

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

Notice 2014-60, page 741.

This notice explains the circumstances under which the 4-year replacement period under section 1033(e)(2) of the Code is extended for livestock sold on account of drought. The Appendix to this notice contains a list of the counties that experienced exceptional, extreme, or severe drought during the preceding 12-month period ending August 31, 2014. Taxpayers may use this list to determine if an extension is available.

T.D. 9696, page 727.

Final regulations under section 162 of the Code describe the circumstances under which expenses paid or incurred for lodging when not traveling away from home (local lodging) may be deductible expenses. Final amendments to the regulations under section 262 provide that expenses for local lodging are nondeductible personal expenses unless they qualify as deductible expenses under section 162.

EMPLOYEE PLANS

Notice 2014-53, page 737.

This notice provides guidance on the changes to the funding stabilization rules for single-employer pension plans under the Internal Revenue Code (Code) and the Employee Retirement Income Security Act of 1974 (ERISA) that were made by section 2003 of the Highway and Transportation Funding Act of 2014 (HATFA), Pub. L. No. 113-159, which was enacted on August 8, 2014.

T.D. 9697, page 729.

This document contains final regulations that modify the regulations providing requirements for limited-scope vision or dental benefits to qualify as excepted benefits and provide requirements

for when an employee assistance program (EAP) qualifies as excepted benefits. Excepted benefits are not subject to the various market reforms imposed by the Affordable Care Act and do not qualify as minimum essential coverage. The final regulations apply to plan years beginning on or after January 1, 2015.

EXCISE TAX

T.D. 9697, page 729.

This document contains final regulations that modify the regulations providing requirements for limited-scope vision or dental benefits to qualify as excepted benefits and provide requirements for when an employee assistance program (EAP) qualifies as excepted benefits. Excepted benefits are not subject to the various market reforms imposed by the Affordable Care Act and do not qualify as minimum essential coverage. The final regulations apply to plan years beginning on or after January 1, 2015.

ADMINISTRATIVE

Notice 2014-61, page 744.

This notice updates the appendix to Notice 2013-1, which lists the Indian tribes who have settled tribal trust cases against the United States. Notice 2012-60 originally was published in IRB 2012-41 (October 9, 2012). Notice 2012-60 was superseded by Notice 2013-1 IRB 2013-3, and the appendix to Notice 2013-1 was superseded by Notice 2013-16 (IRB 2013-14), then Notice 2013-36, then Notice 2013-55, then Notice 2014-22, and then Notice 2014-38. However, two additional tribes have settled their cases against the United States since the publication of Notice 2014-38, so we are publishing an updated appendix to Notice 2013-1. This notice would supersede Notice 2014-38. Notice 2013-1 Appendix is modified and superseded.

Finding Lists begin on page ii.
Index for July through October begins on page iv.

The IRS Mission

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

The contents of this publication are not copyrighted and may be reprinted freely. A citation of the Internal Revenue Bulletin as the source would be appropriate.

Part I. Rulings and Decisions Under the Internal Revenue Code of 1986

Section 162.—Deductibility of Expenses for Lodging

26 CFR 1.162–32: *Deductibility of expenses for lodging when an individual is not traveling away from home (local lodging).*

T.D. 9696

**DEPARTMENT OF THE
TREASURY
Internal Revenue Service
26 CFR Part 1**

Local Lodging Expenses

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulations.

SUMMARY: This document contains final regulations relating to the deductibility of expenses for lodging when an individual is not traveling away from home (local lodging). The regulations affect taxpayers who pay or incur local lodging expenses.

DATES: *Effective Date:* These regulations are effective on October 1, 2014.

Applicability Dates: For dates of applicability, see §§ 1.162–32(d) and 1.262–1(b)(5).

