributions under § 1.403(b)-5(a), other than the requirement to limit compensation taken into account under the plan in accordance with § 401(a)(17).

(b) Section 8 of this revenue procedure generally requires every § 403(b) pre-approved plan to satisfy the requirements of the 2007 regulations. Under section 8.06(2) and (3) of this revenue procedure, every § 403(b) pre-approved plan must satisfy the universal availability requirement with respect to elective deferrals under § 1.403(b)-5(b) and must limit compensation taken into account under the plan with respect to nonelective contributions in accordance with § 401(a)(17), unless the adopting eligible employer is a Church or QCCO. Under section 8.06(4), a § 403(b) pre-approved plan that permits contributions subject to § 401(m) must include terms that satisfy § 401(m), unless the plan is available for adoption only as a governmental plan or by a Church or QCCO.

(c) A § 403(b) prototype plan that is a standardized plan as defined in section 6.01 of this revenue procedure limits the adoption agreement elections available to the adopting employer with respect to nonelective contributions to safe harbors that automatically satisfy the nondiscrimination requirements of §§ 401(a)(4) and 410(b). A § 403(b) nonstandardized prototype plan or a § 403(b) volume submitter plan may allow the employer to make elections with respect to nonelective contributions that require testing of the coverage and benefits under the plan to determine if the plan satisfies the nondiscrimination requirements of §§ 401(a)(4) and 410(b).

(d) An employer that adopts a § 403(b) volume submitter plan may modify the terms of the approved specimen volume submitter plan, in addition to selecting among options under the plan, without causing the employer's plan to be treated as an individually designed plan, provided the employer's plan is "substantially similar," within the meaning of section 7.01 of this revenue procedure, to the approved specimen plan.

(11) Taking into account the factors in the preceding paragraph, this revenue procedure provides in general that:

(a) Any eligible employer that adopts a standardized § 403(b) prototype plan may rely on an opinion letter for the plan.

(b) An eligible employer that adopts a nonstandardized § 403(b) prototype plan may rely on an opinion letter for the plan if the plan is a governmental plan or if the employer is a Church or QCCO.

(c) Any other eligible employer, including an employer that is a Non-QCCO, that adopts a nonstandardized § 403(b) prototype plan may rely on the opinion letter for the plan, except with respect to whether nonelective contributions under the plan satisfy the requirements of §§ 401(a)(4) and 410(b).

(d) An eligible employer that adopts a § 403(b) volume submitter plan may rely upon an advisory letter for the plan, except (i) to the extent that the employer modifies the terms of the approved specimen plan (other than by selecting options that are permitted under the terms of the approved specimen plan); and (ii) if the plan is not a governmental plan or a plan of a Church or QCCO, with respect to whether any nonelective contributions under the plan sat-

isfy the requirements of §§ 401(a)(4) and 410(b).

Other limitations on employer reliance on opinion and advisory letters are described in sections 14 and 15 of this revenue procedure.

(12) This revenue procedure eliminates the provision of the draft revenue procedure that would have required every § 403(b) prototype plan to provide for full and immediate vesting of all contributions under the plan. Under this revenue procedure, a § 403(b) pre-approved plan may provide a vesting schedule for nonelective employer contributions, rather than full and immediate vesting of such contributions. Except in the case of certain volume submitter plans, as described below, nonelective employer contributions (and earnings thereon) under a § 403(b) pre-approved plan must vest at least as rapidly as would be required to satisfy the minimum vesting requirements of § 411(a)(2)(B), if the plan were a qualified plan under § 401(a), even if the plan is not subject to the parallel minimum vesting requirements under section 203 of ERISA. A volume submitter plan document that is designed to be used for a plan that is not subject to the minimum vesting requirements of section 203 of ERISA (for example, because the plan is a governmental plan) is not required to provide that nonelective employer contributions will vest at least as rapidly as would be required to satisfy § 411(a)(2)(B). Every § 403(b) pre-approved plan that provides that an employee's right to nonelective employer contributions is forfeitable must also satisfy the following requirements: (i) the portion of a participant's interest in the plan that is not vested is maintained in a separate account for the participant that is treated as a separate contract to which § 403(c) (or, in case of a custodial account, § 401(a)) applies; (ii) as amounts in the participant's separate account become nonforfeitable, they are removed from the separate account and treated as amounts held under a § 403(b) plan, to the extent permitted under § 1.403(b)-3(d)(2)(ii); and (iii) all nonvested amounts remaining in the participant's separate account become nonforfeitable upon termination of the plan.

(13) The preamble to the 2007 regulations notes that a written plan facilitates the allocation of responsibilities among vari-

ous parties to a plan, helping ensure that these responsibilities are met. This revenue procedure therefore requires every § 403(b) pre-approved plan to provide that an appendix to the plan identify the parties responsible for the various administrative functions under the plan necessary to comply with the requirements of § 403(b) and other tax requirements, including such requirements that apply on the basis of the aggregated investment arrangements issued to a participant under the plan, and list all the vendors of investment arrangements approved for use under the plan, including sufficient information to identify the approved investment arrangements. This requirement replaces the requirement in the draft revenue procedure that this information be set forth in the adoption agreement of a § 403(b) prototype plan. Changes to the information in the required appendix will not affect the employer's ability to rely on an opinion or advisory letter.

(14) This revenue procedure requires every pre-approved plan sponsor to timely notify adopting eligible employers of amendments and restatements of the plan and, in general, to inform employers of the need to timely adopt the plan in the case of both initial adoption and restatement of the plan. This requirement replaces the provision in the draft revenue procedure that would have required sponsors to have both a procedure to verify that adopting employers have timely adopted and signed the plan when required and a procedure for employers to acknowledge receipt of plan amendments if the employer is not required to complete a new adoption agreement.

(15) This revenue procedure clarifies that, under the remedial amendment provisions of the procedure, retroactive amendments that are permitted to correct defects in the form of the plan include amendments to investment arrangements and any other documents that are incorporated by reference into the plan.

(16) A number of commentators urged the Service to modify the provision in the draft revenue procedure that would have required every § 403(b) prototype plan to provide that in the event of any conflict between the terms of the basic plan document and adoption agreement and the terms of any investment arrangement under the plan, or of any other document

that is incorporated by reference into the plan, the terms of the basic plan document and adoption agreement would control. After considering these comments, the Service has concluded that a provision of the type described in the draft revenue procedure is fundamental to proper operation of a § 403(b) pre-approved plan program, particularly since the investment arrangements and other documents that may be incorporated by reference will not be reviewed by the Service, and since the change recommended by commentators would result in an unacceptable degree of uncertainty as to which terms control in the event of conflict. Accordingly, this revenue procedure requires every § 403(b) pre-approved plan to incorporate by reference the terms of the investment arrangements under the plan and to provide that, in the event of any conflict between the terms of the basic plan document and adoption agreement or volume submitter plan and the terms of investment arrangements (or of any other documents incorporated by reference into the plan), the terms of the basic plan document and adoption agreement or volume submitter plan shall govern. Furthermore, an eligible employer may not rely on an opinion or advisory letter for the employer's § 403(b) pre-approved plan if the terms of any investment arrangement under the employer's plan provide that such arrangement's terms govern in the event of a conflict with the basic plan document and adoption agreement or volume submitter plan. The Service recognizes that this requirement will require vendors to be aware of and follow pre-approved plan provisions that may affect them. The Service made certain other changes, as described in section 4.02(17), that, in conjunction with the requirement to incorporate by reference the terms of investment arrangements, are intended to address concerns expressed by commentators regarding the requirement that the terms of a pre-approved plan's basic plan document and adoption agreement or volume submitter plan govern if there is a conflict with the terms of an investment arrangement under the plan. (Also see section 8.03.)

(17) In some cases, the objections described in section 4.02(16) (to the requirement that the terms of the basic plan document and adoption agreement or volume submitter plan govern in case of conflict)

may have been based in part on a perception that the adoption of a prototype plan effectively prohibits the inclusion of additional features in the investment arrangements under the plan, or the availability of different features in different investment arrangements under the plan, and that the Service would not approve plans that allow adopting employers to provide that the availability of certain features may depend on the participant's choice of investment arrangement. In revising the sample plan language, the Service has clarified that, subject to the provisions of sections 8.04 and 8.05, such options are available to drafters of pre-approved plans.

(18) A provision in the draft revenue procedure would have allowed a prototype sponsor to correct certain typographical errors and incorrect cross-references in an approved § 403(b) prototype plan without adversely affecting adopting employers' reliance on the opinion letter if the correction would not change the original intended meaning. As explained in section 3.04(1)(d) of Rev. Proc. 2011-49, the ability to correct errors in this manner is no longer available for pre-approved qualified plans and will not be available for pre-approved 403(b) plans.

SECTION 5. WHAT IS A § 403(b) PROTOTYPE PLAN?

.01 A § 403(b) prototype plan is a defined contribution plan that is intended to satisfy the requirements of § 403(b) and is made available by a prototype sponsor for adoption by eligible employers. (A § 403(b) prototype plan is one of two types of § 403(b) pre-approved plans, the other being a § 403(b) volume submitter plan which is described in section 7 of this revenue procedure.) See section 11 of this revenue procedure regarding the entities that are permitted to sponsor a § 403(b) prototype plan. Each pre-approved form of a § 403(b) prototype plan, as made available for adoption by eligible employers, consists of one (and only one) basic plan document and one (and only one) adoption agreement. The basic plan document contains all the nonelective provisions of the prototype plan that apply to the plans of all adopting eligible employers. The basic plan document may not include any options or blanks to be completed. The adoption agreement facilitates the selec-

tion of plan design alternatives available under the basic plan document. By completing the adoption agreement, an eligible employer may establish a plan (that is, the combination of the basic plan document and the completed adoption agreement) that in form satisfies the requirements of § 403(b).

.02 In pre-approved form, an adoption agreement can be used with only one basic plan document. A basic plan document can be used with more than one adoption agreement, but each basic plan document/adoption agreement pair constitutes one separate § 403(b) prototype plan. Thus, for example, if a prototype sponsor sponsors one basic plan document and offers adopting employers the choice of three adoption agreements to be used with the basic plan document to establish a plan, the prototype sponsor has three separate § 403(b) prototype plans and would need to submit three applications for opinion letters under this procedure. A § 403(b) prototype plan that is adopted by an eligible employer is a single plan regardless of whether there are multiple investment arrangements or multiple vendors (that is, insurance companies or regulated investment company custodians) under the plan. Adoption of two § 403(b) prototype plans (that is, execution of two separate adoption agreements) constitutes the adoption of two separate § 403(b) plans, regardless of whether the two plans use the same basic plan document.

.03 A prototype sponsor may maintain more than one basic plan document. For example, a prototype sponsor may maintain one or more basic plan documents to be used only with plans that limit contributions to elective deferrals as well as one or more basic plan documents to be used with plans that provide for elective deferrals and employer nonelective contributions, whether or not such plans also provide for matching contributions and/or after-tax employee contributions.

.04 A single basic plan document may not be used for both a § 403(b) plan that is a retirement income account and a § 403(b) plan that is not a retirement income account. Thus, a separate basic plan document is required for a plan that is intended to constitute a retirement income account under § 403(b)(9).

.05 As described above, a basic plan document may have more than one adop-

tion agreement. Each plan (that is, each basic plan document/adoption agreement pair) must be either a standardized plan or a nonstandardized plan. (See section 6 for an explanation of the difference between a standardized plan and a nonstandardized plan.) This is because a standardized plan may not include certain options that are available to adopting employers of nonstandardized plans. Therefore, each adoption agreement must specify whether it is a standardized plan adoption agreement or a nonstandardized plan adoption agreement.

SECTION 6. STANDARDIZED PROTOTYPE PLANS AND NONSTANDARDIZED PROTOTYPE PLANS

.01 Each § 403(b) prototype plan is either a standardized plan or a nonstandardized plan. A § 403(b) prototype plan is a standardized plan if:

(1) the only contributions which an adopting eligible employer may elect to provide under the plan are elective deferrals; or

(2) the form of the plan satisfies the requirements of section 6.02 with respect to any contributions under the plan other than elective deferrals, irrespective of the elections the adopting eligible employer makes in the adoption agreement, and without regard to the terms of any investment arrangements under the plan or any documents incorporated by reference into the plan.

.02 The form of a § 403(b) prototype plan satisfies the requirements of this section 6.02 with respect to any contributions under the plan other than elective deferrals if all of the following conditions are satisfied with respect to such contributions:

(1) The plan by its terms benefits all employees except those who may be excluded under § 1.410(b)-6. For this purpose, "employee" means an employee, within the meaning of § 1.403(b)-2(b)(9), of the adopting eligible employer and any eligible employer within the meaning of § 1.403(b)-2(b)(8) in the adopting eligible employer's controlled group. The controlled group consists of the adopting eligible employer and each other employer that is aggregated with the adopting eligible employer under § 414(b), (c), (m) or (o), including § 1.414(c)-5. Thus, if there is more than one eligible employer

in the controlled group, the plan must benefit all the employees of all the eligible employers in the controlled group except those employees that may be excluded under § 1.410(b)–6. A plan does not fail to satisfy this requirement with respect to contributions other than elective deferrals merely because the plan provides that individuals who become employees as the result of a transaction described in § 410(b)(6)(C), relating to certain employer acquisitions and dispositions, are excluded from eligibility to participate in the plan during the period beginning on the date of the transaction and ending on a date that is not later than the earlier of the last day of the first plan year beginning after the date of the transaction or the date of a significant change in the plan or in the coverage of the plan.

(2) All benefits, rights, and features under the plan (other than those, if any, that have been prospectively eliminated) are currently available to all employees benefiting under the plan. (For information regarding benefits, rights, and features, and the determination of current availability, see § 1.401(a)(4)–4.)

(3) If the plan provides for employer nonelective contributions (other than matching contributions), the plan must satisfy one of the design-based safe harbors described in § 1.401(a)(4)–2(b)(2) with respect to such contributions.

(4) For purposes of determining the amount of contributions other than elective deferrals, the plan must define compensation as total compensation. For this purpose, total compensation means a definition of compensation that includes all compensation within the meaning of § 415(c)(3) (disregarding § 415(c)(3)(E)) and excludes all other compensation, or a definition that satisfies the rules under § 1.414(s)–1(c).

.03 A nonstandardized § 403(b) prototype plan is a § 403(b) prototype plan that is not a standardized plan. For example, a § 403(b) prototype plan is a nonstandardized plan if the adoption agreement allows the adopting employer to select an allocation formula for nonelective contributions that does not satisfy one of the design-based safe harbors described in § 1.401(a)(4)–2(b)(2).

SECTION 7. WHAT IS A § 403(b) VOLUME SUBMITTER PLAN?

.01 The term “§ 403(b) volume submitter plan” refers to either a “specimen § 403(b) plan” of a volume submitter practitioner or a plan of a client of the volume submitter practitioner that is substantially similar to the volume submitter’s approved specimen plan. For this purpose, an employer’s plan is not substantially similar to an approved specimen § 403(b) plan, and will be considered to be an individually designed plan rather than a pre-approved plan, if the Service determines (for example, during an examination of the plan) that differences between the terms of the employer’s plan and the terms of the approved specimen plan are so extensive or complex as to be incompatible with the pre-approved plan program. (A § 403(b) volume submitter plan is one of two types of § 403(b) pre-approved plans, the other being a § 403(b) prototype plan which is described in section 5 of this revenue procedure.) See section 11 of this revenue procedure regarding the entities that are permitted to sponsor a § 403(b) volume submitter specimen plan. A “specimen § 403(b) plan” is a model plan document (rather than the actual plan of an eligible employer) of a volume submitter that is intended to satisfy the requirements of § 403(b). A specimen § 403(b) plan is not required to, but may, include an adoption agreement. If more than one adoption agreement may be used with a specimen § 403(b) plan, each specimen plan/adoption agreement pair is a separate volume submitter plan. If an adoption agreement is used for a volume submitter plan, it must satisfy the requirements for prototype adoption agreements in section 9.03.

.02 A § 403(b) volume submitter plan that is adopted by an eligible employer is a single plan regardless of whether there are multiple investment arrangements or multiple vendors (that is, insurance companies or regulated investment company custodians) under the plan. Adoption of two § 403(b) volume submitter plans constitutes the adoption of two separate § 403(b) plans, regardless of whether both plans are substantially similar to a single specimen § 403(b) plan.

.03 A volume submitter may maintain more than one specimen plan. For example, a volume submitter may maintain

one or more specimen plans that limit contributions to elective deferrals as well as one or more specimen plans that provide for elective deferrals and employer nonelective contributions, whether or not the plans also provide for matching contributions and/or after-tax employee contributions.

.04 A single specimen plan may not be used for both a § 403(b) plan that is a retirement income account and a § 403(b) plan that is not a retirement income account. Thus, a separate specimen plan is required for a plan that is intended to constitute a retirement income account under § 403(b)(9).

SECTION 8. PROVISIONS REQUIRED IN EVERY § 403(b) PRE-APPROVED PLAN

.01 Sections 8.04 through 8.10 describe provisions that must be included in every § 403(b) pre-approved plan.

.02 The Service’s review of a § 403(b) pre-approved plan will consider only the terms of the basic plan document and adoption agreement or the volume submitter plan, as applicable. Accordingly, the provisions described in sections 8.04 through 8.10 must be included in the basic plan document or adoption agreement of every § 403(b) prototype plan and in every § 403(b) volume submitter plan, regardless of the terms of any investment arrangements under the plan or any other documents that may be incorporated by reference. This does not preclude the adoption of a § 403(b) pre-approved plan (including a standardized prototype plan, as described in section 6) if different investment arrangements under a plan have different features or prevent the inclusion of additional provisions in the terms of the investment arrangements under the plan or other documents incorporated by reference. Nor does it prevent a § 403(b) pre-approved plan from using investment arrangements that are more restrictive than required by § 403(b) or the basic plan document and adoption agreement or the volume submitter plan. However, the terms of the basic plan document and adoption agreement or the volume submitter plan, as applicable, must satisfy the requirements of applicable law and sections 8.04 through 8.10 independent of any investment arrangements under the plan

or any other documents incorporated by reference.

.03 For example, an eligible employer's § 403(b) prototype plan may offer both investment arrangements that permit loans and investment arrangements that do not. In this case, (1) the basic plan document must include provisions reflecting the requirements of the 2007 regulations, including § 1.403(b)-6, and § 1.72(p)-1, and (2) the basic plan document and adoption agreement, as completed by the employer, must provide that, to the extent permitted by the terms governing the applicable investment arrangement, participant loans are available. Similarly, an eligible employer's § 403(b) volume submitter plan must satisfy the requirements described in the preceding sentence if the plan offers both investment arrangements that permit loans and investment arrangements that do not. For sample plan language that satisfies these requirements, see the Listing of Required Modifications (for § 403(b) plans) which may be downloaded from the Internet at the following address: http://www.irs.gov/pub/irs-tege/403b_lrm0313.pdf. The following are additional examples that illustrate the application of section 8.03:

(1) A § 403(b) pre-approved plan may provide that the forms of annuity benefit available under the plan are those described in the investment arrangements under the plan. However, the terms of the basic plan document and adoption agreement or the volume submitter plan, as applicable, must ensure that the required minimum distribution requirements of § 401(a)(9) will be satisfied regardless of the form of benefit paid, and the distributable events under the plan must be described in the basic plan document and adoption agreement or the volume submitter plan, as applicable.

(2) A § 403(b) pre-approved plan may provide that hardship distributions of elective deferrals are available to the extent permitted under each investment arrangement under the plan. In this case, the basic plan document and adoption agreement or the volume submitter plan must either provide that hardship distributions are available only for the financial needs described in § 1.401(k)-1(d)(3)(iii)(B) or must set forth nondiscriminatory and objective standards for determining the existence of an immediate and heavy fi-

ancial need. In addition, the basic plan document and adoption agreement or the volume submitter plan must provide that the participant's elective deferrals will be suspended for 6 months following the hardship distribution and set forth the other requirements that must be satisfied for a distribution to be treated as necessary to satisfy the financial need. The terms of any agreement governing the relationship between the vendor of an investment arrangement under the plan and the employer must provide that the vendor will timely notify the employer of a participant's hardship distribution and the requirement to suspend the participant's elective deferrals.