FOR FURTHER INFORMATION CONTACT: Peter Ford, (202) 317-7011 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Background

This document contains final regulations that amend the Income Tax Regulations (26 CFR part 1) under sections 162 and 262 of the Internal Revenue Code (Code) relating to the deduction of local lodging expenses. On April 25, 2012, a notice of proposed rulemaking (REG–137589–07) was published in the **Federal Register** (77 FR 24657). One written comment responding to the notice of proposed rulemaking was received. No public hearing was requested or held. After consideration of the comment, the regulations

are adopted as amended by this Treasury decision.

Summary of Comment and Explanation of Provisions

The provisions of the proposed regulations under section 162 of the Code were designated as § 1.162–31, however, after the proposed regulations were published, unrelated regulations were finalized as § 1.162–31. Accordingly, the final regulations in this document under section 162 are designated as § 1.162–32.

Under the general rule in § 1.162–31(a) of the proposed regulations, local lodging expenses for an individual are personal, living, or family expenses that are nondeductible by the individual under section 262(a). Depending on the facts and circumstances, however, local lodging expenses may be deductible under section 162 as ordinary and necessary business expenses. Section 1.162–31(b) of the proposed regulations provides a safe harbor, pursuant to which local lodging expenses that meet certain criteria are treated as ordinary and necessary business expenses of an individual. Local lodging expenses that meet either the facts and circumstances test of paragraph (a) or the safe harbor requirements of paragraph (b) are deductible by an individual if incurred directly. Alternatively, if the expenses are incurred by an employer on behalf of an employee, the value of the local lodging may be excludible from the income of the employee as a working condition fringe under section 132(a) and (d). To the extent an employer reimburses an employee for local lodging expenses, the reimbursement may be excludible from the employee's gross income if the expense allowance arrangement satisfies the requirements of an accountable plan under section 62(c) and the applicable regulations. The expenses are also deductible by the employer as ordinary and necessary business expenses.

The commenter requested that the final regulations be revised to make it clear that a taxpayer's local lodging expenses that do not satisfy the safe harbor under § 1.162–31(b) of the proposed regulations may nonetheless be deductible under

§ 1.162–31(a) of the proposed regulations depending on the taxpayer's facts and circumstances. In response to this comment, the final regulations clarify that the examples illustrate the facts and circumstances test. Specifically, the examples illustrate situations in which certain conditions of the safe harbor are not satisfied and, therefore, the facts and circumstances test determines the appropriate treatment.

An example in the proposed regulations describes circumstances in which a professional sports team provides local lodging to players and coaches for a non-compensatory business purpose. The commenter suggested that the final regulations clarify that local lodging provided to other employees of a sports team also may be ordinary and necessary non-compensatory business expenses. In response to this comment, the final regulations revise the example to clarify that the reference to players and coaches is illustrative and not exclusive.

The commenter requested that the final regulations clarify the circumstances in which meal expenses paid or incurred in connection with lodging expenses are deductible. The final regulations do not adopt this comment, as the proposed regulations did not provide rules relating to meal expenses and those issues are beyond the scope of these regulations.

Effective/Applicability Date

These regulations apply to expenses paid or incurred on or after October 1, 2014. Taxpayers may apply these regulations to expenses paid or incurred in taxable years ending before October 1, 2014, for which the period of limitation on credit or refund under section 6511 has not expired.

Special Analyses

This Treasury decision is not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. Therefore, a regulatory assessment is not required. It also has been determined that section 553(b) of

the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations and, because the regulations do not impose a collection of information on small entities, the Regulatory Flexibility Act (5 U.S.C. chapter 6) does not apply. Pursuant to section 7805(f) of the Code, the notice of proposed rulemaking that preceded these final regulations was submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business. No comments were received.

Drafting Information

The principal author of these regulations is R. Matthew Kelley of the Office of Associate Chief Counsel (Income Tax and Accounting). However, other personnel from the IRS and the Treasury Department participated in their development.

* * * * *

Adoption of Amendments to the Regulations

Accordingly, 26 CFR part 1 is amended as follows:

PART 1—INCOME TAXES

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

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

Par. 2. Section 1.162-32 is added to read as follows:

§ 1.162-32 Expenses paid or incurred for lodging when not traveling away from home.