.04 A § 403(b) pre-approved plan includes the investment arrangements under the plan in addition to the basic plan document and adoption agreement or the volume submitter plan. Every § 403(b) pre-approved plan must therefore incorporate by reference the terms of the investment arrangements under the plan. While the Service's review of an application for an opinion or advisory letter is limited to the terms of the basic plan document and adoption agreement or the volume submitter plan, as applicable, the terms of investment arrangements and other documents that are incorporated by reference must satisfy applicable law and may not have any provisions that are inconsistent with § 403(b). For example, if the forms of annuity benefit available under a plan are described in investment arrangements under the plan, the terms of the investment arrangements must satisfy, if applicable to the plan, the joint and survivor annuity requirements of section 205 of ERISA and any applicable related rules, such as rules relating to transfers of benefits that are subject to the joint and survivor annuity requirement, and may not have any provisions that are inconsistent with § 403(b).

.05 Every § 403(b) pre-approved plan must provide that, in the event of any conflict between the terms of the pre-approved plan and the terms of investment arrangements under the plan (or of any other documents incorporated by reference into the plan), the terms of the pre-approved plan shall govern. Furthermore, an eligible employer may not rely on an opinion or advisory letter issued with respect to a § 403(b) pre-approved plan if any investment arrangement under the plan provides

that the terms of the investment arrangement shall govern in the event of any conflict between the terms of the arrangement and the terms of the pre-approved plan. An eligible employer that adopts a § 403(b) pre-approved plan should take this requirement into account in considering investment arrangements to be offered under the plan as well as other documents that may be incorporated by reference. Since the terms of investment arrangements under a § 403(b) pre-approved plan must be incorporated by reference into the plan and those arrangements may not have any provisions that are inconsistent with § 403(b), plan terms that are required in a pre-approved plan under this section 8 or section 9 or 10 should not create a conflict with the terms of the investment arrangements under a properly drafted § 403(b) pre-approved plan. If there nevertheless is such a conflict, the terms of the pre-approved plan must control. For sample plan language for § 403(b) pre-approved plans, see: http://www.irs.gov/pub/irs-tege/403b_lrm0313.pdf.

.06 Every § 403(b) pre-approved plan must satisfy the requirements of §§ 1.403(b)-1 through 1.403(b)-11, including the following requirements:

(1) The plan must contain all the material terms and conditions for eligibility, benefits, applicable limitations, the investment arrangements available under the plan, and the time and form under which benefit distributions will be made.

(2) The plan must satisfy the universal availability requirement with respect to elective deferrals described in § 1.403(b)-5(b), unless the adopting eligible employer is a Church or QCCO.

(3) The plan must limit the amount of compensation that can be taken into account with respect to any contribution under the plan to the limitation in effect under § 401(a)(17), unless the adopting eligible employer is a Church or QCCO. The plan may provide that, if the plan is a governmental plan, the transition rule in § 1.401(a)(17)-1(d)(4)(ii) will be applied in determining the amount of a participant's compensation that may be taken into account.

(4) Unless the plan is designed by the prototype sponsor or volume submitter to be available for adoption only as a governmental plan or by a Church or QCCO, the plan must include terms that satisfy the

applicable requirements of § 401(m) if the plan provides for matching or other contributions that are subject to the requirements of § 401(m).

(5) The plan must set forth the terms governing all of the plan's provisions relating to benefits, including any hardship distributions and other distribution events, loans, plan-to-plan transfers, contract-to-contract exchanges, and contributions and rollovers into the plan that are available under the plan, and may incorporate by reference the specific terms and conditions for those benefits set forth in the investment arrangements.

.07 The plan may provide a vesting schedule for nonelective employer contributions, rather than provide for full and immediate vesting of such contributions. Except in the case of certain volume submitter plans, as described below, nonelective employer contributions (and earnings thereon) under a § 403(b) pre-approved plan must vest at least as rapidly as would be required to satisfy the minimum vesting requirements of § 411(a)(2)(B), if the plan were a qualified plan under § 401(a), even if the plan is not subject to the parallel minimum vesting requirements under section 203 of ERISA. A volume submitter plan document that is designed to be used for a plan that is not subject to the minimum vesting requirements of section 203 of ERISA (for example, because the plan is a governmental plan) is not required to provide that nonelective employer contributions will vest at least as rapidly as would be required to satisfy § 411(a)(2)(B). Every § 403(b) pre-approved plan that provides a vesting schedule for nonelective employer contributions must also satisfy the following requirements: (i) the portion of a participant's interest in the plan that is not vested must be maintained in a separate account for the participant that is treated as a separate contract to which § 403(c) (or, in case of a custodial account, § 401(a)) applies; (ii) as amounts in the participant's separate account become nonforfeitable, they must be removed from the separate account and treated as amounts held under a § 403(b) plan, to the extent permitted under § 1.403(b)-3(d)(2)(ii); and (iii) all nonvested amounts remaining in the participant's separate account must become nonforfeitable upon termination of the plan.

.08 Every § 403(b) pre-approved plan must provide that an appendix to the plan will identify the parties responsible for the various administrative functions under the plan to comply with the requirements of § 403(b) and other tax requirements, including the requirements that apply on the basis of the aggregated investment arrangements issued to a participant under the plan, and will list all the vendors of investment arrangements approved for use under the plan, including sufficient information to identify the approved investment arrangements. Changes to the information in the required appendix will not affect the employer's ability to rely on an opinion or advisory letter.

.09 Every § 403(b) pre-approved plan must provide a procedure for amendment of the plan by the prototype sponsor or volume submitter practitioner, as applicable, so that changes in the Code, regulations, revenue rulings, or other guidance published by the Service, or corrections of prior approved plans, may be applied to all eligible employers that have adopted the plan.

.10 Every § 403(b) pre-approved plan must provide that the prototype sponsor or volume submitter, as applicable, will inform the adopting eligible employer of any amendments made to the plan and will notify the employer of the discontinuance or abandonment of the plan.

SECTION 9. ADDITIONAL PROVISIONS REQUIRED IN EVERY § 403(b) PROTOTYPE PLAN

.01 Under § 1.415(f)-1(a)(3), all § 403(b) annuity contracts purchased by an employer for a participant are treated as one § 403(b) annuity contract for purposes of § 415. Section 1.415(f)-1(f)(2) contains a special rule providing that, if a participant on whose behalf a § 403(b) annuity contract is purchased is in control of any employer for a limitation year, the § 403(b) annuity contract is aggregated with all other defined contribution plans maintained by that employer. For these purposes, a custodial account and a retirement income account are treated as a § 403(b) annuity contract. Every § 403(b) prototype plan must include plan language reflecting these rules. In particular, the plan language must coordinate the application of the § 415 limits

to all the § 403(b) prototype plans of the adopting eligible employer and its related employers so that, if the only § 403(b) plans maintained by the adopting employer and its related employers are prototype plans, the plans will satisfy § 415(c) and § 1.415(f)-1(a)(3) without requiring the addition of overriding plan language. Every § 403(b) prototype plan must also allow the adopting eligible employer to add overriding language to the adoption agreement if necessary to coordinate the application of the § 415 limits if the adopting eligible employer or its related employers also maintain § 403(b) plans that are not prototype plans. For this purpose, the term "related employers" means all employers that are aggregated with the adopting eligible employer under § 414(b) and (c) (each as modified by § 415(h)), (m), and (o), including § 1.414(c)-5. Sample language provided in the Listing of Required Modifications (for § 403(b) plans) may be downloaded from the Internet at the following address: http://www.irs.gov/pub/irs-tege/403b_lrm0313.pdf.

.02 Every § 403(b) prototype plan must provide that the eligible employer will be considered to have adopted an individually designed plan, and the eligible employer is not entitled to reliance on an opinion letter issued with respect to the plan, if:

(1) the eligible employer amends any provision of the plan, including the adoption agreement (other than (a) to change the choice of options in the adoption agreement, (b) to add overriding language in the adoption agreement if necessary to satisfy § 415 because of the required aggregation of multiple plans, (c) to change information in the required appendix described in section 8.08, or (d) to adopt sample or model amendments published by the Service that specifically provide that their adoption by an adopter of an approved § 403(b) prototype plan will not cause such plan to be treated as individually designed); or

(2) the eligible employer chooses to discontinue participation in the plan as amended by the prototype sponsor and does not substitute another approved § 403(b) prototype plan.

.03 The adoption agreement of every § 403(b) prototype plan must satisfy the following requirements:

(1) Although a single adoption agreement may be made available to different categories of eligible employers, the adoption agreement must require the adopting employer to show its status as an eligible employer by indicating whether the employer is:

(a) a government-sponsored educational organization described in § 170(b)(1)(A)(ii) (a “public school”);

(b) a tax-exempt organization described in § 501(c)(3) which is exempt from tax under § 501(a);

(c) an employer of a minister described in § 414(e)(5)(A); or

(d) a minister described in § 414(e)(5)(A).

(2) The adoption agreement must require the adopting employer to show its status with respect to the nondiscrimination requirements in § 1.403(b)–5 by indicating whether the plan is:

(a) a governmental plan of a public school;

(b) a governmental plan of a tax-exempt organization described in § 501(c)(3);

(c) a plan of an employer that is a Church or QCCO; or

(d) a plan (other than a plan described in (a), (b), or (c)) of an employer that is a tax-exempt organization described in § 501(c)(3).

(3) The adoption agreement must allow the adopting eligible employer to add overriding plan language if necessary to satisfy § 415 because of the required aggregation of multiple plans. See section 9.01.

(4) The adoption agreement must contain a dated employer signature line. The eligible employer must sign the adoption agreement when it first adopts the plan and must complete and sign a new adoption agreement if the plan has been restated. In addition, the eligible employer must complete a new signature page if it modifies any prior elections or makes new elections in its adoption agreement. The signature requirement may be satisfied by an electronic signature that reliably authenticates and verifies the adoption of the adoption agreement, or restatement, amendment or modification thereof, by the eligible employer.

(5) The adoption agreement must state that it is to be used only with one specific basic plan document, and must identify that document.

(6) The adoption agreement must contain a cautionary statement to the effect that the failure to properly fill out the adoption agreement may result in failure of the plan to satisfy the requirements of § 403(b). The Service expects that § 403(b) prototype plan documents will be written in a manner designed to assist adopting eligible employers in the correct completion of the adoption agreement.

(7) The adoption agreement must include the prototype sponsor’s name, address, and telephone number (or a space for the address and telephone number of the prototype sponsor’s authorized representative) for inquiries by adopting eligible employers regarding the adoption of the plan, the meaning of plan provisions, or the effect of the opinion letter.

.04 The adoption agreement of every nonstandardized § 403(b) prototype plan must satisfy the following additional requirements:

(1) The adoption agreement must state that, unless the plan is a governmental plan, a Church, or a QCCO, the plan must satisfy the requirements of §§ 401(a)(4) and 410(b) with respect to nonelective contributions under the plan on a continuing basis.

(2) The adoption agreement must state that the opinion letter may not be relied upon with respect to whether the plan satisfies the requirements of §§ 401(a)(4) and 410(b).

SECTION 10. ADDITIONAL PROVISIONS REQUIRED IN EVERY § 403(b) PRE-APPROVED PLAN INTENDED TO BE A RETIREMENT INCOME ACCOUNT UNDER § 403(b)(9)

.01 Every § 403(b) pre-approved plan that is intended to be a retirement income account under § 403(b)(9) must state the intent to constitute a retirement income account in accordance with § 1.403(b)–9(a)(2)(ii) and must satisfy the other requirements of this section 10.

.02 The terms of the plan must satisfy the separate accounting, investment performance, and exclusive benefit requirements of § 1.403(b)–9(a)(2)(i).

.03 If the plan provides for benefits in the form of a life annuity, the plan must satisfy the present value and benefit guarantee requirements of § 1.403(b)–9(a)(5),

and the present value must be based on reasonable actuarial assumptions that are either set forth in the plan or incorporated by reference into the plan.

SECTION 11. WHO CAN SPONSOR A § 403(b) PROTOTYPE PLAN OR A § 403(b) VOLUME SUBMITTER SPECIMEN PLAN? WHO CAN BE A MASS SUBMITTER?

.01 A person is eligible to sponsor a § 403(b) prototype plan if the person (1) has an established place of business in the United States where it is accessible during every business day, and (2) expects at least 30 eligible employers to adopt its § 403(b) prototype plan basic plan document(s). A Church-related organization is eligible to sponsor a § 403(b) prototype plan that is intended to be a retirement income account under § 403(b)(9), without regard to the number of eligible employers that are expected to adopt the plan. A person eligible to sponsor a § 403(b) prototype plan may request opinion letters for any number of basic plan documents and adoption agreements.

.02 A person is eligible to sponsor a § 403(b) volume submitter specimen plan if the person (1) has an established place of business in the United States where it is accessible during every business day and (2) expects at least 30 eligible employers to adopt its § 403(b) volume submitter plan(s). A Church-related organization is eligible to sponsor a § 403(b) volume submitter plan that is intended to be a retirement income account under § 403(b)(9), without regard to the number of eligible employers that are expected to adopt the plan. A person eligible to sponsor a § 403(b) volume submitter specimen plan may request advisory letters for any number of specimen plans.

.03 Any person that has an established place of business in the United States where it is accessible during every business day may sponsor a plan as a word-for-word identical adopter or minor modifier of a § 403(b) prototype plan or as a word-for-word identical adopter of a § 403(b) volume submitter specimen plan of a mass submitter, regardless of the number of eligible employers expected to adopt the plan. A mass submitter is any person that (1) has an established place of business in the United States where it

is accessible during every business day, and (2) submits opinion or advisory letter applications on behalf of at least 30 prototype sponsors, or 30 volume submitters, respectively, each of which is sponsoring, on a word-for-word identical basis, the same basic plan document or specimen plan. A minor modifier means a person that is sponsoring a § 403(b) prototype plan that is word-for-word identical to the plan of a mass submitter, but for minor changes that do not require in-depth technical review in order to issue an opinion letter. A § 403(b) prototype plan or volume submitter specimen plan of a mass submitter must include language designating the mass submitter as agent for the prototype sponsor or volume submitter for purposes of making plan amendments. A mass submitter may request opinion or advisory letters for any number of basic plan documents and adoption agreements or specimen plans.

.04 The filing of an application for an opinion or advisory letter for a § 403(b) prototype plan or volume submitter specimen plan constitutes a representation that the requirements in this section 11 are satisfied.

SECTION 12. DUTIES OF A PRE-APPROVED PLAN SPONSOR

.01 Except in the case of a Church-related organization that sponsors a § 403(b) prototype plan intended to be a retirement income account under § 403(b)(9), a pre-approved plan sponsor must maintain a written record of the eligible employers that have adopted the plan and, upon written request, must provide the Service a list of the names, addresses, and employer identification numbers of all eligible employers that, to the best of the sponsor's knowledge, have adopted the plan, other than employers that ceased to maintain the plan as a prototype plan more than three years prior to the request.

.02 Unless the pre-approved plan sponsor has withdrawn its opinion or advisory letter application pursuant to section 18, notified the Service and adopting eligible employers that it is abandoning the plan pursuant to section 19, or been notified by the Service under section 20 that its opinion or advisory letter has been revoked, the pre-approved plan sponsor must continue to maintain the approved status of the plan

as provided in section 16. Thus, the pre-approved plan sponsor must timely amend the plan for changes in the Code, regulations, revenue rulings, or other guidance published by the Service, and must apply for new opinion or advisory letters when required. The pre-approved plan sponsor must provide to the eligible employer the plan and any restatements thereof, all amendments and all opinion or advisory letters, and must comply with the notice requirements under this procedure and any other written guidance. The plan, restatements, amendments, and opinion or advisory letters may be provided to adopting eligible employers electronically.

.03 The pre-approved plan sponsor must have a procedure to notify adopting eligible employers of amendments and restatements of the plan and to inform the employers, when applicable, of the need to timely adopt the plan in the case of both initial adoption and restatement of the plan. The pre-approved plan sponsor must also notify adopting employers that failure to timely adopt the plan or restatement, when required, or failure to take into account plan amendments in the operation of the plan could result in adverse tax consequences.

.04 The filing of an application for an opinion or advisory letter for a § 403(b) pre-approved plan constitutes a representation that the pre-approved plan sponsor agrees to comply with the requirements of this revenue procedure. Failure to do so may result in the loss of eligibility to sponsor § 403(b) pre-approved plans and the revocation of opinion or advisory letters that have been issued to the pre-approved plan sponsor.

.05 Also see section 16.03 regarding a pre-approved plan sponsor's duty to timely notify an adopting employer if the sponsor determines that the employer's plan may no longer satisfy the requirements of § 403(b).

SECTION 13. SCOPE OF AN OPINION OR ADVISORY LETTER

.01 An opinion or advisory letter for a § 403(b) pre-approved plan constitutes a determination that the form of the plan documents, as adopted by a particular adopting eligible employer, satisfies the requirements of § 403(b) only under the

circumstances, and to the extent, described in sections 14 and 15.

.02 The Service's review of a pre-approved plan sponsor's application for an opinion or advisory letter for a § 403(b) pre-approved plan will consider only the terms of the basic plan document and adoption agreement or the volume submitter plan, as applicable. The Service's review will not consider, and an opinion or advisory letter will not express an opinion with respect to, the terms of any investment arrangements under the plan of any adopting eligible employer or any other documents that may be incorporated by reference into an adopting eligible employer's plan.

.03 An opinion or advisory letter for a § 403(b) plan does not express an opinion, and may not be relied upon, with respect to whether any plan is subject to the requirements of Title I of ERISA or whether a plan satisfies any of those requirements.

.04 Opinion and advisory letters will not be issued for any of the following:

(1) TEFRA church defined benefit plans. (See § 1.403(b)-10(f)(2).)

(2) Plans grandfathered under Rev. Rul. 82-102, 1982-1 C.B. 62.

(3) Plans that include blanks or fill-in provisions for the eligible employer to complete unless the provisions have parameters that preclude the eligible employer from completing the provisions in a manner that could cause the plan to fail to satisfy § 403(b).

(4) Plans that incorporate by reference the limitations of § 415 or the ACP test of § 401(m)(2).

The Service may, in its discretion, decline to issue opinion or advisory letters for other types of plans not described in this section 13.04. For example, in the case of a plan that is subject to Title I of ERISA, the Service may, in its discretion, decline to issue an opinion or advisory letter if the plan fails to satisfy a Code provision that is parallel to a provision in Part 2 of Subtitle B of Title I of ERISA (such as §§ 410 and 411 of the Internal Revenue Code).

SECTION 14. EMPLOYER RELIANCE ON AN OPINION LETTER

.01 Governmental plans and plans of Churches or QCCOs. An eligible employer that adopts a § 403(b) prototype

plan, whether standardized or nonstandardized, may rely upon an opinion letter issued for the plan that the form of the adopting eligible employer's plan satisfies the requirements of § 403(b) if the plan is a governmental plan or if the adopting eligible employer is a Church or QCCO. However, the issuance of an opinion letter does not constitute a determination that the plan is a governmental plan or that the adopting employer is a Church or QCCO.

.02 Standardized plans adopted by other § 501(c)(3) tax-exempt employers. An eligible employer that adopts a standardized § 403(b) prototype plan that is not a governmental plan or a plan of a Church or QCCO may rely upon an opinion letter issued for the plan that the form of the adopting eligible employer's plan satisfies the requirements of § 403(b), including, if applicable, the requirements of §§ 401(a)(4) and 410(b), if (1) the only contributions under the plan are elective deferrals, or (2) the plan provides for contributions other than elective deferrals, all of the employers in the adopting eligible employer's controlled group are eligible employers within the meaning of § 1.403(b)-2(b)(8). If the plan provides for contributions other than elective deferrals and the adopting eligible employer's controlled group includes any employer that is not an eligible employer within the meaning of § 1.403(b)-2(b)(8), the adopting eligible employer may rely on the opinion letter, except with respect to whether nonelective contributions under the plan satisfy the requirements of §§ 401(a)(4) and 410(b).