(a) *In general.* Expenses paid or incurred for lodging of an individual who is not traveling away from home (local lodging) generally are personal, living, or family expenses that are nondeductible by the individual under section 262(a). Under certain circumstances, however, local lodging expenses may be deductible under section 162(a) as ordinary and necessary expenses paid or incurred in connection with carrying on a taxpayer's trade or business, including a trade or business as an employee. Whether local lodging expenses are paid or incurred in carrying on a taxpayer's trade or business is determined under all the facts and circumstances. One factor is whether the tax-

payer incurs an expense because of a bona fide condition or requirement of employment imposed by the taxpayer's employer. Expenses paid or incurred for local lodging that is lavish or extravagant under the circumstances or that primarily provides an individual with a social or personal benefit are not incurred in carrying on a taxpayer's trade or business.

(b) *Safe harbor for local lodging at business meetings and conferences.* An individual's local lodging expenses will be treated as ordinary and necessary business expenses if—

(1) The lodging is necessary for the individual to participate fully in or be available for a bona fide business meeting, conference, training activity, or other business function;

(2) The lodging is for a period that does not exceed five calendar days and does not recur more frequently than once per calendar quarter;

(3) If the individual is an employee, the employee's employer requires the employee to remain at the activity or function overnight; and

(4) The lodging is not lavish or extravagant under the circumstances and does not provide any significant element of personal pleasure, recreation, or benefit.

(c) *Examples.* The provisions of the facts and circumstances test of paragraph (a) of this section are illustrated by the following examples. In each example the employer and the employees meet all other requirements (such as substantiation) for deductibility of the expense and for exclusion from income of the value of the lodging as a working condition fringe or of reimbursements under an accountable plan.

Example 1. (i) Employer conducts a seven-day training session for its employees at a hotel near Employer's main office. The training is directly connected with Employer's trade or business. Some employees attending the training are traveling away from home and some employees are not traveling away from home. Employer requires all employees attending the training to remain at the hotel overnight for the bona fide purpose of facilitating the training. Employer pays the costs of the lodging at the hotel directly to the hotel and does not treat the value as compensation to the employees.

(ii) Because the training is longer than five calendar days, the safe harbor in paragraph (b) of this section does not apply. However, the value of the lodging may be excluded from income if the facts and circumstances test in paragraph (a) of this section is satisfied.

(iii) The training is a bona fide condition or requirement of employment and Employer has a noncompensatory business purpose for paying the lodging expenses. Employer is not paying the expenses primarily to provide a social or personal benefit to the employees, and the lodging Employer provides is not lavish or extravagant. If the employees who are not traveling away from home had paid for their own lodging, the expenses would have been deductible by the employees under section 162(a) as ordinary and necessary business expenses. Therefore, the value of the lodging is excluded from the employees' income as a working condition fringe under section 132(a) and (d).

(iv) Employer may deduct the lodging expenses, including lodging for employees who are not traveling away from home, as ordinary and necessary business expenses under section 162(a).

Example 2. (i) The facts are the same as in *Example 1*, except that the employees pay the cost of their lodging at the hotel directly to the hotel, Employer reimburses the employees for the cost of the lodging, and Employer does not treat the reimbursement as compensation to the employees.

(ii) Because the training is longer than five calendar days, the safe harbor in paragraph (b) of this section does not apply. However, the reimbursement of the expenses for the lodging may be excluded from income if the facts and circumstances test in paragraph (a) of this section is satisfied.

(iii) The training is a bona fide condition or requirement of employment and Employer is reimbursing the lodging expenses for a noncompensatory business purpose and not primarily to provide a social or personal benefit to the employees and the lodging Employer provides is not lavish or extravagant. The employees incur the expenses in performing services for the employer. If Employer had not reimbursed the employees who are not traveling away from home for the cost of the lodging, the expenses would have been deductible by the employees under section 162(a) as ordinary and necessary business expenses. Therefore, the reimbursements to the employees are made under an accountable plan and are excluded from the employees' gross income.

(iv) Employer may deduct the lodging expense reimbursements, including reimbursements for employees who are not traveling away from home, as ordinary and necessary business expenses under section 162(a).

Example 3. (i) Employer is a professional sports team. Employer requires its employees (for example, players and coaches) to stay at a local hotel the night before a home game to conduct last minute training and ensure the physical preparedness of the players. Employer pays the lodging expenses directly to the hotel and does not treat the value as compensation to the employees.

(ii) Because the overnight stays occur more than once per calendar quarter, the safe harbor in paragraph (b) of this section does not apply. However, the value of the lodging may be excluded from income if the facts and circumstances test in paragraph (a) of this section is satisfied.

(iii) The overnight stays are a bona fide condition or requirement of employment and Employer has a noncompensatory business purpose for paying the

lodging expenses. Employer is not paying the lodging expenses primarily to provide a social or personal benefit to the employees and the lodging Employer provides is not lavish or extravagant. If the employees had paid for their own lodging, the expenses would have been deductible by the employees under section 162(a) as ordinary and necessary business expenses. Therefore, the value of the lodging is excluded from the employees' income as a working condition fringe.

(iv) Employer may deduct the expenses for lodging the employees at the hotel as ordinary and necessary business expenses under section 162(a).

Example 4. (i) Employer hires Employee, who currently resides 500 miles from Employer's business premises. Employer pays for temporary lodging for Employee near Employer's business premises while Employee searches for a residence.

(ii) Employer is paying the temporary lodging expense primarily to provide a personal benefit to Employee by providing housing while Employee searches for a residence. Employer incurs the expense only as additional compensation and not for a noncompensatory business purpose. If Employee paid the temporary lodging expense, the expense would not be an ordinary and necessary employee business expense under section 162(a) because the lodging primarily provides a personal benefit to Employee. Therefore, the value of the lodging is includible in Employee's gross income as additional compensation.

(iii) Employer may deduct the lodging expenses as ordinary and necessary business expenses under section 162(a) and § 1.162-25T.

Example 5. (i) Employee normally travels two hours each way between her home and her office. Employee is working on a project that requires Employee to work late hours. Employer provides Employee with lodging at a hotel near the office.

(ii) Employer is paying the temporary lodging expense primarily to provide a personal benefit to Employee by relieving her of the daily commute to her residence. Employer incurs the expense only as additional compensation and not for a noncompensatory business purpose. If Employee paid the temporary lodging expense, the expense would not be an ordinary and necessary business expense under section 162(a) because the lodging primarily provides a personal benefit to Employee. Therefore, the value of the lodging is includible in Employee's gross income as additional compensation.

(iii) Employer may deduct the lodging expenses as ordinary and necessary business expenses under section 162(a) and § 1.162-25T.

Example 6. (i) Employer requires an employee to be "on duty" each night to respond quickly to emergencies that may occur outside of normal working hours. Employees who work daytime hours each serve a "duty shift" once each month in addition to their normal work schedule. Emergencies that require the duty shift employee to respond occur regularly. Employer has no sleeping facilities on its business premises and pays for a hotel room nearby where the duty shift employee stays until called to respond to an emergency.

(ii) Because an employee's expenses for lodging while on the duty shift occur more frequently than once per calendar quarter, the safe harbor in para-

graph (b) of this section does not apply. However, the value of the lodging may be excluded from income if the facts and circumstances test in paragraph (a) of this section is satisfied.

(iii) The duty shift is a bona fide condition or requirement of employment and Employer has a noncompensatory business purpose for paying the lodging expenses. Employer is not providing the lodging to duty shift employees primarily to provide a social or personal benefit to the employees and the lodging Employer provides is not lavish or extravagant. If the employees had paid for their lodging, the expenses would have been deductible by the employees under section 162(a) as ordinary and necessary business expenses. Therefore, the value of the lodging is excluded from the employees' income as a working condition fringe.