.03 Nonstandardized plans adopted by other § 501(c)(3) tax-exempt employers. An eligible employer that adopts a nonstandardized § 403(b) prototype plan that is not a governmental plan or a plan of a Church or QCCO may rely upon an opinion letter issued for the plan that the form of the adopting eligible employer's plan satisfies the requirements of § 403(b), except with respect to whether nonelective contributions under the plan satisfy the requirements of §§ 401(a)(4) and 410(b).

.04 No reliance on § 415 in certain circumstances. Notwithstanding the other provisions of this section 14, an opinion letter issued for a § 403(b) prototype plan may not be relied upon with respect to the requirements of § 415 if the adopting eligible employer or any of its related employers maintains another § 403(b) plan cov-

ering any of the same participants as the § 403(b) prototype plan, unless the other plan is also a § 403(b) prototype plan. For this purpose, the term "related employers" means all employers that are aggregated with the adopting eligible employer under § 414(b) and (c) (each as modified by § 415(h)), (m), and (o), including § 1.414(c)-5. (Also see §§ 1.415(c)-1(d) and 1.415(f)-1(f) for special rules applicable to § 403(b) plans.)

.05 No reliance on inherently factual issues. An opinion letter for a § 403(b) prototype plan also may not be relied upon with respect to issues of an inherently factual nature, such as whether the effective availability of any benefits, rights, and features is nondiscriminatory, or with respect to whether a plan satisfies the requirements of §§ 401(a)(4) and 410(b) with respect to former employees.

SECTION 15. EMPLOYER RELIANCE ON AN ADVISORY LETTER

.01 In general. An eligible employer that adopts a § 403(b) volume submitter plan may rely upon an advisory letter issued for the plan that the form of the adopting eligible employer's plan satisfies the requirements of § 403(b) except (i) to the extent that the employer modifies the terms of the approved specimen plan (other than by selecting options that are permitted under the terms of the approved specimen plan); and (ii) if the plan is not a governmental plan or a plan of a Church or QCCO, with respect to whether nonelective contributions under the plan satisfy the requirements of §§ 401(a)(4) and 410(b). The issuance of an advisory letter does not constitute a determination that the plan is a governmental plan or that the adopting employer is a Church or QCCO.

.02 No reliance on § 415 in certain circumstances. Notwithstanding the other provisions of this section 15, an advisory letter issued for a § 403(b) volume submitter plan may not be relied upon with respect to the requirements of § 415 if the adopting eligible employer or any of its related employers maintain another § 403(b) plan covering any of the same participants as the § 403(b) volume submitter plan. For this purpose, the term "related employers" means all employers that are aggre-

gated with the adopting eligible employer under § 414(b) and (c) (each as modified by § 415(h)), (m), and (o), including § 1.414(c)-5. (Also see §§ 1.415(c)-1(d) and 1.415(f)-1(f) for special rules applicable to § 403(b) plans.)

.03 No reliance on inherently factual issues. An advisory letter for a § 403(b) volume submitter plan also may not be relied upon with respect to issues of an inherently factual nature.

SECTION 16. MAINTENANCE OF APPROVED STATUS

.01 A § 403(b) pre-approved plan must be amended by the pre-approved plan sponsor and, if necessary, the adopting eligible employer(s), to retain its approved status if any provisions therein fail to meet the requirements of § 403(b) as a result of a change in the Code, regulations, revenue rulings, or other guidance published by the Service. The Service expects future guidance to require the restatement of every § 403(b) pre-approved plan by the pre-approved plan sponsor every six years. Upon issuance of a new opinion or advisory letter for the restated plan, adopting eligible employers would generally be required to adopt the restated plan (by completing a new adoption agreement, in the case of a prototype plan).

.02 As provided in section 8.05, every § 403(b) pre-approved plan must provide that, in the event of any conflict between the terms of the pre-approved plan and the terms of investment arrangements under the plan (or of any other documents incorporated by reference into the plan), the terms of the pre-approved plan shall govern. An eligible employer may not rely on an opinion or advisory letter issued with respect to a § 403(b) pre-approved plan if any investment arrangement under the plan provides that the terms of the investment arrangement shall govern in the event of any conflict between the terms of the arrangement and the terms of the pre-approved plan. Employers and their advisors should take this requirement into account in considering any investment arrangements to be offered under a § 403(b) pre-approved plan.

.03 If a pre-approved plan sponsor determines that a § 403(b) pre-approved plan as adopted by an eligible employer may no longer satisfy the requirements of § 403(b)

and the pre-approved plan sponsor does not or cannot correct the failure to satisfy § 403(b) under the self-correction or voluntary correction components of the Employee Plans Compliance Resolution System (EPCRS), the pre-approved plan sponsor must notify the eligible employer that the plan may no longer satisfy § 403(b), advise the eligible employer that adverse tax consequences may ensue, and inform the eligible employer about the availability of EPCRS. See Rev. Proc. 2013-12, 2013-4 IRB 313. This section 16.03 does not impose a requirement on a pre-approved plan sponsor to monitor an adopting employer's plan's compliance with the requirements of § 403(b), but it provides that the pre-approved plan sponsor has a duty to inform the adopting employer if the sponsor has knowledge that the employer's plan may no longer satisfy those requirements.

SECTION 17. HOW TO APPLY FOR AN OPINION OR ADVISORY LETTER

.01 The Service will accept applications for opinion and advisory letters for § 403(b) pre-approved plans beginning June 28, 2013.

.02 A separate application is required for each adoption agreement that is offered for adoption by a prototype sponsor and each specimen plan of a volume submitter. For example, assume a pre-approved plan sponsor maintains three volume submitter specimen plans and two prototype plan basic plan documents. One of the volume submitter plans does not use an adoption agreement, another has only one adoption agreement, and the third has two adoption agreements. Assume that there are three adoption agreements that may be used with each prototype plan basic plan document. In this case, the pre-approved plan sponsor must submit 10 separate applications, four applications for the volume submitter plans and six applications for the prototype plans.

.03 An application for an opinion letter for a § 403(b) prototype plan may be filed by a prototype sponsor, by a mass submitter with respect to its mass submitter plan, or by a mass submitter on behalf of a word-for-word identical adopter or minor modifier of the mass submitter's plan. An application for an advisory letter for a § 403(b) volume submitter specimen plan

may be filed by a volume submitter practitioner, by a mass submitter with respect to its mass submitter plan, or by a mass submitter on behalf of a word-for-word identical adopter of the mass submitter's plan. The Service is developing forms for these applications and will issue an announcement when the forms become available. Until such time as the forms are available, an application for an opinion or advisory letter for a § 403(b) prototype or specimen plan may be made by submitting the plan to the Service along with a completed and signed "Application for Approval of § 403(b) Pre-approved Plan," as provided in the appendix to this revenue procedure. The applicable user fee, determined under section 6.03 or section 6.04 of Rev. Proc. 2013-8, 2013-1 I.R.B. 237, as if the application were for a master and prototype plan or a § 401(a) volume submitter plan, respectively, must also be included with the application. The request is to be sent to:

Internal Revenue Service
Commissioner, TE/GE
Attention: SE:T:EP:RA
P.O. Box 27063
McPherson Station
Washington, DC 20038

.04 In the case of an initial submission of a mass submitter's basic plan document or specimen plan under this revenue procedure, the mass submitter's application(s) must also be accompanied by applications for opinion or advisory letters filed on behalf of at least 30 word-for-word identical adopters of the basic plan document or specimen plan, as applicable, unless the mass submitter has already satisfied this requirement in connection with a previous application under this revenue procedure involving another basic plan document or specimen plan, as applicable. After satisfying the 30 word-for-word identical adopter requirement, the mass submitter may submit additional applications on behalf of other pre-approved plan sponsors that wish to adopt a word-for-word identical plan, or, in the case of a § 403(b) prototype plan, a minor modifier plan. In addition, the mass submitter may then submit requests for opinion or advisory letters for its other § 403(b) prototype or specimen plans, as applicable, regardless of the number of identical adopters of such other plans. Until such time as the applica-

tion forms are available, Appendix A must be completed, signed, and included with each application that is submitted on behalf of an identical adopter or minor modifier. The applicable user fee, determined under section 6.03 or 6.04 of Rev. Proc. 2013-8, as if the application were for a master and prototype plan or a § 401(a) volume submitter plan, respectively, must also be included with the application.

.05 Sample plan language to be used in drafting § 403(b) pre-approved plans is available from Employee Plans Rulings and Agreements. Such language is not automatically required in § 403(b) pre-approved plans, but should be used as a guide in drafting such plans. To expedite the review of their plans, pre-approved plan sponsors are encouraged to use the Service's sample plan language and to identify if such language is being used in their plan documents. The sample plan language may be downloaded from the Internet at the following address: http://www.irs.gov/pub/irs-tege/403b_lrm0313.pdf.

.06 A failure to disclose a material fact or misrepresentation of a material fact in the application may adversely affect the reliance that would otherwise be obtained through issuance by the Service of an opinion or advisory letter. Similarly, failure to accurately provide any of the information called for on any form required by this revenue procedure may result in no reliance.

.07 The Service may, at its discretion, require any additional information that it deems necessary in connection with its review of a § 403(b) pre-approved plan. If a letter requesting changes to plan documents is sent to the pre-approved plan sponsor or an authorized representative, a response to any questions raised or any material requested must be received no later than 30 days from the date of the letter, and the response must include either a copy of the plan with the changes highlighted or, if the changes are not extensive, replacement pages. If the changes are not received within 30 days, the application may be considered withdrawn. An extension of the 30-day time limit will be granted for good cause, as determined by the Service.

.08 The Service will return, without further action, plans that are not in substantial compliance with the approval requirements or plans that are so deficient that

they cannot be reviewed in a reasonable amount of time. A plan may be considered not to be in substantial compliance if, for example, it omits an applicable Code section, contains conflicting provisions, or merely incorporates by reference an applicable Code section. The Service will not consider these plans until after they are revised, and they will be treated as new requests as of the date they are resubmitted. No additional user fee will be charged if an inadequate submission is amended to be in substantial compliance and is resubmitted to the Service within 30 days following the date the pre-approved plan sponsor is notified of the inadequacy.

.09 If the plan document submitted as part of an opinion or advisory letter request contains a provision that gives rise to an issue for which the Service determines that contrary published authority exists, failure to disclose and address the significant contrary authority may result in requests for additional information, which will delay action on the request.

.10 An opinion or advisory letter issued to a pre-approved plan sponsor is not transferable to any other entity. For this purpose, a change of employer identification number is deemed to be a change of entity.

.11 A change only in a pre-approved plan sponsor's name is not deemed to be a change of entity. However, the pre-approved plan sponsor must notify the Service in writing of the change in name and certify that it still meets the conditions for sponsorship described in section 11. No opinion or advisory letter will be issued and no user fee will be required for a mere change in name.

SECTION 18. WITHDRAWAL OF REQUESTS

.01 A pre-approved plan sponsor may withdraw its request for an opinion or advisory letter at any time prior to the issuance of such letter by notifying EP Rulings and Agreements in writing of such withdrawal. The notification is to be sent to the address in section 17.03. The pre-approved plan sponsor must also notify each eligible employer that has adopted the plan that the request has been withdrawn. Such an eligible employer will be deemed to have an individually designed plan.

.02 Even though a request is withdrawn, EP Rulings and Agreements will retain all

correspondence and documents associated with that request and will not return them to the pre-approved plan sponsor. EP Rulings and Agreements may furnish its views concerning the approval status of the plan to EP Examinations, which has audit jurisdiction over the returns of the eligible employers that have adopted the plan.

SECTION 19. ABANDONMENT OF SPONSORSHIP OF § 403(b) PLANS

.01 A pre-approved plan sponsor must notify EP Rulings and Agreements in writing of a § 403(b) pre-approved plan that is no longer used by any eligible employer and which the pre-approved plan sponsor no longer intends to offer for adoption. Such written notification is to be sent to the address in section 17.03 and should refer to the file folder number appearing on the latest opinion or advisory letter issued.

.02 A pre-approved plan sponsor that intends to abandon a § 403(b) pre-approved plan that is in use by any adopting eligible employer must inform each adopting eligible employer that the form of the plan has been terminated, that the eligible employer's plan will become an individually designed plan (unless the eligible employer adopts another § 403(b) pre-approved plan), and that any employer reliance will not continue if there is a change in § 403(b), the regulations, revenue rulings, or other guidance published by the Service. After so informing all adopting eligible employers, the pre-approved plan sponsor must notify EP Rulings and Agreements in accordance with section 19.01.

SECTION 20. REVOCATION

An opinion or advisory letter found to be in error or not in accord with the current views of the Service may be revoked. However, except in rare or unusual circumstances, such revocation will not be applied retroactively if the conditions set forth in sections 13 and 14 of Rev. Proc. 2013-4, 2013-1 I.R.B. 126 (disregarding references therein to §§ 7428 and 7476) are met. For this purpose, opinion and advisory letters will be given the same effect as rulings. Revocation may be effected by a notice to the pre-approved plan sponsor to which the letter was originally issued or by publication in the Internal Revenue

Bulletin. The pre-approved plan sponsor should then notify each adopting eligible employer of the revocation as soon as possible. The content of the notification to each adopting eligible employer must explain how the revocation affects any reliance an adopting eligible employer has on the applicable opinion or advisory letter.

SECTION 21. RETROACTIVE REMEDIAL AMENDMENT

.01 Effective January 1, 2009, a contract (that is, an annuity contract, custodial account, or retirement income account) does not satisfy the requirements of § 403(b) unless the contract is maintained pursuant to a written plan that, in both form and operation, satisfies the requirements of the 2007 regulations. The transition relief in Notice 2009-3 sets forth conditions under which a § 403(b) plan will not be treated as failing to satisfy the requirements of § 403(b) during the 2009 calendar year. The relief in Notice 2009-3 applies solely with respect to the 2009 calendar year.

.02 This section 21 allows an eligible employer to retroactively correct defects in the form of its written § 403(b) plan (including any defects in documents incorporated by reference into the plan) in order to satisfy the written plan requirement in the 2007 regulations by timely adopting a § 403(b) pre-approved plan or by otherwise timely amending its plan. For this purpose, a defect in the form of a plan is a provision, or the absence of a required provision, that causes the plan to fail to satisfy the requirements of § 403(b). Under this remedial amendment provision, an eligible employer must amend its plan to the extent necessary to correct any form defects retroactive to the first day of the plan's remedial amendment period. For this purpose, "the first day of the plan's remedial amendment period" means the later of January 1, 2010, or the effective date of the plan.

.03 The form of a plan will be treated as satisfying the requirements of the 2007 regulations as of the first day of the plan's remedial amendment period if (1) on or before such day, the eligible employer adopts a written plan that is intended to satisfy the requirements of § 403(b), and (2) on or before the last day of the re-

medial amendment period, the employer amends the plan, including any investment arrangements and any other documents incorporated by reference into the plan, to the extent necessary to correct any form defects retroactive to the first day of the remedial amendment period. The latter requirement is automatically satisfied (except to the extent any documents incorporated by reference into the plan must be amended) if the employer retroactively adopts a § 403(b) pre-approved plan with an opinion or advisory letter on or before the last day of the remedial amendment period. (An eligible employer that timely amends its plan is not required, but may nevertheless choose, to amend its plan retroactive to January 1, 2009. However, for purposes of Notice 2009-3 and whether the Service will treat the eligible employer's § 403(b) plan as satisfying the requirements of § 403(b) during the 2009 calendar year, only the plan that was adopted on or before December 31, 2009 and in effect on that date, will be taken into account.)

.04 For purposes of this section 21, a § 403(b) pre-approved plan with an opinion or advisory letter means a plan for which an opinion or advisory letter is issued pursuant to a timely filed application under this revenue procedure. An application for an opinion or advisory letter under this revenue procedure is timely filed if (a) the application is filed with the Service by April 30, 2014, or (b) for word-for-word identical adopters or minor modifiers of mass submitter plans, the opinion or advisory letter application for the mass submitter plan is filed with the Service April 30, 2014, irrespective of when the opinion or advisory letter application for the identical adopter or minor modifier plan is filed.

.05 The Service will announce, in subsequent guidance, the date that will be the last day of the remedial amendment period for all eligible employers for purposes of this section 21. The guidance will be published in conjunction with the issuance of opinion and advisory letters pursuant to timely filed applications under this revenue procedure. The Service expects that the announced date will provide every eligible employer a period in excess of one year from the date of the announcement during which to either adopt a pre-approved § 403(b) plan with an opinion or advisory letter or otherwise

amend its plan. Persons wishing to comment on the expected subsequent guidance should submit comments in writing by October 28, 2013. Written comments may be sent to CC:PA:LPD:PR (Rev. Proc. 2013-22), Room 5203, Internal Revenue Service, POB 7604, Ben Franklin Station, Washington, D.C. 20044. Comments may be hand delivered Monday through Friday between the hours of 8 a.m. and 4 p.m. to CC:PA:LPD:PR (Rev. Proc. 2013-22), Courier's Desk, Internal Revenue Service, 1111 Constitution Ave., NW, Washington, D.C. Alternatively, comments may be submitted via the Internet to notice.comments@irs.counsel.treas.gov (Rev. Proc. 2013-22).

.06 For purposes of this section 21, a "written plan that is intended to satisfy the requirements of § 403(b)" includes both a new plan that is intended to satisfy those requirements and an existing plan that has been amended with the intent of satisfying those requirements, including a plan that is based on the model plan language in Rev. Proc. 2007-71 and a plan that is an adoption of a § 403(b) pre-approved plan that has been timely submitted for an opinion or advisory letter under this revenue procedure.

SECTION 22. EFFECT ON OTHER DOCUMENTS

.01 The definition of "opinion letter" in section 3.05 of Rev. Proc. 2013-4 is modified to provide that an opinion letter also includes a written statement issued by Employee Plans Rulings and Agreements to a prototype plan sponsor as to the acceptability, for purposes of § 403(b), of the form of a § 403(b) prototype plan. See Rev. Proc. 2013-22.

.02 The definition of "advisory letter" in section 3.11 of Rev. Proc. 2013-4 is modified to provide that an advisory letter also includes a written statement issued by Employee Plans Rulings and Agreements to a volume submitter practitioner as to the acceptability, for purposes of § 403(b), of the form of a § 403(b) specimen plan. See Rev. Proc. 2011-49 and Rev. Proc. 2013-22.

.03 Rev. Proc. 2013-8 is modified to provide that the user fee for an application for an opinion or advisory letter for a § 403(b) pre-approved plan is the fee that would apply under section 6.03 or 6.04 of

that revenue procedure if the application were for an opinion letter for a § 401(k) prototype plan or an advisory letter for a § 401(a) volume submitter plan.

SECTION 23. EFFECTIVE DATE

This revenue procedure is effective April 29, 2013.

SECTION 24. PAPERWORK REDUCTION ACT

The collections of information contained in this revenue procedure have been reviewed and approved by the Office of Management and Budget in accordance with the Paperwork Reduction Act (44 U.S.C. 3507) under control number 1545-1520.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number.

The collections of information in this revenue procedure are in sections 9.03(3), 12, 16, 17, 18.01, 19, 20, and 21. This information is required to obtain advance approval from the Service of the form of prototype and similar plans. Employers will adopt these preapproved plans to satisfy requirements of 26 U.S.C. 403(b). This information will be used to enable the Service to make determinations that the form of a written plan satisfies the requirements of 26 U.S.C. 403(b) and is entitled to favorable tax treatment. The collections of information are voluntary, to obtain a benefit. The likely respondents are insurance companies, other financial institutions, law, actuarial and consulting firms, employee benefit practitioners, and nonprofit institutions.