(iv) Employer may deduct the lodging expenses as ordinary and necessary business expenses under section 162(a).

(d) *Effective/applicability date.* This section applies to expenses paid or incurred on or after October 1, 2014. However, taxpayers may apply these regulations to local lodging expenses that are paid or incurred in taxable years for which the period of limitation on credit or refund under section 6511 has not expired.

Par. 3. In § 1.262-1, paragraph (b)(5) is revised to read as follows:

§ 1.262-1 Personal, living, and family expenses.

* * * * *

(b) * * *

(5) Expenses incurred in traveling away from home (which include transportation expenses, meals, and lodging) and any other transportation expenses are not deductible unless they qualify as expenses deductible under section 162 (relating to trade or business expenses), section 170 (relating to charitable contributions), section 212 (relating to expenses for production of income), section 213 (relating to medical expenses), or section 217 (relating to moving expenses), and the regulations under those sections. The taxpayer's costs of commuting to his place of business or employment are personal expenses and do not qualify as deductible expenses. For expenses paid or incurred before October 1, 2014, a taxpayer's expenses for lodging when not traveling away from home (local lodging) are nondeductible personal expenses. However, taxpayers may deduct local lodging expenses that qualify under section 162 and are paid or incurred in taxable years for which the period of limitation on credit or refund

under section 6511 has not expired. For expenses paid or incurred on or after October 1, 2014, a taxpayer's local lodging expenses are personal expenses and are not deductible unless they qualify as deductible expenses under section 162. Except as permitted under section 162 or 212, the costs of a taxpayer's meals not incurred in traveling away from home are nondeductible personal expenses.

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Heather C. Maloy
*Acting Deputy Commissioner for
Services and Enforcement.*

Approved July 11, 2014.

Mark J. Mazur
*Assistant Secretary of the Treasury
(Tax Policy).*

(Filed by the Office of the Federal Register on September 9, 2014, 8:45 a.m., and published in the issue of the Federal Register for October 1, 2014, 79 F.R. 59112)

Section 9831.—General Exceptions

T.D. 9697

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 CMS-9946-F 45 CFR Part 146

Amendments to Excepted Benefits

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: Final rules.

SUMMARY: This document contains final regulations that amend the regulations regarding excepted benefits under the Employee Retirement Income Security Act of 1974, the Internal Revenue Code (the Code), and the Public Health Service Act. Excepted benefits are generally exempt from the health reform requirements that were added to those laws by the Health Insurance Portability and Accountability Act and the Patient Protection and Affordable Care Act. In addition, eligibility for excepted benefits does not preclude an individual from eligibility for a premium tax credit under section 36B of the Code if an individual chooses to enroll in coverage under a Qualified Health Plan through an Affordable Insurance Exchange. These regulations finalize some but not all of the proposed rules with minor modifications; additional guidance on limited wraparound coverage is forthcoming.

DATES: *Effective Date.* These final regulations are effective on December 1, 2014..

Applicability Date. These final regulations apply to group health plans and group health insurance issuers for plan years beginning on or after January 1, 2015.

FOR FURTHER INFORMATION

CONTACT: Amy Turner or Beth Baum, Employee Benefits Security Administration, Department of Labor, at (202) 693-8335; Karen Levin, Internal Revenue Service, Department of the Treasury, at (202) 317-5500; Jacob Ackerman, Centers for

Medicare & Medicaid Services, Department of Health and Human Services, at (301) 492-4179.

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 website (<http://www.dol.gov/ebsa>). In addition, information from HHS on private health insurance for consumers can be found on the Centers for Medicare & Medicaid Services (CMS) website (www.cms.gov/ccio) and information on health reform can be found at www.HealthCare.gov.

SUPPLEMENTARY INFORMATION:

I. Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104–191, 110 Stat. 1936, added title XXVII of the Public Health Service Act (PHS Act), part 7 of the Employee Retirement Income Security Act of 1974 (ERISA), and chapter 100 of the Internal Revenue Code (the Code), providing portability and nondiscrimination provisions with respect to health coverage. These provisions of the PHS Act, ERISA, and the Code were later augmented by other consumer protection laws, including the Mental Health Parity Act of 1996,¹ the Mental Health Parity and Addiction Equity Act of 2008,² the Newborns’ and Mothers’ Health Protection Act,³ the Women’s Health and Cancer Rights Act,⁴ the Genetic Information Nondiscrimination Act of 2008,⁵ the Children’s Health In-

surance Program Reauthorization Act of 2009,⁶ Michelle’s Law,⁷ and the Affordable Care Act.⁸

The Affordable Care Act reorganizes, amends, and adds to the provisions of part A of title XXVII of the PHS Act relating to group health plans and health insurance issuers in the group and individual markets. The term “group health plan” includes both insured and self-insured group health plans.⁹ Section 715(a)(1) of ERISA and section 9815(a)(1) of the Code, as added by the Affordable Care Act, incorporate the provisions of part A of title XXVII of the PHS Act into ERISA and the Code to make them applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. The PHS Act sections incorporated by these references are sections 2701 through 2728.

Sections 2722 and 2763 of the PHS Act, section 732 of ERISA, and section 9831 of the Code provide that the requirements of title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code, respectively, generally do not apply to excepted benefits. Excepted benefits are described in section 2791 of the PHS Act, section 733 of ERISA, and section 9832 of the Code.

The parallel statutory provisions establish four categories of excepted benefits. The first category includes benefits that are generally not health coverage¹⁰ (such as automobile insurance, liability insurance, workers compensation, and accidental death and dismemberment coverage). The benefits in this category are excepted in all circumstances. In contrast, the benefits in the second, third, and fourth categories are types of health coverage but are

¹Pub. L. 104–204, 110 Stat. 2944 (September 26, 1996).

²Pub. L. 110–343, 122 Stat. 3881 (October 3, 2008).

³Pub. L. 104–204, 110 Stat. 2935 (September 26, 1996).

⁴Pub. L. 105–277, 112 Stat. 2681–436 (October 21, 1998).

⁵Pub. L. 110–233, 122 Stat. 881 (May 21, 2008).

⁶Pub. L. 111–3, 123 Stat. 65 (February 4, 2009).

⁷Pub. L. 110–381, 122 Stat. 4081 (October 9, 2008).

⁸The Patient Protection and Affordable Care Act, Public Law 111–148, was enacted on March 23, 2010, and the Health Care and Education Reconciliation Act, Public Law 111–152, was enacted on March 30, 2010. (These statutes are collectively known as the “Affordable Care Act”.)

⁹The term “group health plan” is used in title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code, and is distinct from the term “health plan,” as used in other provisions of title I of the Affordable Care Act. The term “health plan” does not include self-insured group health plans.

¹⁰See 62 FR 16894, 16903 (Apr. 8, 1997), which states that these benefits are generally not health insurance coverage.

excepted only if certain conditions are met.

The second category of excepted benefits is limited excepted benefits, which may include limited-scope vision or dental benefits, and benefits for long-term care, nursing home care, home health care, or community-based care. Section 2791(c)(2)(C) of the PHS Act, section 733(c)(2)(C) of ERISA, and section 9832(c)(2)(C) of the Code authorize the Secretaries of Health and Human Services (HHS), Labor, and the Treasury (collectively, the Secretaries) to issue regulations establishing other similar limited benefits as excepted benefits. The Secretaries exercised this authority previously with respect to certain health flexible spending arrangements (health FSAs).¹¹ To be excepted under this second category, the statute (specifically, ERISA section 732(c)(1), PHS Act section 2722(c)(1), and section 9831(c)(1) of the Code) provides that limited benefits must either: (1) be provided under a separate policy, certificate, or contract of insurance; or (2) otherwise not be an integral part of a group health plan, whether insured or self-insured.