The estimated total annual reporting and/or recordkeeping burden is 26,471 hours.

The estimated annual burden per respondent/recordkeeper varies from 1/2 to 2,000 hours depending on individual circumstances, with an estimated average of 3.56 hours. The estimated number of respondents and/or recordkeepers is 7444.

The estimated annual frequency of responses is on occasion.

Books or records relating to a collection of information must be retained as long as their contents may become material in

the administration of any internal revenue law. Generally tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

DRAFTING INFORMATION

The principal authors of this revenue procedure are Angelique Carrington and James P. Flannery of the Employee Plans, Tax Exempt and Government Entities Division. For further information

regarding this revenue procedure, please contact the Employee Plans taxpayer assistance answering service at 1-877-829-5500 (a toll-free number) or e-mail Ms. Carrington or Mr. Flannery at *RetirementPlanQuestions@irs.gov*.

APPENDIX

Application for Approval of § 403(b) Pre-approved Plan

1. Enter amount of user fee submitted: \$
2. Name of applicant:
 - a. EIN:
 - b. Address:
 - c. Phone:
3. Person to contact:
 - a. Phone:
 - b. Email address:
 - c. Power of attorney attached?
4. Type of applicant (check one):
 - a. Prototype sponsor
 - b. Prototype mass submitter
 - c. Volume submitter practitioner
 - d. Volume submitter mass submitter
 - e. Identical adopter of mass submitter plan
 - f. Minor modifier of mass submitter prototype plan
5. Form of plan (check one);
 - a. Prototype plan
 - b. Volume submitter specimen plan without adoption agreement
 - c. Volume submitter specimen plan with adoption agreement
6. If the plan is a prototype plan, indicate whether the plan is a (check one):
 - a. Standardized plan
 - b. Nonstandardized plan
- 7.a. Prototype plan basic plan document number (Each of the prototype sponsor's or prototype mass submitter's basic plan documents must be assigned a 2-digit number, starting with 01. Enter the number you have assigned to the basic plan document that is associated with the adoption agreement for which this application is filed.):
- 7.b. Prototype plan adoption agreement number (Each different adoption agreement associated with a single basic plan document must be assigned a 3-digit number, beginning with 001. Enter the number you have assigned to the adoption agreement for which this application is filed.):
- 7.c. Volume submitter specimen plan number (Each of the volume submitter practitioner's or volume submitter mass submitter's specimen plans must be assigned a 2-digit number, starting with 01. Enter the number you have assigned to the specimen plan for which this application is filed.):
- 7.d. Volume submitter plan adoption agreement number, if applicable (Each different adoption agreement associated with a single specimen plan must be assigned a 3-digit number, beginning with 001. Enter the number you have assigned to the adoption agreement for which this application is filed.):
8. If 4e or 4f is checked, complete the following information for the mass submitter's plan on which this application is based, to the extent the information is available when this application is filed:
 - a. Name of mass submitter:
 - b. File folder number:
 - c. Letter serial number:
 - d. Date of letter:
 - e. Basic plan document number or specimen plan number (if b, c, and d not available):
 - f. Adoption agreement number, if applicable (if b, c, and d not available)
9. Investment arrangement(s) permitted under the prototype or specimen plan:
 - a. Annuity contracts issued by an insurance company
 - b. Custodial accounts
 - c. Retirement income account

10. Type(s) of contributions permitted under the prototype or specimen plan:

- a. Elective deferrals (other than Roth)
- b. Roth elective deferrals
- c. After-tax employee contributions
- d. Matching contributions
- e. Other nonelective employer contributions

11. Are the following documents included with the application:

- a. Basic plan document or specimen plan?
- b. Adoption agreement (if the application is for a prototype plan or for a specimen plan that uses an adoption agreement)?

12. If 4a or 4c is checked, do you expect at least 30 eligible employers to adopt your § 403(b) prototype plan basic plan documents(s) or volume submitter specimen plan(s)?

13. If 4b or 4d is checked, are applications on behalf of at least 30 prototype sponsors or volume submitters who are sponsoring the identical basic plan document or specimen plan included with this application?

14. If the answer to 13 is "no," enter the number of the basic plan document or specimen plan for which the requirement described in 13 is met:

15. Applicant's signature under penalties of perjury (required if 4a, b, c, or d checked):

Under penalties of perjury, I declare that I have examined this application, including accompanying statements, and to the best of my knowledge and belief it is true, correct, and complete.

Signature:

Title:

Date:

16. Prototype sponsor's or volume submitter's and mass submitter's signatures under penalties of perjury (required if 4e or 4f checked):

Under penalties of perjury, I declare that the prototype sponsor or volume submitter practitioner identified in line 2 of this application has adopted a prototype plan or a specimen plan that is identical to the mass submitter plan identified in line 7 or, in the case of a prototype plan, is a minor modifier of the mass submitter plan identified in line 7.

Prototype sponsor's or volume submitter's signature:

Title:

Date:

Mass submitter's signature:

Title:

Date:

Part IV. Items of General Interest

DEPARTMENT OF THE TREASURY Internal Revenue Service 26 CFR Part 54

DEPARTMENT OF LABOR Employee Benefits Security Administration 29 CFR Part 2590

DEPARTMENT OF HEALTH AND HUMAN SERVICES 45 CFR Parts 147, 148, and 156

Proposed Rules

REG-120391-10

Coverage of Certain Preventive Services Under the Affordable Care Act

AGENCIES: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services.

ACTION: Proposed rules.

SUMMARY: This document proposes amendments to rules regarding coverage for certain preventive services under section 2713 of the Public Health Service Act, as added by the Patient Protection and Affordable Care Act, as amended, and incorporated into the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code. Section 2713 of the Public Health Service Act requires coverage without cost sharing of certain preventive health services, including certain contraceptive services, in non-exempt, non-grandfathered group health plans and health insurance coverage. The proposed rules would amend the authorization to exempt group health plans established or maintained by certain religious employers (and group health insurance coverage provided in connection with such plans) with

respect to the requirement to cover contraceptive services. The proposed rules would also establish accommodations for group health plans established or maintained by eligible organizations (and group health insurance coverage offered in connection with such plans), including student health insurance coverage arranged by eligible organizations that are religious institutions of higher education. This document also proposes related amendments to regulations concerning excepted benefits and Affordable Insurance Exchanges.

DATES: Comments are due on or before April 8, 2013.

ADDRESSES: In commenting, please refer to file code CMS-9968-P. Because of staff and resource limitations, the Departments cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments to <http://www.regulations.gov>. Follow the “Submit a comment” instructions.

2. *By regular mail.* You may mail written comments to the following address **ONLY:**

Centers for Medicare &
Medicaid Services,
Department of Health and
Human Services,
Attention: CMS-9968-P,
P.O. Box 8013,
Baltimore, MD 21244-1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address **ONLY:**

Centers for Medicare &
Medicaid Services,
Department of Health and
Human Services,
Attention: CMS-9968-P,
Mail Stop C4-26-05,
7500 Security Boulevard,
Baltimore, MD 21244-1850.

4. *By hand or courier.* You may deliver (by hand or courier) your written comments to the following addresses **ONLY:**

a. For delivery in Washington, DC—

Centers for Medicare &
Medicaid Services,
Department of Health and
Human Services,
Room 445-G, Hubert H.
Humphrey Building,
200 Independence Avenue, S.W.,
Washington, DC 20201.

Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without federal government identification, commenters are encouraged to leave their comments in the Centers for Medicare & Medicaid Services drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.

b. For delivery in Baltimore, MD—

Centers for Medicare &
Medicaid Services,
Department of Health and
Human Services,
7500 Security Boulevard,
Baltimore, MD 21244-1850.

If you intend to deliver your comments to the Baltimore address, call (410) 786-9994 in advance to schedule your arrival with one of our staff members.

Do not mail comments to the addresses indicated as appropriate for hand or courier delivery because they may be delayed and received after the close of the comment period.

For information on viewing public comments, see the beginning of the “SUPPLEMENTARY INFORMATION” section.

FOR FURTHER INFORMATION CONTACT: Jacob Ackerman, Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS), at (410) 786-1565.

Amy Turner or Beth Baum, Employee Benefits Security Administration (EBSA), Department of Labor, at (202) 693-8335.

Karen Levin, Internal Revenue Service (IRS), Department of the Treasury, at (202) 927-9639 (not a toll-free call).

Customer Service Information: Individuals interested in obtaining information from the Department of Labor concerning employment-based health coverage laws may call the EBSA Toll-Free Hotline at 1-866-444-EBSA (3272) or visit the Department of Labor's web site (www.dol.gov/ebsa). In addition, information from HHS on private health insurance coverage can be found on CMS's web site (www.cciio.cms.gov), and information on health care reform can be found at www.HealthCare.gov.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. The Departments post all comments received before the close of the comment period on the following web site as soon as possible after they have been received: www.regulations.gov. Follow the search instructions on that web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately three weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4:00 p.m. To schedule an appointment to view public comments, call (800) 743-3951.

I. Background

The Patient Protection and Affordable Care Act (Pub. L. 111-148) was enacted on March 23, 2010, and amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) on March 30, 2010. These statutes are referred to collectively as the Affordable Care Act. The Affordable Care Act reorganizes, amends, and adds to the provisions of

part A of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets. The Affordable Care Act adds section 715(a)(1) to the Employee Retirement Income Security Act of 1974 (ERISA) and section 9815(a)(1) to the Internal Revenue Code (Code) to incorporate the provisions of part A of title XXVII of the PHS Act into ERISA and the Code, and to make them applicable to group health plans. The PHS Act sections incorporated by these references are sections 2701 through 2728.

Section 2713 of the PHS Act, as added by the Affordable Care Act and incorporated into ERISA and the Code, requires that non-grandfathered group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage provide benefits for certain preventive health services without the imposition of cost sharing. These preventive health services include, with respect to women, preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

The Departments of Health and Human Services (HHS), Labor, and the Treasury (collectively, the Departments) published interim final rules with a request for comments implementing section 2713 of the PHS Act in the July 19, 2010 **Federal Register** (75 FR 41726) (2010 interim final rules). Among other things, the 2010 interim final rules provide that a plan or issuer must provide coverage, without cost sharing, for certain newly recommended preventive health services starting with the first plan year (or, in the individual market, policy year) that begins on or after the date that is one year after the date on which the recommendation or guideline is issued.¹

On August 1, 2011, HRSA adopted and released guidelines for women's preventive services based on recommendations of the independent Institute of Medicine, which had undertaken a review of the scientific and medical evidence on women's preventive services (Women's Preventive Services: Required Health Plan Coverage

Guidelines, or HRSA Guidelines).² As relevant here, the HRSA Guidelines include all Food and Drug Administration (FDA)-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity, as prescribed by a health care provider (collectively, contraceptive services).³ Accordingly, under section 2713 of the PHS Act and the 2010 interim final rules, non-grandfathered group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage are required to provide coverage without cost sharing of women's preventive health services, including contraceptive services, consistent with the HRSA Guidelines in plan years (or, in the individual market, policy years) beginning on or after August 1, 2012, except as discussed later in this section.

Contemporaneous with the issuance of the HRSA Guidelines, the Departments amended the 2010 interim final rules (76 FR 46621) (2011 amended interim final rules). The amendment provided HRSA with the authority to exempt group health plans established or maintained by religious employers (and group health insurance coverage provided in connection with such plans) from the requirement to cover contraceptive services pursuant to the HRSA Guidelines.⁴ The 2011 amended interim final rules specified that, for purposes of this exemption, a religious employer is one that: (1) has the inculcation of religious values as its purpose; (2) primarily employs persons who share its religious tenets; (3) primarily serves persons who share its religious tenets; and (4) is a nonprofit organization described in section 6033(a)(1) and (a)(3)(A)(i) or (iii) of the Code. Section 6033(a)(3)(A)(i) and (iii) of the Code refers to churches, their integrated auxiliaries, and conventions or associations of churches, as well as to the exclusively religious activities of any religious order. HRSA exercised this authority in the HRSA Guidelines such that group health plans established or maintained by these religious employers (and group health insurance coverage provided in connection with such plans)

¹ 26 CFR 54.9815-2713T(b)(1); 29 CFR 2590.715-2713(b)(1); 45 CFR 147.130(b)(1).

² The HRSA Guidelines are available at: <http://www.hrsa.gov/womensguidelines>.

³ This excludes services relating to a man's reproductive capacity, such as vasectomies and condoms.

⁴ The 2011 amended interim final rules were issued and effective on August 1, 2011, and published on August 3, 2011.

are exempt from the requirement to cover contraceptive services.

On February 10, 2012, the Departments issued final rules that adopted the definition of religious employer in the 2011 amended interim final rules for purposes of the exemption from the requirement to cover contraceptive services (2012 final rules).⁵ Contemporaneous with the issuance of the 2012 final rules, HHS, with the agreement of the Departments of Labor and the Treasury, issued guidance establishing a temporary enforcement safe harbor for group health plans established or maintained by certain nonprofit organizations that have religious objections to contraceptive coverage (and any group health insurance coverage provided in connection with such plans).⁶

The guidance provides that, under the temporary enforcement safe harbor, the Departments will not take any enforcement action against an employer, group health plan, or health insurance issuer for failing to cover some or all recommended contraceptive services in a non-grandfathered group health plan (or any group health insurance coverage provided in connection with such a plan) where the plan is established or maintained by an organization meeting all of the following criteria:

- The organization is organized and operates as a nonprofit entity.
- From February 10, 2012, onward, the group health plan established or maintained by the organization has consistently not covered all or the same subset of recommended contraceptive services, consistent with any applicable state law, because of the religious beliefs of the organization.
- The group health plan established or maintained by the organization (or another entity on behalf of the plan, such as a health insurance issuer or third party administrator) provides to participants a notice indicating that some or

all contraceptive services will not be covered under the plan for the first plan year beginning on or after August 1, 2012, as set forth in the guidance.

- The organization self-certifies that it satisfies the foregoing three criteria and documents its self-certification, as set forth in the guidance.

The temporary enforcement safe harbor is also available for insured student health insurance coverage arranged by nonprofit institutions of higher education with religious objections to contraceptive coverage that similarly meet the four criteria.⁷

The temporary enforcement safe harbor is in effect until the first plan year that begins on or after August 1, 2013. The Departments committed to rulemaking during this 1-year safe harbor period to provide women with contraceptive coverage without cost sharing as required by section 2713 of the PHS Act, while protecting certain additional organizations from having to contract, arrange, pay, or refer for any contraceptive coverage to which they object on religious grounds.

The first step toward realizing these policy goals was an advance notice of proposed rulemaking (ANPRM) published on March 21, 2012 (77 FR 16501). The ANPRM presented potential approaches and solicited comments on alternative ways to fulfill the requirements of section 2713 of the PHS Act when health coverage is established or maintained by eligible organizations, or arranged by eligible organizations that are religious institutions of higher education,⁸ with religious objections to contraceptive coverage. The 90-day comment period on the ANPRM closed on June 19, 2012.

These proposed rules mark the next step in the process. The proposed rules would make two principal changes to the preventive services coverage rules to provide women contraceptive coverage without cost sharing, while taking into account religious objections to contraceptive services

of eligible organizations, including eligible organizations that are religious institutions of higher education, that establish or maintain or arrange health coverage. First, the proposed rules would amend the criteria for the religious employer exemption to ensure that an otherwise exempt employer plan is not disqualified because the employer's purposes extend beyond the inculcation of religious values or because the employer serves or hires people of different religious faiths. Second, the proposed rules would establish accommodations for health coverage established or maintained by eligible organizations, or arranged by eligible organizations that are religious institutions of higher education, with religious objections to contraceptive coverage. The proposed rules also propose related amendments to other rules, consistent with the proposed accommodations. The Departments intend to finalize all such proposed amendments before the end of the temporary enforcement safe harbor.

Comments are welcome on any aspect of the proposed rules, including on how best to provide women with contraceptive coverage without cost sharing as required by section 2713 of the PHS Act, while protecting eligible organizations from having to contract, arrange, pay, or refer for any contraceptive coverage to which they object on religious grounds.

II. Overview of the Public Comments on the Advance Notice of Proposed Rulemaking

The Departments received approximately 200,000 comments in response to the ANPRM. Commenters represented a wide variety of stakeholders, including religious groups; religiously affiliated educational institutions, health care organizations, charities, and associations; civil rights organizations; consumer groups; group health plan sponsors and administrators; third party administrators and other

⁵ The 2012 final rules were published on February 15, 2012 (77 FR 8725).

⁶ Guidance on the Temporary Enforcement Safe Harbor for Certain Employers, Group Health Plans, and Group Health Insurance Issuers with Respect to the Requirement to Cover Contraceptive Services Without Cost Sharing Under Section 2713 of the Public Health Service Act, Section 715(a)(1) of the Employee Retirement Income Security Act, and Section 9815(a)(1) of the Internal Revenue Code, issued on February 10, 2012, and reissued on August 15, 2012. Available at: <http://ccio.cms.gov/resources/files/prev-services-guidance-08152012.pdf>. The guidance, as reissued on August 15, 2012, clarifies, among other things, that group health plans that took some action before February 10, 2012, to try, without success, to exclude or limit contraceptive coverage are not precluded from eligibility for the safe harbor.

⁷ See final rule on student health insurance coverage published by HHS on March 21, 2012 (77 FR 16456 and 16457).

⁸ In these proposed rules, any proposed accommodation specific to a religious institution of higher education is intended to accommodate the religious institution of higher education only with respect to its arrangement of student health insurance coverage. With respect to the establishment or maintenance of a group health plan by a religious institution of higher education, the religious institution of higher education is intended to be accommodated the same way as any other religious organization that has established or maintained a group health plan.

plan service providers; health insurance issuers; law and public policy organizations; states; secular organizations; private citizens; and women's rights and reproductive health advocacy organizations.

Comments addressed both the religious employer exemption and the suggested accommodations, among other issues. Although the Departments do not separately address each comment received, the significant issues raised in the comments are summarized in this section. The Departments considered these comments in developing the policies in these proposed rules.

A. Comments on the Religious Employer Exemption

Some commenters asserted that the definition of religious employer as formulated in the 2012 final rules is too narrow. Some of these commenters expressed concern that the group health plans of a number of religious employers, including houses of worship, do not qualify for the exemption because the employers' purposes extend beyond the inculcation of religious values or because the employers serve or hire people of different religious faiths. Commenters noted that employers may not know the religious beliefs of those they serve or hire, and that employment discrimination laws may prohibit them from inquiring about the religious beliefs of their employees. Other commenters expressed concern that the definition of religious employer is not broad enough to allow them to continue their current exclusion of contraceptive services from coverage under their group health plans and warned that, if the definition of religious employer is not broadened, they could cease to offer health coverage to their employees in order to avoid having to offer coverage to which they object on religious grounds.

Commenters also asserted that federal laws, including the Affordable Care Act, provide for conscience clauses and religious exemptions broader than the religious employer exemption provided for in the 2012 final rules. Other commenters asserted that the narrow scope of the exemption raises concerns under the First Amendment and the Religious Freedom Restoration Act (RFRA). Some commenters asserted that the criteria for

the religious employer exemption could result in excessive government entanglement in religion. Several commenters expressed concern that the definition of religious employer sets a precedent for use in other areas of federal and state law. These commenters urged that the definition of religious employer be broadened such that more group health plans may qualify for the exemption.

Other commenters, however, disputed claims that the contraceptive coverage requirement infringes on rights protected by the First Amendment or RFRA, noting that the requirement is neutral and generally applicable. They also explained that the requirement does not substantially burden religious exercise and, in any event, serves compelling governmental interests and is the least restrictive means to achieve those interests.

Some commenters supported the inclusion of contraceptive services in the HRSA Guidelines and urged that the Departments not broaden the religious employer exemption. These commenters asserted that the definition of religious employer is appropriately targeted at houses of worship and argued that making contraceptive coverage available to as many women as possible would enhance access to important preventive health care services and would significantly reduce long-term health care costs and consequences associated with unplanned pregnancies. These commenters asserted that expanding the exemption would undermine the benefits of the law. Some commenters believed that the exemption should be eliminated entirely due to the importance of extending these benefits to as many women as possible.