The third category of excepted benefits, referred to as “noncoordinated excepted benefits,” includes both coverage for only a specified disease or illness (such as cancer-only policies), and hospital indemnity or other fixed indemnity insurance. In the group market, these benefits are excepted only if all of the following conditions are met: (1) the benefits are provided under a separate policy, certificate, or contract of insurance; (2) there is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor; and (3) the benefits are paid with respect to any event without regard to whether

benefits are provided under any group health plan maintained by the same plan sponsor.¹²

The fourth category of excepted benefits is supplemental excepted benefits. Such benefits must be: (1) coverage supplemental to Medicare, coverage supplemental to the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) or to Tricare, or similar coverage that is supplemental to coverage provided under a group health plan; and (2) provided under a separate policy, certificate, or contract of insurance.¹³

In 2004, the Departments of the Treasury, Labor, and HHS published final regulations with respect to excepted benefits (the HIPAA regulations).¹⁴ (Subsequent references to the “Departments” include all three Departments, unless the headings or context indicate otherwise.)

On December 24, 2013, the Departments issued proposed regulations with respect to the second category of excepted benefits, limited excepted benefits (2013 proposed regulations).¹⁵ The 2013 proposed regulations proposed to: (1) eliminate the requirement that participants pay an additional premium or contribution for limited-scope vision or dental benefits to qualify as benefits that are not an integral part of the plan; (2) set forth the criteria under which employee assistance programs (EAPs) constitute excepted benefits; and (3) allow plan sponsors in limited circumstances to offer, as excepted benefits, coverage that wraps around certain individual health insurance coverage. The Departments stated that, until rulemaking is finalized, through at least 2014, for purposes of enforcing the provisions of title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code, the Departments will consider dental and vision benefits and EAP benefits meeting the condi-

tions of the 2013 proposed regulations to qualify as excepted benefits.

After consideration of comments on the 2013 proposed regulations, the Departments are publishing final regulations regarding dental and vision benefits and EAP benefits. The Departments also intend to publish regulations that address limited wraparound coverage in the future, taking into account the extensive comments received on this issue.

II. Overview of the Final Regulations

A. Dental and Vision Benefits

Under the HIPAA regulations, vision and dental benefits are excepted if they are limited in scope (described as benefits, substantially all of which are for treatment of the eyes or mouth, respectively) and are either: (1) provided under a separate policy, certificate, or contract of insurance; or (2) are otherwise not an integral part of a group health plan. While only insured coverage may qualify under the first test, both insured and self-insured coverage may qualify under the second test. The HIPAA regulations provided that benefits are not an integral part of a plan if participants have the right to elect not to receive coverage for the benefits, and, if participants elect to receive coverage for such benefits, they pay an additional premium or contribution for the coverage. By contrast, health FSA benefits could qualify as excepted benefits without any participant contribution under the HIPAA regulations.¹⁶

As stated in the preamble to the 2013 proposed regulations, following enactment of the Affordable Care Act, various stakeholders asked the Departments to amend the HIPAA regulations in order to remove conditions for limited-scope vision and dental benefits to be treated as excepted benefits. Specifically, some em-

¹¹26 CFR 54.9831-1(c)(3)(v); 29 CFR 2590.732(c)(3)(v); 45 CFR 146.145(b)(3)(v).

¹²26 CFR 54.9831-1(c)(4); 29 CFR 2590.732(c)(4); 45 CFR 146.145(b)(4). See also Q7 in FAQs about Affordable Care Act Implementation Part XI, available at <http://www.dol.gov/ebsa/faqs/faq-aca11.html>.