Several commenters requested clarification as to whether, if employees of multiple employers are covered under a single group health plan, each employer must independently meet the definition of religious employer for the plan to qualify for the exemption.

B. Comments on the Suggested Accommodations for Health Coverage Established or Maintained by Religious Organizations or Arranged by Religious Institutions of Higher Education

Several commenters asserted that the suggested accommodations described in

the ANPRM would fail to adequately accommodate religious objections to contraceptive coverage. These commenters emphasized that, in their view, religious organizations would continue to be involved, whether directly or indirectly, in providing coverage for services that they find religiously objectionable. For example, with respect to insured group health plans, these commenters disputed the claim that contraceptive coverage is at least cost neutral and argued that plan sponsors would end up funding the coverage in the form of higher premiums or fees. These commenters generally argued that, in order to provide adequate relief, the Departments would need to rescind the contraceptive coverage requirement in its entirety, provide an exemption for the group health plan of any organization with a religious or moral objection to contraceptive coverage, or provide government funding for provision of contraceptive services.

Other commenters recommended that the Departments expand the suggested accommodations to encompass the group health plans of a broader class of religiously affiliated organizations. Several commenters stated that the rules should accommodate all organizations with a religious or moral objection to contraceptive coverage, whether the organization is religious or secular, or nonprofit or for-profit, among other potential distinctions. These commenters also argued that an accommodation should be available without regard to whether an organization has covered contraceptive services in its group health plan in the past.

Some commenters recommended using criteria in other federal laws, such as the National Labor Relations Act, for determining whether the group health plan of an organization qualifies for an accommodation. Some commenters suggested accommodating the group health plans of religiously affiliated organizations recognized as tax-exempt under an IRS group ruling.

In contrast, other commenters urged that any accommodation apply only to health coverage established or maintained by a limited class of religiously affiliated organizations or arranged by a limited class of religiously affiliated institutions of higher education. For example, several commenters suggested limiting any accommodation to only health coverage

established or maintained by nonprofit organizations owned or controlled by a church, association of churches, or religious order, or arranged by nonprofit institutions of higher education owned or controlled by a religious organization as defined for purposes of Title IX of the Education Amendments of 1972. These commenters also generally argued that health coverage established or maintained by for-profit organizations or arranged by for-profit institutions of higher education, or health coverage established or maintained by organizations, or arranged by institutions of higher education, that object to only some types of contraceptive services, should not qualify for an accommodation.

A number of commenters supported a self-certification process, similar to that used for the temporary enforcement safe harbor, for religious organizations seeking to avail themselves of an accommodation. Some commenters urged that the Departments adopt appropriate oversight and enforcement mechanisms to monitor compliance with the criteria for any accommodation and recommended self-certification as a tool to promote transparency and support compliance and enforcement. Other commenters suggested that the Departments consider any such self-certification to be conclusive to avoid inquiry into a religious organization's character, mission, or practices.

Comments were quite varied regarding the ANPRM's suggested approaches with respect to the provision of contraceptive coverage to participants and beneficiaries enrolled in self-insured group health plans established or maintained by religious organizations with religious objections to such coverage. Many commenters supported the general approach suggested in the ANPRM of ensuring that participants and beneficiaries enrolled in such self-insured plans receive contraceptive coverage without cost sharing. These commenters stated that any accommodation should not create delays in or barriers to contraceptive benefits, and that these benefits should be provided without participants and beneficiaries having to specifically elect such benefits.

Concerns were raised by some commenters about an objecting organization's

ability to not administer, facilitate, or otherwise involve itself in the provision of contraceptive coverage to such participants and beneficiaries. Many commenters were concerned about how third party administrators would be able to fund these benefits. They noted that drug rebates, one suggested source of funds, often belong to another entity (such as the plan sponsor and/or the plan participants and beneficiaries), not the third party administrator, and stated that, in their view, costs incurred by third party administrators would ultimately be passed on to plan sponsors and/or plan participants and beneficiaries unless a separate source of funding could be found, such as some form of public funding or stand-alone contraceptive coverage with no premium or cost sharing. Others raised questions about the responsibility for communications regarding contraceptive coverage. Some third party administrators were concerned about becoming surrogate insurers, which might subject them to the application of state insurance laws. At the same time, other commenters believed that, with funding, notice, and adequate claims information, contraceptive coverage could be administered effectively by third party administrators.

III. Provisions of the Proposed Rules

A. Overview

The Departments aim to secure the protections under section 2713 of the PHS Act that are designed to enhance coverage of important preventive services for women without cost sharing while accommodating the religious objections to contraceptive coverage of eligible organizations.

The Departments propose two key changes to the preventive services coverage rules codified in 26 CFR 54.9815–2713T, 29 CFR 2590.715–2713, and 45 CFR 147.130 to meet these goals. First, the proposed rules would amend the criteria for the religious employer exemption to ensure that an otherwise exempt employer plan is not disqualified because the employer's purposes extend beyond the inculcation of religious values or because the employer serves or hires people of different religious faiths. Second, the proposed rules would establish accommo-

dations for health coverage established or maintained by eligible organizations, or arranged by eligible organizations that are religious institutions of higher education, with religious objections to contraceptive coverage.

Amendments to rules concerning excepted benefits and Affordable Insurance Exchanges (Exchanges) are also proposed in connection with the proposed accommodations.

B. Explanation of Terms

In these proposed rules, all references to “contraceptive coverage” are references to coverage of the contraceptive services that are required to be covered without cost sharing in accordance with the HRSA Guidelines (that is, all FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity, as prescribed by a health care provider).

All references to “accommodation” are references to an arrangement under which contraceptive coverage is provided without cost sharing to plan participants and beneficiaries (or, in the case of student health insurance coverage, student enrollees and their covered dependents) independent of health coverage established or maintained or arranged by an objecting religious organization, including an objecting religious institution of higher education.

Finally, all references to “religious organization” and “religious institution of higher education” are references to the class of organizations and institutions of higher education that establish or maintain or arrange health coverage that qualifies for an accommodation. These organizations are collectively referred to as “eligible organizations” in these proposed rules.

C. Religious Employer Exemption and Accommodations for Health Coverage Established or Maintained or Arranged by Eligible Organizations

For purposes of organization and clarity, proposed 45 CFR 147.130(a)⁹ would provide that the requirement to provide coverage for recommended preventive ser-

⁹ For simplicity, this preamble refers only to provisions of 45 CFR 147.130. Parallel provisions to 45 CFR 147.130 are contained in 26 CFR 54.9815–2713T and 29 CFR 2590.715–2713.

VICES without cost sharing is subject to a new 45 CFR 147.131, which would establish standards and processes related to both the religious employer exemption and the accommodations for health coverage established or maintained or arranged by eligible organizations, as discussed in more detail later in this section.

Accordingly, the proposed rules would move to new 45 CFR 147.131¹⁰ the language currently in 45 CFR 147.130(a)(1)(iv)(A) and (B) (incorporated by reference in the rules of the Departments of Labor and the Treasury) that authorizes HRSA to exempt group health plans of religious employers (and group health insurance coverage provided in connection with such plans) from the contraceptive coverage requirement and that defines religious employer for this purpose, and would amend the authorization and definition as discussed later in this section.

1. Religious Employer Exemption

Currently, under the 2012 final rules, a religious employer is one that: (1) has the inculcation of religious values as its purpose; (2) primarily employs persons who share its religious tenets; (3) primarily serves persons who share its religious tenets; and (4) is a nonprofit organization described in section 6033(a)(1) and 6033(a)(3)(A)(i) or (iii) of the Code. Section 6033(a)(3)(A)(i) and (iii) of the Code refers to churches, their integrated auxiliaries, and conventions or associations of churches, as well as to the exclusively religious activities of any religious order. The Departments explained in the 2011 amended interim final rules that this definition was intended to focus the religious employer exemption on “the unique relationship between a house of worship and its employees in ministerial positions.”¹¹

Some commenters brought to the Departments’ attention that the group health plans of certain religious entities that meet the fourth prong of the definition of religious employer (providing that a religious employer is a nonprofit organization described in section 6033(a)(1) and (a)(3)(A)(i) or (iii) of the Code) may not qualify for the exemption because

those entities provide benevolent services to their communities. For example, if a church maintains a soup kitchen that provides free meals to low-income individuals irrespective of their religious faiths, it could fail to satisfy the third prong of the definition of religious employer (providing that a religious employer primarily serves persons who share its religious tenets). The same question could arise if a church runs a parochial school that employs people of different religious faiths.

The Departments agree that the exemption should not exclude group health plans of religious entities that would qualify for the exemption but for the fact that, for example, they provide charitable social services to persons of different religious faiths or employ persons of different religious faiths when running a parochial school. Indeed, this was never the Departments’ intention in connection with the 2011 amended interim final rules or the 2012 final rules. Accordingly, in 45 CFR 147.131(a) (and the related rules of the Departments of Labor and the Treasury), the Departments propose to amend the definition of religious employer that was adopted in the 2012 final rules by eliminating the first three prongs of the definition and clarifying the application of the fourth. Under this proposal, an employer that is organized and operates as a nonprofit entity and referred to in section 6033(a)(3)(A)(i) or (iii) of the Code would be considered a religious employer for purposes of the religious employer exemption. For this purpose, an organization that is organized and operates as a nonprofit entity is not limited to any particular form of entity under state law, but may include organizations such as trusts and unincorporated associations, as well as nonprofit, not-for-profit, non-stock, public benefit, and similar types of corporations. However, for this purpose, an organization is not considered to be organized and operated as a nonprofit entity if its assets or income accrue to the benefit of private individuals or shareholders. Under this standard, it is not necessary to determine the federal tax-exempt status of the nonprofit entity in determining whether the religious employer exemption applies. The Departments note that eliminating the

first three prongs would avoid any inquiry into an employer’s purposes, as well as any inquiry into the religious beliefs of its employees and the religious beliefs of those it serves.

The Departments believe that this proposal would not expand the universe of employer plans that would qualify for the exemption beyond that which was intended in the 2012 final rules. As previously noted, when the Departments first defined religious employer, the primary goal was to exempt the group health plans of houses of worship. Section 6033(a)(3)(A)(i) and (iii) of the Code refers to churches, their integrated auxiliaries, and conventions or associations of churches, as well as to the exclusively religious activities of any religious order. By restricting the exemption primarily to group health plans established or maintained by churches, synagogues, mosques, and other houses of worship, and religious orders, the fourth prong of the current definition of religious employer would alone suffice to meet the goal. By eliminating the first three prongs of the current definition, there no longer would be any question as to whether group health plans of houses of worship that provide educational, charitable, or social services to their communities qualify for the exemption.

The Departments welcome comments on this proposal, including whether it would unduly expand the universe of employer plans that would qualify for the exemption and whether additional or different language is needed to clarify the scope of the exemption.

2. Accommodations for Health Coverage Established or Maintained or Arranged by Eligible Organizations

In proposed 45 CFR 147.131(b) through (e) (and the related rules of the Departments of Labor and the Treasury) and as discussed later in this section, the Departments propose policies relating to the accommodation of certain group health plans and group health insurance coverage with respect to the contraceptive coverage requirement. The Departments propose a comparable accommodation with respect to student health insurance coverage

¹⁰ For simplicity, this preamble refers only to provisions of 45 CFR 147.131. Parallel provisions to 45 CFR 147.131 are contained in 26 CFR 54.9815–2713A and 29 CFR 2590.715–2713A.

¹¹ 76 FR 46623.

arranged by eligible organizations that are religious institutions of higher education. The Departments believe these proposed accommodations, as opposed to the exemption that is provided to religious employers, are warranted given that participants and beneficiaries in group health plans established or maintained by eligible organizations, as well as student enrollees and their covered dependents in student health insurance coverage arranged by eligible organizations, may be less likely than participants and beneficiaries in group health plans established or maintained by religious employers to share such religious objections of the eligible organizations. The proposed accommodations would provide such plan participants and beneficiaries contraceptive coverage without cost sharing while insulating their employers or institutions of higher education from contracting, arranging, paying, or referring for such coverage.

a. Definition of Eligible Organization

These proposed rules would provide that group health plans established or maintained by eligible organizations with religious objections to contraceptive coverage (and group health insurance coverage provided in connection with such plans), and student health insurance coverage arranged by eligible organizations that are religious institutions of higher education with such objections, comply with the requirement to provide coverage for contraceptive services under section 2713 of the PHS Act if the conditions of the accommodation are satisfied.

For purposes of these proposed rules only, the Departments propose to define an eligible organization as an organization that meets all of the following criteria:

- The organization opposes providing coverage for some or all of the contraceptive services required to be covered under section 2713 of the PHS Act on account of religious objections.
- The organization is organized and operates as a nonprofit entity.
- The organization holds itself out as a religious organization.
- The organization self-certifies that it satisfies the first three criteria, as described later in this section.

This proposed definition of eligible organization is intended to allow health coverage established or maintained or arranged by nonprofit religious organizations, including nonprofit religious institutional health care providers, educational institutions, and charities, with religious objections to contraceptive coverage to qualify for an accommodation. For this purpose, an organization that is organized and operated as a nonprofit entity is not limited to any particular form of entity under state law, but may include organizations such as trusts and unincorporated associations, as well as nonprofit, not-for-profit, non-stock, public benefit, and similar types of corporations. However, for this purpose an organization is not considered to be organized and operated as a nonprofit entity if its assets or income accrue to the benefit of private individuals or shareholders.

The Departments believe that the proposed definition of eligible organization would strike an appropriate balance because it would limit any accommodation to nonprofit organizations that hold themselves out as religious. The Departments solicit comments on whether the proposed definition of eligible organization would allow an appropriate universe of nonprofit religious organizations and institutions of higher education establishing or maintaining or arranging health coverage to qualify for an accommodation, including comments on whether it would be too broad or too narrow.

The Departments do not propose that the definition of eligible organization extend to for-profit secular employers. Religious accommodations in related areas of federal law, such as the exemption for religious organizations under Title VII of the Civil Rights Act of 1964, are available to nonprofit religious organizations but not to for-profit secular organizations. Accordingly, the Departments believe it would be appropriate to define eligible organization to include nonprofit religious organizations, but not to include for-profit secular organizations.

b. Self-Certification

Each organization seeking accommodation under the proposed rules would be required to self-certify that it meets the definition of eligible organization, fol-

lowing a self-certification process similar to that under the temporary enforcement safe harbor. The self-certification would also specify the contraceptive services for which the organization will not establish, maintain, administer, or fund coverage. The organization would not be required to submit the self-certification to any of the Departments. The organization would maintain the self-certification (executed by an authorized representative of the organization) in its records for each plan year to which the accommodation applies and make the self-certification available for examination upon request so that regulators, issuers, third party administrators, and plan participants and beneficiaries may verify that an organization has qualified for an accommodation, while avoiding any inquiry into the organization's character, mission, or practices. The Departments intend to specify in guidance the form to be used for the self-certification.

c. Separate Contraceptive Coverage Without Cost Sharing for Plan Participants and Beneficiaries

These proposed rules aim to provide women with contraceptive coverage without cost sharing and to protect eligible organizations from having to contract, arrange, pay, or refer for contraceptive coverage to which they object on religious grounds.

1. Insured Plans

To achieve these goals, under HHS's authority in section 2792 of the PHS Act to promulgate rules "necessary or appropriate" to carry out the provisions of title XXVII of the PHS Act, and the parallel authorities of the Department of Labor in section 734 of ERISA and the Department of the Treasury in section 9833 of the Code, these proposed rules would provide that, in the case of an insured group health plan established or maintained by an eligible organization, the health insurance issuer providing group coverage in connection with the plan would assume sole responsibility, independent of the eligible organization and its plan, for providing contraceptive coverage without cost sharing, premium, fee, or other charge to plan participants and beneficiaries.

The eligible organization would provide the issuer with a copy of its self-cer-

tification. If the plan uses a separate issuer for certain coverage, such as prescription drug coverage, the eligible organization may also need to provide a copy of its self-certification to the separate issuer. Nothing more would be required of the eligible organization to qualify for the accommodation.

The proposed rules would direct the issuer receiving the copy of the self-certification to ensure that the coverage for those contraceptive services identified in the self-certification is not included in the group policy, certificate, or contract of insurance; that such coverage is not reflected in the group health insurance premium; and that no fee or other charge in connection with such coverage is imposed on the eligible organization or its plan.

The proposed rules would further direct the issuer receiving the copy of the self-certification to provide contraceptive coverage under individual policies, certificates, or contracts of insurance (hereinafter referred to as individual health insurance policies) for plan participants and beneficiaries without cost sharing, premium, fee, or other charge. The coverage would not be offered by or through a group health plan. (As discussed later in this section, the Departments propose that this type of individual health insurance policy be a new category of excepted benefits.)

The issuer would automatically enroll plan participants and beneficiaries in a separate individual health insurance policy that covers recommended contraceptive services. The Departments envision that the issuer would ensure that contraceptive coverage for plan participants and beneficiaries is effective at the beginning of the plan year of their group health plan, to the extent possible, to prevent a delay or gap in contraceptive coverage. The eligible organization would have no role in contracting, arranging, paying, or referring for this separate contraceptive coverage. Such coverage would be offered at no charge to plan participants and beneficiaries, that is, the issuer would provide benefits for such contraceptive services without the imposition of any cost sharing requirement (such as a copayment, coinsurance, or a deductible), premium, fee, or other charge, consistent with section 2713 of the PHS

Act. The requirements of section 2713 of the PHS Act, its implementing regulations, and other applicable federal and state law (as well as their enforcement mechanisms) would continue to apply with respect to such coverage. For example, an issuer providing such coverage could use reasonable medical management techniques consistent with 45 CFR 147.130(a)(4).

The Departments believe that, in the case of insured group health plans, this proposed arrangement would alleviate the need for the eligible organization to contract, arrange, pay, or refer for contraceptive coverage while providing contraceptive coverage to plan participants and beneficiaries at no additional cost. Actuaries, economists, and insurers estimate that providing contraceptive coverage is at least cost neutral, and may result in cost-savings when taking into account all costs and benefits for the insurer.¹² In this instance, contraceptive coverage without cost sharing would be provided to plan participants and beneficiaries through individual health insurance policies, separate from the group policy through which all other coverage would be provided to plan participants and beneficiaries. The Departments believe that issuers generally would find that providing such contraceptive coverage is cost neutral because they would be insuring the same set of individuals under both policies and would experience lower costs from improvements in women's health and fewer childbirths.

The Departments note that a health insurance issuer providing coverage in connection with a plan established or maintained by an eligible organization would be held harmless under the accommodation if a representation by the organization to the issuer that the organization is an eligible organization on which the issuer relied in good faith were determined later to be incorrect. Conversely, the eligible organization and its plan would be held harmless if the issuer were to fail to comply with the requirement that it provide separate contraceptive coverage for plan participants and beneficiaries at no charge.

The Departments request comments on this proposed arrangement.

2. *Self-Insured Plans*

The Departments are considering alternative approaches for providing participants and beneficiaries in self-insured group health plans established or maintained by eligible organizations with contraceptive coverage at no additional cost, while protecting the eligible organizations from having to contract, arrange, pay, or refer for such coverage. Under each of these approaches, a health insurance issuer that provides individual health insurance policies for contraceptive coverage for plan participants and beneficiaries at no additional cost would be able to offset the costs of providing such coverage by claiming an adjustment in Federally-facilitated Exchange (FFE) user fees that would reduce the amount of the such fees for the issuer (or an affiliated issuer), as discussed later in this section. The Departments envision that the issuer would ensure that contraceptive coverage for plan participants and beneficiaries is effective at the beginning of the plan year of their group health plans, to the extent possible, to prevent a delay or gap in contraceptive coverage. Under each of these approaches, HHS would assist in identifying issuers offering the separate individual health insurance policies for contraceptive coverage.

Under all approaches, if there is a third party administrator for the self-insured group health plan of the eligible organization, the eligible organization would provide the third party administrator with a copy of its self-certification. If the plan uses a separate third party administrator for certain coverage, such as prescription drug coverage, the eligible organization would also provide a copy of its self-certification to the separate third party administrator if the coverage administered by the separate third party administrator includes coverage of any contraceptive service listed in the self-certification.

Further, under all approaches, a third party administrator receiving a copy of the self-certification would automatically arrange separate individual health insurance policies for contraceptive coverage from an issuer providing such policies, as described above. The issuer providing the

¹² Bertko, John, F.S.A., M.A.A.A., Director of Special Initiatives and Pricing, Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services, Glied, Sherry, Ph.D., Assistant Secretary for Planning and Evaluation, Department of Health and Human Services (ASPE/HHS), et al., "The Cost of Covering Contraceptives Through Health Insurance," (February 9, 2012), available at: <http://aspe.hhs.gov/health/reports/2012/contraceptives/tb.shtml>.

coverage (or an affiliated issuer) would receive an additional adjustment in the user fees that otherwise would be charged by an FFE in an amount that would offset a reasonable charge by the third party administrator for performing this service. In turn, the issuer would be required to pass the amount of this additional adjustment in FFE user fees on to the third party administrator as a condition of receiving any FFE user fee adjustment, and would be required to attest to HHS that it has in fact passed the amount of this additional adjustment on to the third party administrator. As a condition of payment of this amount by the issuer, the third party administrator would not be permitted to charge any amount to the eligible organization, its plan, or to plan participants or beneficiaries for performing the service. The Departments note that the issuer could either be affiliated with or be independent of the third party administrator.

The Departments solicit comment on which of the proposed approaches below would best provide participants and beneficiaries in self-insured group health plans established or maintained by eligible organizations with contraceptive coverage at no additional cost, while protecting eligible organizations from having to contract, arrange, pay, or refer for such coverage. The Departments also request comment on whether there are other approaches that should be considered that would achieve the same goals.

Under the first approach, a third party administrator receiving the copy of the self-certification would have an economic incentive to voluntarily arrange for the separate individual health insurance policies for contraceptive coverage for plan participants and beneficiaries because it would be compensated for a reasonable charge for automatically arranging for the contraceptive coverage through payment by the issuer of the contraceptive coverage. Under this approach, in automatically arranging for the contraceptive coverage, the third party administrator would be acting, not as the third party administrator to the self-insured plan of the eligible organization, but rather in its independent

capacity apart from its capacity as the agent of the plan. Under this approach, the self-insured plan of the eligible organization would be treated as complying with the requirement to provide contraceptive coverage based on the third party administrator's receipt of the copy of the self-certification.

Under the second approach, coverage under the plan of the eligible organization would comply with the requirement to provide contraceptive coverage without cost sharing only if the third party administrator administering coverage in connection with the plan automatically arranges for an issuer to assume sole responsibility for providing separate individual health insurance policies offering contraceptive coverage without cost sharing, premium, fee, or other charge to plan participants and beneficiaries, the eligible organization, or its plan. As discussed above, any reasonable administrative costs of the third party administrator in performing this service would be covered through payment by the issuer of the contraceptive coverage. If the third party administrator performs the services, coverage under the plan of the eligible organization would comply with 45 CFR 147.130. While the third party administrator would not be directly responsible for assuring compliance with section 2713 of the PHS Act, the Departments expect that third party administrators would seek to assist eligible organizations such that eligible organizations would be able to avail themselves of the proposed accommodation.

Under the third approach, the third party administrator receiving the copy of the self-certification would be directly responsible for automatically arranging for contraceptive coverage for plan participants and beneficiaries. Specifically, the self-certification would have the effect of designating the third party administrator¹³ as the plan administrator under section 3(16) of ERISA solely for the purpose of fulfilling the requirement that the plan provide contraceptive coverage without cost sharing. The third party administrator would satisfy its responsibility to automatically arrange for contraceptive coverage

for plan participants and beneficiaries by arranging for an issuer to assume sole responsibility for providing separate individual health insurance policies offering contraceptive coverage without cost sharing, premium, fee, or other charge to plan participants and beneficiaries, the eligible organization, or its plan. The Departments note that there would be no obligation on a third party administrator to enter into or continue a third party administration contract with an eligible organization if the third party administrator were to object to having to carry out this responsibility. Although this approach would place the legal responsibility for assuring compliance with section 2713 of the PHS Act solely on the third party administrator, it would have legal implications under ERISA's reporting, disclosure, claims processing, and fiduciary provisions for both the third party administrator and the eligible organization. The Departments seek comment specifically on potential issues arising under ERISA if the third party administrator were to become the designated plan administrator under section 3(16) of ERISA, and therefore a plan fiduciary, even for the limited purposes contemplated.

The Departments also seek comment on whether there is a need to provide an accommodation for self-insured plans of eligible organizations without third party administrators, and, if so, how best to ensure that participants and beneficiaries in such plans receive separate contraception coverage without cost sharing. No comments were submitted in response to the request in the ANPRM on the extent to which there are such plans without a third party administrator. The Departments continue to believe that there are very few, if any, self-insured plans of eligible organizations in this circumstance.

The Departments solicit comment on these alternative approaches.

3. Notice of Availability of Contraceptive Coverage and Coordination of Benefits

The proposed rules would direct a health insurance issuer providing separate individual health insurance policies for contraceptive coverage at no additional

¹³ To the extent the plan uses more than one third party administrator (for example, one pharmacy benefit manager (PBM) to handle claims administration for prescription drugs and another entity to handle claims for inpatient and outpatient medical/surgical benefits), each third party administrator would become the plan administrator upon receiving the copy of the self-certification with respect to the types of claims that it normally processes (that is, the PBM would continue to handle claims for prescription drugs and the other entity would continue to handle claims for inpatient and outpatient medical/surgical benefits), and each would do so in accordance with section 2713 of the PHS Act (even if plan terms might otherwise provide differently) as plan administration with an independent funding source.

cost to participants and beneficiaries in plans of eligible organizations to provide a written notice to plan participants and beneficiaries regarding the availability of the separate contraceptive coverage. Issuers providing such contraceptive coverage would be responsible for providing the notice of availability of such coverage to participants and beneficiaries in both insured and self-insured group health plans of eligible organizations. The notice would be provided directly to plan participants and beneficiaries by the issuer, separate from but contemporaneous with (to the extent possible) any application materials distributed in connection with enrollment (or re-enrollment) in group coverage established, maintained, or arranged by the eligible organization in any plan year to which the accommodation is to apply. As such, this notice generally would be provided annually. To satisfy the proposed notice requirement, issuers could use the model language set forth in the proposed rules or substantially similar language. The Departments request comments on the proposed notice requirement, including ways to improve the proposed model language, the timing and delivery (including electronically) of the notice to plan participants and beneficiaries, and whether this notice requirement could be combined with other existing notice requirements to simplify administration for issuers.

The Departments also seek comment on whether there are efficient ways to limit the benefits provided under the separate individual health insurance policies for contraceptive coverage to match the contraceptive benefits identified in the self-certification or whether the separate individual health insurance policies for contraceptive coverage should simply cover the full set of recommended contraceptive services. One option would be to require coordination of benefits such that the contraceptive coverage is secondary to the coverage provided by the group health plan established or maintained by the eligible organization (and any group health insurance coverage provided in connection with the plan). The Departments solicit comment on this issue.

d. Adjustments of Federally-Facilitated Exchange (FFE) User Fees

To fund contraceptive coverage for participants and beneficiaries in self-insured plans established or maintained by eligible organizations at no cost to plan participants or beneficiaries, HHS proposes that the existing proposed FFE user fee calculation, set forth in the December 7, 2012 proposed rule titled “Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014” (77 FR 73213), take into account that an issuer that offers a qualified health plan (QHP) through an FFE (or an affiliated issuer in a state without an FFE) provides such contraceptive coverage by reducing the amount of the user fee.

Consistent with Office of Management and Budget (OMB) Circular No. A25-R, the proposed revised FFE user fee calculation (which would result in an adjustment of the FFE user fee) would facilitate the proposed accommodation of self-insured plans established or maintained by eligible organizations by ensuring that plan participants and beneficiaries have separate individual health insurance policies for contraceptive coverage at no additional cost such that eligible organizations are not required to administer or fund such coverage. It would thereby support many of the goals of the Affordable Care Act, including improving the health of the population, reducing health care costs, providing access to health coverage, encouraging eligible organizations to continue to offer health coverage, and ensuring access to affordable QHPs via efficiently operated Exchanges. Moreover, as described in the 2012 final rules and the ANPRM, there are significant benefits associated with contraceptive coverage without cost sharing. Such contraceptive coverage significantly furthers the governmental interests in promoting public health and in promoting gender equality.

Under this proposal, the FFE user fee calculation would take into account contraceptive coverage that is provided by an issuer in a state without an FFE so long as the issuer is affiliated with an issuer that offers a QHP through an FFE.¹⁴ The affiliated issuer would not be required to be a QHP issuer. An issuer that provides con-

traceptive coverage in a state without an FFE could offset the estimated cost of such coverage through an affiliated QHP issuer in a state with an FFE. This would encourage issuers to provide this type of coverage widely, to meet the goal of providing all plan participants and beneficiaries of self-insured plans established or maintained by eligible organizations with separate contraceptive coverage without cost sharing.

HHS proposes that, in order for the FFE user fee calculation to take into account that a QHP issuer (or an affiliated issuer) provides contraceptive coverage, the issuer providing coverage for contraceptive services for the plan participants and beneficiaries of a self-insured plan established or maintained by an eligible organization must provide coverage for all recommended contraceptive services identified in the self-certification of the eligible organization, and do so without cost sharing, premiums, fees, or other costs to the plan participants and beneficiaries. It also must pay the reasonable charge of third party administrators. The contraceptive coverage would be subject to all applicable federal and state laws, including state filing and rate review requirements. HHS seeks comment on ways to streamline the regulatory processes for, and minimize the costs of, obtaining approval of such coverage in all states.

HHS further proposes that, if an issuer provides contraceptive coverage to plan participants and beneficiaries of self-insured plans of eligible organizations at no additional cost, and it, or another issuer in the same issuer group, is required to pay an FFE user fee, an adjustment in the FFE user fee may be sought for the estimated cost of the contraceptive coverage. HHS would use the definition of issuer group proposed at 45 CFR 156.20 for this purpose. That section proposes that issuer group means all entities treated under section 52(a) or (b) of the Code as a member of the same controlled group of corporations as (or under common control with) a health insurance issuer, or issuers affiliated by the common use of a nationally licensed service mark. HHS seeks comment on whether this definition would provide the appropriate amount of flexibility

¹⁴ For simplicity, the discussion that follows uses the shorthand “contraceptive coverage” to refer to contraceptive coverage for participants and beneficiaries in self-insured plans established or maintained by eligible organizations at no cost to plan participants or beneficiaries.

in calculating the FFE user fee to correctly reflect the costs of issuers in states without an FFE, and on the advantages and disadvantages of permitting an adjustment in the FFE user fee with respect to unaffiliated issuers.

Under this proposal, the issuer providing the contraceptive coverage would provide certain information and documentation (jointly with the affiliated QHP issuer if applicable) to HHS. First, monthly data on the number of individuals for whom the contraceptive coverage is being provided would be submitted, along with an attestation that a copy of the self-certification of the eligible organization was provided by the third party administrator that arranged for the coverage for the plan participants and beneficiaries. Second, the issuer(s) would be required to provide an attestation that coverage for all recommended contraceptive services identified in the self-certification of the eligible organization is being provided, and being provided without cost sharing, premiums, fee, or other costs to the plan participants or beneficiaries. The issuer also would attest to HHS that it passed the portion of its adjustment attributable to reasonable charges by third party administrators on to those parties. Third, the issuer(s) would be required to identify the QHP(s) being offered through an FFE with respect to which the FFE user fee adjustment is to be made. In addition, if the issuer providing the contraceptive coverage is not the QHP issuer for which the adjustment in the FFE user fee is being sought, HHS proposes to require an attestation that the issuers are from the same issuer group. Finally, the issuer(s) would be required to submit to HHS an estimate of the cost of the contraceptive coverage, along with data or documentation supporting that estimate. HHS approval of the cost estimate would be required before a QHP issuer could receive an FFE user fee adjustment. HHS solicits comment on whether additional information or attestations should be required of issuers, for example, whether issuers should be required to attest that they provided the required notice of availability of contraceptive coverage to plan participants and beneficiaries.

HHS is considering two approaches to ensuring that the cost estimate reasonably reflects the cost of the contraceptive coverage. One approach would require the issuer(s) to submit to HHS the estimated

per capita cost of the contraceptive coverage, as well as an actuarial memorandum prepared by a member of the American Academy of Actuaries in accordance with generally accepted actuarial principles and methodologies validating the estimate. HHS seeks comment on appropriate standards to guide such calculations. Under this approach, HHS expects that, in 2016 and beyond, the estimated cost of providing the contraceptive coverage would be based on the issuer's experience in previous years.

HHS also proposes that the estimate of the cost of the contraceptive coverage could include a reasonable charge for the issuer's administrative costs, including the costs of obtaining regulatory approval of the contraceptive coverage policy in the applicable state as well as a third party administrator's charge. HHS seeks comment on the magnitude of a reasonable administrative charge. HHS recognizes that the contraceptive coverage that issuers would provide under this proposed accommodation could see limited enrollment in a particular state. Given the potentially narrow markets available to the issuers of the contraceptive coverage, the *per capita* cost of administering this type of coverage may be higher than that for major medical coverage or other excepted benefits. On the other hand, given that a third party administrator would be connecting the plan participants and beneficiaries with the issuer, and there would therefore be reduced marketing costs, the administrative costs could be lessened. HHS seeks comment on the appropriate magnitude of these administrative costs generally, as well as ways of minimizing the administrative costs. In particular, HHS notes the issues associated with reimbursing for fixed costs, including the cost of obtaining regulatory approval for the policy in the applicable state. Fixed administrative costs could be amortized across the expected life of the policy, or could be reimbursed in the first year of operation. HHS seeks comment on the appropriate manner of compensating for such costs.

HHS also seeks comment on whether HHS should limit the number of issuers providing the contraceptive coverage in each state with respect to which an FFE user fee adjustment may be made. If HHS were to modify its proposal in this way, HHS would add that an issuer must be will-

ing and have the ability to offer the contraceptive coverage to any participant or beneficiary in a self-insured plan of an eligible organization who resides in the state.

HHS notes that the estimate of the cost of the contraceptive coverage could include a reasonable margin. HHS seeks comment on the magnitude of a reasonable margin, and notes that the proposed HHS Notice of Benefit and Payment Parameters for 2014 proposes a presumed margin of 3 percent within allowable administrative costs for the risk corridors program.

The proposed inclusion of reasonable administrative costs and margin in the estimate of the cost of the contraceptive coverage is intended to ensure that issuers receive reasonable compensation for providing the contraceptive coverage, as they would expect to receive in their other commercial businesses. HHS would review the submission by the issuer(s) to ensure that the cost estimate reflects reasonable assumptions and was calculated in accordance with applicable standards and generally accepted actuarial principles and methodologies. HHS would multiply the estimated *per capita* cost of the contraceptive coverage by the number of individuals being provided the contraceptive coverage each month in order to determine the magnitude of the FFE user fee adjustment. The amount should also take into account the reasonable administrative charges of third party administrators.

Alternatively, HHS could provide a national *per capita* estimate for the cost of the contraceptive coverage, which would also include adjustments for reasonable administrative costs and margin. This estimate could then be multiplied by the monthly enrollment in the contraceptive coverage in order to determine the magnitude of the FFE user fee adjustment for each QHP issuer concerned. This latter approach would provide for a more standardized approach, but could result in FFE user fee adjustments that do not fund the entire cost of the contraceptive coverage for some issuers, or that overcompensate other issuers. The former approach, however, would place a greater administrative burden on issuers, and would require a more in-depth review by HHS. HHS seeks comment on these two approaches, as well as alternative approaches for determining the estimated cost of the contraceptive coverage.

In both approaches to establishing an estimated cost of providing the contraceptive coverage described above, HHS seeks comment on the appropriate manner of accounting for a third party administrator's administrative costs of arranging for the contraceptive coverage in the issuer's estimated cost of the contraceptive coverage. For example, a flat administrative fee approved by HHS could be included in that estimated cost — with that flat administrative fee including an appropriate margin for the third party administrator. However, such an approach risks providing over- or under-incentives to the third party administrator for arranging for the contraceptive coverage, if the flat administrative fee is too high or too low. Alternatively, the third party administrator's actual reasonable charge, or actual reasonable administrative costs, for arranging the contraceptive coverage could be included in the estimated cost of the contraceptive coverage. HHS seeks comment on these and other approaches to estimating the third party administrator's administrative costs, and how HHS may ensure that they reflect reasonable administrative costs.

HHS proposes that, if the information described previously is provided and the cost estimate is approved, the FFE user fee will be reduced for the issuer of the identified QHP(s) by the amount of the approved estimate of the cost of the contraceptive coverage (multiplied by enrollment in the coverage for the month). While a highly unlikely occurrence given the relatively small population under consideration, HHS proposes that, if the amount of the adjustment is greater than the amount of the obligation to pay the FFE user fee in a particular month, the issuer of the identified QHP(s) will be provided a credit for the FFE user fee charged in succeeding months in the amount of the excess, consistent with OMB Circular No. A25-R. HHS seeks comment on whether a QHP issuer's FFE user fee should be adjusted for any excess in succeeding months at all; whether, if a QHP issuer's FFE user fee is adjusted for any excess in succeeding months, any time limit should be placed on how much later the adjustment should take place; and alternative methods of compensating an issuer with greater contraceptive coverage costs than its (or its affiliated QHP issuer's) FFE user fees.

HHS also proposes that an issuer providing contraceptive coverage for which the FFE user fee has been adjusted (whether the adjustment was provided to the issuer or an affiliated QHP issuer) must maintain for 10 years and make available to HHS upon request: documentation demonstrating that the contraceptive coverage was provided to participants or beneficiaries in a self-insured plan of an eligible organization, as evidenced by the copy of the self-certification that was provided by the third party administrator that arranged for such coverage; documentation demonstrating that the contraceptive coverage was provided without the imposition of any cost sharing, premium, fee, or other charge; documentation or data supporting the estimate of the cost of the contraceptive coverage; and documentation or data on the actual cost of providing the contraceptive coverage. This record-keeping requirement is consistent with timeframes under the False Claims Act, 31 U.S.C. 3729–3733. HHS is considering mechanisms for ensuring program integrity with respect to the provision of the contraceptive coverage under this proposed accommodation. These mechanisms may include requiring cooperation with audits and investigations, and requiring corrective action. HHS seeks comment on the oversight requirements that should be implemented with respect to the contraceptive coverage under this proposal.

Finally, HHS is proposing that a QHP issuer that is to receive an FFE user fee adjustment as described above prior to January 1, 2014, will be provided a credit in the amount of the adjustment beginning in January 2014. HHS seeks comment on issuers' ability to fund the contraceptive coverage under the proposal between the end of the temporary enforcement safe harbor and December 31, 2013, if HHS is not able to provide the FFE user fee adjustment until January 2014.

The Departments also seek comment on alternative ways to finance separate contraceptive coverage without cost sharing with respect to participants and beneficiaries in self-insured plans of eligible organizations.

e. Treatment of Multiple Employer Group Health Plans

The Departments recognize that, in some instances, several affiliated employers — only some of which are eligible organizations or religious employers — offer health coverage to their employees and their covered dependents through a single group health plan. The Departments considered allowing all employers in such instances to qualify for an accommodation or the religious employer exemption if any single employer met the definition of eligible organization or religious employer. Alternatively, the Departments considered precluding all employers in such instances from qualifying for an accommodation or the religious employer exemption if any single employer failed to meet the definition of eligible organization or religious employer.

The Departments propose to make the accommodation or the religious employer exemption available on an employer-by-employer basis. That is, each employer would have to independently meet the definition of eligible organization or religious employer in order to take advantage of the accommodation or the religious employer exemption with respect to its employees and their covered dependents. Conversely, an employer that did not meet the definition of eligible organization or religious employer could not take advantage of the accommodation or the religious employer exemption with respect to its employees and their covered dependents. This approach would prevent what could be viewed as a potential way for employers that are not eligible for the accommodation or the religious employer exemption to avoid the contraceptive coverage requirement by offering coverage in conjunction with an eligible organization or religious employer through a common plan. The Departments seek comment on this approach, including comments on the extent to which an employer-by-employer approach would pose administrative challenges for plans and issuers, as well as comments on alternative approaches.

f. Student Health Insurance Coverage

Many institutions of higher education administer programs that provide students and their dependents with access to health

coverage. Some institutions of higher education sponsor self-insured student health plans, but the vast majority of student health plans are insured, meaning that a health insurance issuer contracts with the institution of higher education to issue a blanket health insurance policy, from which students can buy coverage. Under final rules published by HHS on March 21, 2012, student health insurance coverage is a type of individual health insurance coverage offered to students and their covered dependents under a written agreement between an institution of higher education and an issuer.¹⁵

Some religiously affiliated colleges and universities object to signing a written agreement for student health insurance coverage that provides benefits for contraceptive services. Such colleges and universities sometimes include funding for student health plans in their student financial aid packages and object to funding student health plans that include coverage for contraceptive services.

The proposed rules would provide for an accommodation for student health insurance coverage arranged by a nonprofit religious institution of higher education with religious objections to contraceptive coverage comparable to the proposed accommodation for group health insurance coverage provided in connection with a group health plan established or maintained by a nonprofit religious organization with religious objections to contraceptive coverage. Accordingly, among other things, upon receiving a copy of the self-certification from an institution of higher education that meets the criteria for being an eligible organization, an issuer offering student health insurance coverage would provide contraceptive coverage, without cost sharing or additional premium, fee, or other charge, directly to student enrollees and their covered dependents, independent of the issuer's written agreement with the institution of higher education to offer the student health plan. The Departments solicit comments on this proposal.

g. Contraceptive-Only Excepted Benefits

In order to implement the proposed accommodations, it would be necessary and appropriate to establish a new contraceptive-only excepted benefits category. Sections 2722(c)(2) and 2763(b) of the PHS Act provide that the requirements of parts A and B of title XXVII of the PHS Act do not apply to any individual health insurance coverage in relation to its provision of excepted benefits described in section 2791(c)(2) of the PHS Act if the benefits are provided under a separate policy, certificate, or contract of insurance. Section 2791(c)(2) of the PHS Act provides that this category of excepted benefits includes limited scope dental or vision benefits, as well as benefits for long-term care, nursing home care, home health care, or community-based care, or any combination thereof. The law authorizes similar limited benefits to be specified in rule as excepted benefits. Additionally, section 2792 of the PHS Act authorizes HHS to promulgate such rules as may be necessary or appropriate to carry out the provisions of title XXVII of the PHS Act. Parallel provisions in section 734 of ERISA and section 9833 of the Code do the same with respect to the Departments of Labor and the Treasury.

Pursuant to the authority in section 2791(c)(2) of the PHS Act (and companion provisions in ERISA and the Code), the proposed rules would provide that benefits for contraceptive services only, when provided under a separate individual market health insurance policy, certificate, or contract of insurance constitute excepted benefits (subject to the conditions discussed later in this section). The Departments propose to establish this new category of excepted benefits to ensure that individual health insurance policies providing contraceptive coverage offered by an issuer pursuant to the proposed accommodations are not subject to certain generally applicable PHS Act and Affordable Care Act requirements, such as guaranteed availability (section 2702 of the PHS Act) given the unique nature of this coverage. Thus, for example, while issuers would offer this coverage to plan participants and beneficiaries in plans

established or maintained by eligible organizations, issuers would not be required to make this coverage available to all other individuals in a state. These proposed amendments are reflected in proposed 45 CFR 148.220(b).

Notwithstanding this proposed excepted benefits status, the Departments believe that a core set of basic consumer protection requirements should apply to individual health insurance policies providing contraceptive-only coverage. This core set of consumer protection requirements would be drawn from the broader set of requirements applicable to individual health insurance coverage under the PHS Act. This core set would include the requirements regarding guaranteed renewability of coverage (section 2703 of the PHS Act), the prohibition against lifetime and annual dollar limits on benefits (section 2711 of the PHS Act), the prohibition against rescissions of coverage (section 2712 of the PHS Act), and internal appeals and external review rights (section 2719 of the PHS Act). Accordingly, pursuant to the authority in section 2792 of the PHS Act to promulgate rules that are "necessary or appropriate" to carry out section 2713 of the PHS Act (and companion provisions in ERISA and the Code), the proposed rules would require compliance with these provisions of federal law as a condition of excepted benefits status. The Departments welcome comments on which requirements of the PHS Act, ERISA, and the Code should or should not apply to individual health insurance policies that provide contraceptive-only coverage. We also seek comments on how to simplify the establishment of these products and how best to ensure their availability in all states, including alternatives to excepted benefits in any state without any such product.

D. No Effect on Other Law

The religious employer exemption and accommodations in these proposed rules are intended to have meaning solely with respect to the contraceptive coverage requirement under section 2713 of the PHS Act and the companion provisions of ERISA and the Code. Whether

¹⁵ Because student health plans are not employment-based, they are not group health plans under federal law. Section 2791(a)(1) of the PHS Act defines "group health plan" as an employee welfare benefit plan as defined in section 3(1) of ERISA to the extent that the plan provides medical care to employees and their dependents directly or through insurance, reimbursement, or otherwise.

an employer or organization (including an institution of higher education) is designated as “religious” for these purposes is not intended as a judgment about the mission, sincerity, or commitment of the employer or organization (including an institution of higher education), or intended to differentiate among the religious merits, commitment, mission, or public or private standing of religious entities. The use of such designation is limited solely to defining the class of employers or organizations (including institutions of higher education) that would qualify for the religious employer exemption and accommodations under these proposed rules. The definition of religious employer or eligible organization in these proposed rules is not being proposed to apply with respect to, or relied upon for the interpretation of, any other provision of the PHS Act, ERISA, the Code, or any other provision of federal law, nor is it intended to set a precedent for any other purpose. For example, nothing in these proposed rules should be construed as affecting the interpretation of federal or state civil rights statutes, such as Title VII of the Civil Rights Act of 1964 or Title IX of the Education Amendments of 1972.

Furthermore, nothing in these proposed rules would preclude employers or others from expressing their opposition, if any, to the use of contraceptives; require anyone to use contraceptives; or require health care providers to prescribe contraceptives if doing so is against their religious beliefs.

Finally, the provisions of these proposed rules would not prevent states from enacting stronger consumer protections than these minimum standards. Federal health insurance regulation generally establishes a federal floor to ensure that individuals in every state have certain basic protections. State health insurance laws requiring coverage for contraceptive services that provide more access to contraceptive coverage than the federal standards would therefore continue under the proposed rules. The Departments solicit comment on the interaction between state law and these proposed rules.

IV. Economic Impact and Paperwork Burden

A. Executive Orders 12866 and 13563 — Department of Health and Human Services and Department of Labor

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, and public health and safety effects; distributive impacts; and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility.

Section 3(f) of Executive Order 12866 defines a “significant regulatory action” as an action that is likely to result in a rule: (1) having an annual effect on the economy of \$100 million or more in any one year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local, or tribal governments or communities (also referred to as “economically significant”); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis must be prepared for major rules with economically significant effects (\$100 million or more in any one year), and an “economically significant” regulatory action is subject to review by the Office of Management and Budget (OMB). The Departments have concluded that these proposed rules are not likely to have economic impacts of \$100 million or more in any one year, and therefore do not meet the definition of “economically significant” under Executive Order 12866.

1. Need for Regulatory Action

As stated earlier in this preamble, the Departments previously issued amended interim final rules authorizing an exemp-

tion for group health plans established or maintained by religious employers (and any group health insurance coverage provided in connection with such plans) from certain coverage requirements under section 2713 of the PHS Act (76 FR 46621, August 3, 2011). The amended interim final rules were finalized on February 15, 2012 (77 FR 8725). The Departments are proposing in these proposed rules to amend the definition of religious employer in the HHS rule at 45 CFR 147.130(a)(1)(iv)(B) (incorporated by reference in the rules of the Departments of Labor and the Treasury) by eliminating the first three prongs of the definition of religious employer that was established in the 2012 final rules and clarifying the fourth prong. Under this proposal, an employer that is an organization that is organized and operates as a nonprofit entity and is referred to in section 6033(a)(3)(A)(i) or (iii) of the Code would be considered a religious employer and its group health plan would qualify for the exemption from the requirement to cover contraceptive services. In addition, the proposed rules would establish accommodations for health coverage established or maintained or arranged by eligible organizations, which have religious objections to contraceptive coverage, while providing women contraceptive coverage without cost sharing.

2. Anticipated Effects

The Departments expect that these proposed rules would not result in any additional significant burden on or costs to the affected entities.

B. Special Analyses — Department of the Treasury

For purposes of the Department of the Treasury, it has been determined that this notice of proposed rulemaking is not a significant regulatory action as defined in Executive Order 12866, as amended by Executive Order 13563. Therefore, a regulatory assessment is not required. It has also been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to this proposed rule. It is hereby certified that the collections of information contained in this notice of proposed rulemaking would not have a significant impact on a substantial number of

small entities. Accordingly, a regulatory flexibility analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required.

The proposed rules would require each organization seeking accommodation under the proposed rules to self-certify that it meets the definition of eligible organization in the proposed rules. Each organization must self-certify that: (1) on account of religious objections, it opposes providing coverage for some or all of the contraceptive items or services that it would otherwise be required to provide; (2) it is organized and operates as a nonprofit entity; and (3) it holds itself out as a religious organization. The self-certification must be executed by an authorized representative of the organization. The organization must maintain the self-certification in its records for each plan year to which the accommodation is to apply and make it available for examination upon request. The proposed rules would also require each eligible organization that establishes or maintains an insured group health plan to provide a copy of its self-certification to the group health insurance issuer. If the group health plan of the eligible organization is self-insured, the proposed rules would direct the eligible organization to provide a copy of its self-certification to the third party administrator.

The Departments intend to specify in guidance the form to be used for the self-certification, similar to the form previously prescribed in guidance for the temporary enforcement safe harbor. The Departments are unable to estimate the number of eligible organizations that would seek an accommodation. The Departments seek comment on the likely number of eligible organizations seeking an accommodation. Of the eligible organizations, some would likely be small entities. It is estimated that each eligible organization would need only approximately 50 minutes of labor (30 minutes of clerical labor at a cost of \$30.64 per hour, 10 minutes for a manager at a cost of \$55.22 per hour, 5 minutes for legal counsel at a cost of \$83.10 per hour, and 5 minutes for a senior executive at a cost of \$112.43 per hour) each year to prepare and provide the information in the self-certification. This would not be a significant economic impact. For these reasons, this information collection requirement would

not have a significant impact on a substantial number of small entities.

The proposed rules also would require health insurance issuers providing separate contraceptive coverage to provide written notice to plan participants and beneficiaries regarding the availability of the contraceptive coverage. The notice would be provided separate from but contemporaneous with (to the extent possible) any application materials distributed in connection with enrollment (or re-enrollment) in group coverage established, maintained, or arranged by the eligible organization in any plan year to which the accommodation is to apply. The proposed rules contain model language for issuers to use to satisfy the notice requirement. There are 446 issuers in the individual and group markets. It is believed that very few, if any, of them are small entities. Moreover, the cost for preparation and distribution of the notice would not be significant. It is estimated that each issuer would need approximately 1 hour of clerical labor (at \$31.64 per hour) and 15 minutes of management review (at \$55.22 per hour) to prepare the notices for a total cost of approximately \$44. It is estimated that each notice would require \$0.46 in postage and \$0.05 in materials cost (paper and ink) and the total postage and materials cost for each notice sent via mail would be \$0.51. For these reasons, these information collection requirements would not have a significant impact on a substantial number of small entities.

HHS is soliciting public comment on each of these issues for purposes of the following section as well.

Pursuant to section 7805(f) of the Code, this proposed rule has been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

C. Paperwork Reduction Act — Department of Health and Human Services

Under the Paperwork Reduction Act of 1995, HHS is required to provide 60-day notice in the **Federal Register** and solicit public comment before an information collection requirement (ICR) is submitted to the Office of Management and Budget (OMB) for review and approval. These proposed rules contain proposed ICRs that are subject to review by OMB. A descrip-

tion of these provisions is given in the following paragraphs with an estimate of the annual burden. In order to fairly evaluate whether an ICR should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that HHS solicit public comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of HHS.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

HHS is soliciting public comment on each of these issues for the following sections of these proposed rules that contain proposed ICRs. Average labor costs (including fringe benefits) used to estimate the costs are calculated using data available from the Bureau of Labor Statistics.

1. Self-Certification (§§147.131(b)(4), 147.131(c)(1), 147.131(c)(2))

Each organization seeking accommodation under the proposed rules would be required to self-certify that it meets the definition of an eligible organization. The self-certification would be executed by an authorized representative of the organization and would also specify the contraceptive services for which the organization will not establish, maintain, administer, or fund coverage. The self-certification would not be submitted to any of the Departments. The form that would be used by organizations for their self-certification would be specified. This form is available for inspection at <http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.html>. The organization would maintain the self-certification in its records for each plan year to which the accommodation is to apply. The eligible organization would need to provide a copy of its self-certification to a health insurance issuer (for insured group health plans or student health insurance

coverage) or to a third party administrator (for self-insured group health plans).

HHS does not have an estimate for how many organizations would seek an accommodation. HHS seeks comment on the likely number of organizations seeking an accommodation or the number of participants and beneficiaries in the plans of such organizations. Therefore, the burden for only one eligible organization, as opposed to all eligible organizations in total, is estimated. It is assumed that, for each eligible organization, clerical staff would gather and enter the necessary information, send the self-certification electronically to the issuer or third party administrator, and retain a copy for record-keeping, a manager and legal counsel would review it, and a senior executive would execute it. HHS estimates that an organization would need approximately 50 minutes (30 minutes of clerical labor at a cost of \$30.64 per hour, 10 minutes for a manager at a cost of \$55.22 per hour, 5 minutes for legal counsel at a cost of \$83.10 per hour, and 5 minutes for a senior executive at a cost of \$112.43 per hour) to execute the self-certification. Therefore, the total annual burden for preparing and providing the information in the self-certification would be approximately \$41 for each eligible organization.

With respect to self-insured plans of eligible organizations, the third party administrator would provide a health insurance issuer a copy of the self-certification of the eligible organization. The third party administrator would be able to provide a copy of the self-certification to the issuer electronically at minimal cost.

2. *Notice of Availability of Contraceptive Coverage (§147.131(d))*

The proposed rules would direct a health insurance issuer providing separate individual contraceptive coverage at no additional cost to participants and beneficiaries in insured plans of eligible organizations (or to student enrollees and covered dependents in student health insurance coverage arranged by eligible organizations) and to participants and beneficiaries in self-insured plans of eligible organizations whose coverage is automatically arranged for them by a third party administrator to provide a written notice to such plan participants and beneficiaries

(or to such student enrollees and covered dependents) regarding the separate contraceptive coverage. The notice would be separate from but contemporaneous with (to the extent possible) any application materials distributed in connection with enrollment (or re-enrollment) in group coverage of the eligible organization in any plan year to which the accommodation is to apply and would be provided annually. To satisfy the proposed notice requirement, issuers could use the model language set forth in the proposed rules or substantially similar language.

It is unknown how many issuers provide health insurance coverage in connection with insured plans of eligible organizations or how many third party administrators provide services to self-insured plans of eligible organizations or how many issuers would provide separate individual contraceptive coverage to plan participants and beneficiaries of self-insured plans of eligible organizations. Therefore, the burden for only one issuer, as opposed to all issuers in total, is estimated. It is estimated that each issuer would need approximately 1 hour of clerical labor (at \$31.64 per hour) and 15 minutes of management review (at \$55.22 per hour) to prepare the notices for a total cost of approximately \$44. It is estimated that each notice would require \$0.46 in postage and \$0.05 in materials cost (paper and ink) and the total postage and materials cost for each notice sent via mail would be \$0.51.

3. *FFE User Fee Adjustments (§156.50(d))*

In order for a QHP issuer to be eligible for the proposed FFE user fee adjustment, the proposed rules would provide that the issuer providing the contraceptive coverage would provide certain information and documentation (jointly with the affiliated QHP issuer for which the reduction in the FFE user fee is being sought, if the issuers are not the same) to HHS. First, monthly data on the number of individuals for whom the contraceptive coverage is being provided would be required, along with an attestation that a copy of the self-certification of the eligible organization was provided by the third party administrator that arranged for the coverage for the plan participants and beneficiaries. Second, the

issuer would provide an attestation that coverage for all recommended contraceptive services identified in the self-certification of the eligible organization is being provided, and being provided without cost sharing, premiums, fee, or other costs to the plan participants or beneficiaries. The issuer also would attest to HHS that it passed the portion of its adjustment attributable to reasonable charges by third party administrators on to those parties. Third, the issuer(s) would identify the QHP(s) being offered through an FFE with respect to which the FFE user fee reduction is to be applied. In addition, where the issuer providing the contraceptive coverage is not the QHP issuer for which the reduction in the FFE user fee is being sought, an attestation that the issuers are from the same issuer group would be submitted. Finally, the issuer(s) would submit to HHS an estimate of the cost of the contraceptive coverage, along with data or documentation supporting that estimate. HHS approval of the cost estimate would be required before a QHP issuer could receive an FFE user fee adjustment.

Although the number of QHP issuers that would seek an FFE user fee adjustment is unknown at this point, HHS anticipates that a small number of issuer groups would provide such contraceptive coverage nationwide, and that, for purposes of efficiency, those issuer groups would consolidate their applications for FFE user fee adjustments with fewer than 9 issuers of QHPs on FFEs. Collections from fewer than 10 persons are exempt from the Paperwork Reduction Act under 44 U.S.C. 3502(3)(A)(i). Therefore, HHS does not plan to seek OMB approval for this proposed ICR. However, in the event that, by the time of the issuance of the final rules, HHS believes that the number of QHP issuers that would seek an FFE user fee adjustment would be greater than 9, HHS would seek OMB approval for this proposed ICR.

To obtain copies of the supporting statement and any related forms for the proposed ICRs referenced above, access CMS's web site at <http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.html> or e-mail your request, including your address, phone number, OMB number, and CMS document identifier, to paperwork@cms.hhs.gov, or

call the Reports Clearance Office at (410) 786-1326.

If you comment on these proposed ICRs, please do either of the following:

1. Submit your comments electronically as specified in the ADDRESSES section of these proposed rules; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: CMS Desk Officer, 9968-P, FAX: (202) 395-5806, or e-mail: OIRA_submission@omb.eop.gov.

D. Paperwork Reduction Act

—*Department of Labor and Department of the Treasury*

As noted above, each organization seeking accommodation under the proposed rules would be required to self-certify that it meets the definition of an eligible organization. This proposed requirement, which is the same in all three sets of proposed rules, is set out in proposed 26 CFR 54.9815-2713A(b)(4) and proposed 29 CFR 2590.715-2713A(b)(4). The Departments are soliciting public comments for 60 days concerning this record-keeping requirement. The Departments will submit a copy of these proposed rules to OMB in accordance with 44 U.S.C. 3507(d) for review of the proposed ICRs. The Departments and OMB are particularly interested in comments that:

- Evaluate whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- Evaluate the accuracy of the agency's estimate of the burden of the collection of information, including the validity of the methodology and assumptions used;
- Enhance the quality, utility, and clarity of the information to be collected; and
- Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, for example, by permitting electronic submission of responses.

Comments should be sent to the Office of Information and Regulatory Affairs, Attention: Desk Officer for the Employee Benefits Security Administration either by FAX to (202) 395-5806 or by e-mail to oira_submission@omb.eop.gov. A copy of the proposed ICRs may be obtained by contacting the PRA addressee: G. Christopher Cosby, Office of Policy and Research, Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210; telephone: (202) 693-8410; FAX: (202) 219-4745 (please note that these numbers are not toll-free numbers); e-mail: ebssa.opr@dol.gov. Proposed ICRs submitted to OMB also are available at www.reginfo.gov (<http://www.reginfo.gov/public/do/PRAMain>).

Consistent with the HHS analysis presented above, the Departments do not have an estimate for how many organizations would seek an accommodation. The Departments seek comment on the likely number of organizations seeking an accommodation and the number of participants and beneficiaries in the plans of such organizations. The Departments rely on the same estimates noted above: 50 minutes per organization to execute the self-certification (*i.e.*, approximately \$41 for each eligible organization).

With respect to self-insured plans of eligible organizations, the third party administrator would provide a health insurance issuer a copy of the self-certification of the eligible organization. The third party administrator would be able to provide a copy of the self-certification to the issuer electronically at minimal cost.

The Departments note that persons are not required to respond to, and generally are not subject to any penalty for failing to comply with, an ICR unless the ICR has a valid OMB control number. The paperwork burden estimates are summarized as follows:

Type of Review: New collection.

Agencies: Employee Benefits Security Administration, Department of Labor; Internal Revenue Service, Department of the Treasury.

Title: Self-Certification; Preventive Services Coverage.

OMB Number: XXXX-XXXX; XXXX-XXXX.

Affected Public: Business or other for-profit; not-for-profit institutions.

Total Respondents: Unknown.

Total Responses: Unknown.

Frequency of Response: Once.

Estimated Total Annual Burden Hours: 50 minutes per respondent.

Estimated Total Annual Burden Cost: Unknown.

V. Unfunded Mandates Reform Act

For purposes of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), as well as Executive Order 12875, these proposed rules do not include any proposed federal mandate that may result in expenditures by state, local, or tribal governments, nor does it include any proposed federal mandates that may impose an annual burden of \$100 million, adjusted for inflation, or more on the private sector.¹⁶

VI. Federalism — Department of Health and Human Services and Department of Labor

Executive Order 13132 outlines fundamental principles of federalism, and requires the adherence to specific criteria by federal agencies in the process of their formulation and implementation of policies that have “substantial direct effects” on states, the relationship between the federal government and states, or the distribution of power and responsibilities among the various levels of government. Federal agencies promulgating rules that have these federalism implications must consult with state and local officials, and describe the extent of their consultation and the nature of the concerns of state and local officials in the preamble to the rules.

In the Departments' view, these proposed rules have federalism implications, but the federal implications are substantially mitigated because, with respect to health insurance issuers, 15 states have enacted specific laws, rules, or bulletins that meet or exceed the federal standards requiring coverage of specified preventive services without cost sharing. The remaining states which provide oversight for these federal law requirements are doing so using their general authority to enforce

¹⁶ In early 2013, that threshold level is approximately \$139 million.

these federal standards. Therefore, the proposed rules are not likely to require substantial additional oversight of states by HHS.

In general, section 514 of ERISA provides that state laws are superseded to the extent that they relate to any covered employee benefit plan, and preserves state laws that regulate insurance, banking, or securities. ERISA also prohibits states from regulating a covered plan as an insurance or investment company or bank. HIPAA added a new preemption provision to ERISA (as well as to the PHS Act) narrowly preempting state requirements for group health insurance coverage. States may continue to apply state law requirements but not to the extent that such requirements prevent the application of the federal requirement that group health insurance coverage provided in connection with group health plans provide coverage for specified preventive services without cost sharing. HIPAA's Conference Report states that the conferees intended the narrowest preemption of state laws with regard to health insurance issuers (H.R. Conf. Rep. No. 104-736, 104th Cong. 2d Session 205, 1996). State insurance laws that are more stringent than the federal requirement are unlikely to "prevent the application of" the preventive services coverage provision, and therefore are not preempted. Accordingly, states have significant latitude to impose requirements on health insurance issuers that are more restrictive than those in federal law.

Guidance conveying this interpretation was published in the **Federal Register** on April 8, 1997 (62 FR 16904), and December 30, 2004 (69 FR 78720), and these proposed rules would clarify and implement the statute's minimum standards and would not significantly reduce the discretion given the states by the statute.

The PHS Act provides that the states may enforce the provisions of title XXVII of the PHS Act as they pertain to issuers, but that the Secretary of HHS will enforce any provisions that a state does not have authority to enforce or that a state has failed to substantially enforce. When exercising its responsibility to enforce provisions of the PHS Act, HHS works coop-

eratively with the state for the purpose of addressing the state's concerns and avoiding conflicts with the exercise of state authority.¹⁷ HHS has developed procedures to implement its enforcement responsibilities, and to afford states the maximum opportunity to enforce the PHS Act's requirements in the first instance. In compliance with Executive Order 13132's requirement that agencies examine closely any policies that may have federalism implications or limit the policymaking discretion of states, the Departments have engaged in numerous efforts to consult and work cooperatively with affected state and local officials.

In conclusion, throughout the process of developing these proposed rules, to the extent feasible within the specific preemption provisions of ERISA and the PHS Act, the Departments have attempted to balance states' interests in regulating health plans and health insurance issuers, and the rights of those individuals that Congress intended to protect in the PHS Act.

VII. Statutory Authority

The Department of the Treasury regulations are proposed to be adopted pursuant to the authority contained in sections 7805 and 9833 of the Code.

The Department of Labor regulations are proposed to be adopted pursuant to the authority contained in 29 U.S.C. 1002(16), 1027, 1059, 1135, 1161-1168, 1169, 1181-1183, 1181 note, 1185, 1185a, 1185b, 1185d, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Public Law 104-191, 110 Stat. 1936; sec. 401(b), Public Law 105-200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Public Law 110-343, 122 Stat. 3881; sec. 1001, 1201, and 1562(e), Public Law 111-148, 124 Stat. 119, as amended by Public Law 111-152, 124 Stat. 1029; Secretary of Labor's Order 3-2010, 75 FR 55354 (September 10, 2010).

The Department of Health and Human Services regulations are proposed to be adopted pursuant to the authority contained in sections 2701 through 2763, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg through 300gg-63, 300gg-91, and 300gg-92), as amended;

and Title I of the Affordable Care Act, sections 1301-1304, 1311-1312, 1321-1322, 1324, 1334, 1342-1343, 1401-1402, and 1412, Pub. L. 111-148, 124 Stat. 119 (42 U.S.C. 18021-18024, 18031-18032, 18041-18042, 18044, 18054, 18061, 18063, 18071, 18082, 26 U.S.C. 36B, and 31 U.S.C. 9701).

* * * * *

DEPARTMENT OF THE TREASURY Internal Revenue Service

Accordingly, 26 CFR part 54 is proposed to be amended as follows:

PART 54—PENSION EXCISE TAXES

Paragraph 1. The authority citation for part 54 continues to read in part as follows:

Authority: 26 U.S.C. 7805.

* * *

Par. 2 Section 54.9801-2 is amended by revising the definition of *excepted benefits* as follows:

§54.9801-2 Definitions.

* * * * *

Excepted benefits means the benefits described as excepted in §54.9831(c), or 45 CFR §148.220 (describing when individual health insurance policies constitute excepted benefits).

* * * * *

Par. 3. Section 54.9815-2713 is amended by adding paragraph (a)(1) introductory text and revising paragraph (a)(1)(iv) to read as follows:

§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 all of the following items and services, and may not impose any cost sharing requirement (such as a copayment, coinsurance, or a deductible) with respect to those items and services:

* * * * *

¹⁷ This authority applies to insurance issued with respect to group health plans generally, including plans covering employees of church organizations. Thus, this discussion of federalism applies to all group health insurance coverage that is subject to the PHS Act, including those church plans that provide coverage through a health insurance issuer (but not to church plans that do not provide coverage through a health insurance issuer).

(iv) With respect to women, to the extent not described in paragraph (a)(1)(i) of this section, evidence-informed preventive care and screenings provided for in binding comprehensive health plan coverage guidelines supported by the Health Resources and Services Administration, in accordance with 45 CFR 147.131(a).

* * * * *

Par. 4. Section 54.9815–2713A is added to read as follows:

§54.9815–2713A Accommodations in connection with coverage of preventive health services.

(a) *Eligible organizations.* An eligible organization is an organization that satisfies all of the following requirements:

(1) The organization opposes providing coverage for some or all of any contraceptive services required to be covered under §54.9815–2713(a)(1)(iv) on account of religious objections.

(2) The organization is organized and operates as a nonprofit entity.

(3) The organization holds itself out as a religious organization.

(4) The organization maintains in its records a self-certification, made in the manner and form specified by the Secretary of Health and Human Services, for each plan year to which the accommodation is to apply, executed by a person authorized to make the certification on behalf of the organization, indicating that the organization satisfies the criteria in paragraphs (a)(1) through (3) of this section, and, specifying those contraceptive services for which the organization will not establish, maintain, administer, or fund coverage, and makes such certification available for examination upon request.

(b) *Contraceptive coverage – self-insured group health plan coverage.* [Reserved.]

(c) *Contraceptive coverage – insured group health plan coverage—*(1) A group health plan established or maintained by an eligible organization and that provides benefits through one or more issuers complies with any requirement under §54.9815–2713(a)(1)(iv) to provide contraceptive coverage if the eligible organization or plan administrator furnishes each issuer that would otherwise provide coverage for any contraceptive services required to be covered under §54.9815–2713(a)(1)(iv) with a copy of the self-certification described in paragraph (a)(4) of this section.

(2) A group health insurance issuer that receives a copy of the self-certification described in paragraph (a)(4) of this section with respect to a plan for which the issuer would otherwise provide coverage for any contraceptive services required to be covered under §54.9815–2713(a)(1)(iv) must automatically provide health insurance coverage for any contraceptive services required to be covered by §54.9815–2713(a)(1)(iv) and identified in the self-certification, through a separate health insurance policy that is excepted under 45 CFR 148.220(b)(7), for each plan participant and beneficiary. The issuer providing the individual market excepted benefits policy may not impose any cost sharing requirement (such as a copayment, coinsurance, or a deductible) with respect to coverage of those services, or impose any premium, fee, or other charge, or portion thereof, directly or indirectly, on the eligible organization, its group health plan, or plan participants or beneficiaries with respect to coverage of those services.

(d) *Notice of availability of contraceptive coverage.* An issuer providing contraceptive coverage arranged pursuant to paragraph (b) or (c) of this section must provide to plan participants and beneficiaries written notice of the availability of the contraceptive coverage, separate from but contemporaneous with (to the extent possible) application materials distributed in connection with enrollment (or re-enrollment) in group coverage of the eligible organization for any plan year to which this paragraph applies. The following model language, or substantially similar language, may be used to satisfy the notice requirement of this paragraph: “The organization that establishes and maintains, or arranges, your health coverage 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 health coverage will not cover the following contraceptive services: [contraceptive services specified in self-certification]. Instead, these contraceptive services will be covered through a separate individual health insurance policy, which is not administered or funded by, or connected in any way to, your health coverage. You and any covered dependents will be enrolled in this separate individual health insurance policy at no additional cost to you. If you have any questions about this notice, contact [contact information for health insurance issuer].”

Signed this 30th day of January, 2013.

Steven T. Miller,
Deputy Commissioner for
Services and Enforcement,
Internal Revenue Service.

Signed this 30th day of January, 2013.

Phyllis C. Borzi,
Assistant Secretary,
Employee Benefits
Security Administration,
Department of Labor.

Dated: January 29, 2013.

Marilyn Tavenner,
Acting Administrator,
Centers for Medicare &
Medicaid Services.

Approved: January 29, 2013.

Kathleen Sebelius,
Secretary,
Department of Health
and Human Services.

(Filed by the Office of the Federal Register on February 1, 2013, 11:15 a.m., and published in the issue of the Federal Register for February 6, 2013, 78 F.R. 8456)

Request for Comments on Voluntary Tip Compliance Agreements

Announcement 2013–29

The Internal Revenue Service (IRS) is interested in updating its suite of voluntary tip compliance agreements and, as part of this process, is seeking public comments.

Background

In Announcement 2012–25, 2012–26 I.R.B. 1054, the IRS stated that it planned to solicit public comments on possible changes to the existing Tip Rate Determination and Education Program (TRDEP). In particular, the IRS is interested in public comments regarding updating two types of voluntary tip compliance agreements under TRDEP, namely, Tip Rate Determination Agreements (TRDAs) and Tip Reporting Alternative Commitments (TRACs).

The IRS introduced TRDEP in October 1993 to the food and beverage industry. In the years that followed, TRDEP was

expanded to the cosmetology, transportation, gaming, and other tipping industries. TRDEP is voluntary and focuses on education and voluntary tip compliance agreements rather than traditional enforcement actions. Over subsequent years, the IRS developed and updated voluntary tip compliance agreements to help employees accurately report their tip income and to help employers meet their filing and reporting obligations.

TRDAs and TRACs have been in existence since the 1990s and may not take advantage of advances in Point of Sale systems and electronic payment settlement method technologies.

The Gaming Industry Tip Compliance Agreement (GITCA), also part of TRDEP, was updated in 2007 by Rev. Proc. 2007–32, 2007–22 I.R.B. 1322. Therefore, the IRS is not seeking comments on GITCA at this time.

Objective

A key objective of updating TRDAs and TRACs is to improve employee tip reporting compliance and utilize technological advancements to decrease taxpayer and administrative burden. The new agreements will incorporate:

1. A greater emphasis on computations derived from Point of Sale systems and the use of electronic payment settlement methods, *i.e.*, credit and debit cards
2. A greater emphasis on accurate tip reporting by indirectly tipped employees
3. The distinction between tips and service charges
4. A commitment by the IRS not to initiate a tip examination on participants
5. A streamlined agreement
6. Updated definitions
7. Simplified, expedited education requirements for existing employees
8. Streamlined application and termination procedures
9. A streamlined process to add additional establishments to existing agreements
10. Streamlined access to TRDEP resources to assist with agreement administration

The IRS is seeking comments on the manner to incorporate the items listed above and other items the public believes would increase tip reporting compliance and ease taxpayer burden. The IRS welcomes comments on all aspects

of TRDAs and TRACs but is particularly interested in suggestions regarding processes, computational methodologies, agreement language, and suggested topics for “Frequently Asked Questions.” Electronic samples of the existing TRDAs and TRACs (some industry specific) are available on *IRS.gov*; enter “MSU tips” in the search box. They may also be obtained from the IRS office listed below:

Internal Revenue Service
National Tip Reporting Compliance
3251 North Evergreen Dr. NE
Grand Rapids, MI 49525

How to Submit Comments

Comments may be submitted on or before [Insert 90 day period], either elec-

tronically at *TIP.Program@irs.gov* or in writing to the IRS office listed above.

Please include the number of this announcement in the subject line of your email or in the header of your written comments.

Definition of Terms

Revenue rulings and revenue procedures (hereinafter referred to as “rulings”) that have an effect on previous rulings use the following defined terms to describe the effect:

Amplified describes a situation where no change is being made in a prior published position, but the prior position is being extended to apply to a variation of the fact situation set forth therein. Thus, if an earlier ruling held that a principle applied to A, and the new ruling holds that the same principle also applies to B, the earlier ruling is amplified. (Compare with *modified*, below).

Clarified is used in those instances where the language in a prior ruling is being made clear because the language has caused, or may cause, some confusion. It is not used where a position in a prior ruling is being changed.

Distinguished describes a situation where a ruling mentions a previously published ruling and points out an essential difference between them.

Modified is used where the substance of a previously published position is being changed. Thus, if a prior ruling held that a principle applied to A but not to B, and the new ruling holds that it applies to both A

and B, the prior ruling is modified because it corrects a published position. (Compare with *amplified* and *clarified*, above).

Obsoleted describes a previously published ruling that is not considered determinative with respect to future transactions. This term is most commonly used in a ruling that lists previously published rulings that are obsoleted because of changes in laws or regulations. A ruling may also be obsoleted because the substance has been included in regulations subsequently adopted.

Revoked describes situations where the position in the previously published ruling is not correct and the correct position is being stated in a new ruling.

Superseded describes a situation where the new ruling does nothing more than restate the substance and situation of a previously published ruling (or rulings). Thus, the term is used to republish under the 1986 Code and regulations the same position published under the 1939 Code and regulations. The term is also used when it is desired to republish in a single ruling a series of situations, names, etc., that were previously published over a period of time in separate rulings. If the new ruling does more than restate the substance

of a prior ruling, a combination of terms is used. For example, *modified* and *superseded* describes a situation where the substance of a previously published ruling is being changed in part and is continued without change in part and it is desired to restate the valid portion of the previously published ruling in a new ruling that is self contained. In this case, the previously published ruling is first modified and then, as modified, is superseded.

Supplemented is used in situations in which a list, such as a list of the names of countries, is published in a ruling and that list is expanded by adding further names in subsequent rulings. After the original ruling has been supplemented several times, a new ruling may be published that includes the list in the original ruling and the additions, and supersedes all prior rulings in the series.

Suspended is used in rare situations to show that the previous published rulings will not be applied pending some future action such as the issuance of new or amended regulations, the outcome of cases in litigation, or the outcome of a Service study.

Abbreviations

The following abbreviations in current use and formerly used will appear in material published in the Bulletin.

A—Individual.
Acq.—Acquiescence.
B—Individual.
BE—Beneficiary.
BK—Bank.
B.T.A.—Board of Tax Appeals.
C—Individual.
C.B.—Cumulative Bulletin.
CFR—Code of Federal Regulations.
CI—City.
COOP—Cooperative.
Ct.D.—Court Decision.
CY—County.
D—Decedent.
DC—Dummy Corporation.
DE—Donee.
Del. Order—Delegation Order.
DISC—Domestic International Sales Corporation.
DR—Donor.
E—Estate.
EE—Employee.
E.O.—Executive Order.

ER—Employer.
ERISA—Employee Retirement Income Security Act.
EX—Executor.
F—Fiduciary.
FC—Foreign Country.
FICA—Federal Insurance Contributions Act.
FISC—Foreign International Sales Company.
FPH—Foreign Personal Holding Company.
F.R.—Federal Register.
FUTA—Federal Unemployment Tax Act.
FX—Foreign corporation.
G.C.M.—Chief Counsel’s Memorandum.
GE—Grantee.
GP—General Partner.
GR—Grantor.
IC—Insurance Company.
I.R.B.—Internal Revenue Bulletin.
LE—Lessee.
LP—Limited Partner.
LR—Lessor.
M—Minor.
Nonacq.—Nonacquiescence.
O—Organization.
P—Parent Corporation.
PHC—Personal Holding Company.
PO—Possession of the U.S.
PR—Partner.

PRS—Partnership.
PTE—Prohibited Transaction Exemption.
Pub. L.—Public Law.
REIT—Real Estate Investment Trust.
Rev. Proc.—Revenue Procedure.
Rev. Rul.—Revenue Ruling.
S—Subsidiary.
S.P.R.—Statement of Procedural Rules.
Stat.—Statutes at Large.
T—Target Corporation.
T.C.—Tax Court.
T.D.—Treasury Decision.
TFE—Transferee.
TFR—Transferor.
T.I.R.—Technical Information Release.
TP—Taxpayer.
TR—Trust.
TT—Trustee.
U.S.C.—United States Code.
X—Corporation.
Y—Corporation.
Z—Corporation.

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Key to Abbreviations:

Ann	Announcement
CD	Court Decision
DO	Delegation Order
EO	Executive Order
PL	Public Law
PTE	Prohibited Transaction Exemption
RP	Revenue Procedure
RR	Revenue Ruling
SPR	Statement of Procedural Rules
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TD	Treasury Decision
TDO	Treasury Department Order

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