¹³26 CFR 54.9831-1(c)(5); 29 CFR 2590.732(c)(5); 45 CFR 146.145(b)(5). The Departments issued additional guidance regarding supplemental health insurance coverage as excepted benefits. See EBSA Field Assistance Bulletin No. 2007-04 (available at <http://www.dol.gov/ebsa/pdf/fab2007-4.pdf>); CMS Insurance Standards Bulletin 08-01 (available at http://www.cms.gov/CCIIO/Resources/Files/Downloads/hipaa_08_01_508.pdf); and IRS Notice 2008-23 (available at http://www.irs.gov/irb/2008-07_IRB/ar09.html).

¹⁴69 FR 78720 (Dec. 30, 2004).

¹⁵78 FR 77632.

¹⁶Under the HIPAA regulations, benefits provided under a health FSA are only excepted for a class of participants if other group health coverage, not limited to excepted benefits, is made available for the year to the class of participants; and the arrangement is structured so that the maximum benefit payable to any participant in the class for a year does not exceed an amount specified in the regulations.

employers represented that, although their vision and dental benefits complied with the pre-Affordable Care Act requirements in title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code (such as the nondiscrimination and preexisting condition exclusion provisions), compliance with certain Affordable Care Act provisions presented additional challenges. These employers argued that, where employers are providing such benefits on a self-insured basis and without a contribution from employees, employers should not be required to charge a nominal contribution from participants simply for the benefits to qualify as excepted benefits. In some cases, the cost of collecting the nominal contribution would be greater than the contribution itself. Moreover, they pointed out that employers providing dental and vision benefits through a separate insurance policy are not required to charge a participant any premium or contribution in order for the dental or vision benefits to be considered excepted benefits. Similarly, consumer groups argued that, if an employer offers primary group health coverage that is treated as unaffordable under the Code, but offers limited-scope vision or dental coverage, such limited-scope vision or dental coverage should qualify as excepted benefits so as not to make such individuals ineligible to receive a premium tax credit under section 36B of the Code if they enroll in coverage under a Qualified Health Plan (QHP) through an Affordable Insurance Exchange, or “Exchange” (also called a Health Insurance Marketplace or Marketplace).

In response to these concerns, and to achieve greater consistency between insured and self-insured coverage, the 2013 proposed regulations proposed eliminating the requirement under the HIPAA regulations that participants pay an additional premium or contribution for limited-scope vision or dental benefits to qualify as benefits that are not an integral part of a plan (and therefore to qualify as excepted benefits).

The Departments invited comments on this approach. Many comments supported the concept of achieving greater consistency regarding the excepted benefits re-

quirements for dental and vision benefits between insured and self-insured plans. One comment argued that the proposal undermined the inclusion of pediatric vision and dental coverage as an essential health benefit. Other comments requested clarification as to whether separately-administered and stand-alone dental and vision benefits offered separate from, or without a connection to, a primary plan could qualify as excepted benefits.

Consistent with the 2013 proposed regulations, these final regulations eliminate the requirement under the HIPAA regulations that participants pay an additional premium or contribution for limited-scope vision or dental benefits to qualify as excepted benefits. As explained in the preamble to the 2013 proposed regulations, without this change, an employer that establishes or maintains a self-insured plan could be required to charge a nominal contribution from participants simply for limited-scope vision and dental benefits to qualify as excepted benefits and, in some cases, the cost of collecting the nominal contribution would be greater than the contribution itself. In addition, if an employer offers primary group health coverage that is unaffordable to individuals, but limited-scope vision or dental coverage, without this modification, accepting the vision or dental coverage could make such individuals ineligible to receive a premium tax credit under section 36B of the Code if they enroll in coverage under a QHP through the Exchange.

In addition, it is the Departments’ view that the final regulations do not undermine the inclusion of pediatric vision or dental coverage as essential health benefits. The requirement that issuers in the small group market offer coverage of essential health benefits is not changed, and that rule does not apply to large or self-insured plans. Moreover, PHS Act section 2711 (as incorporated into ERISA by section 715 and the Code by section 9815) allows self-insured plans to choose any definition of essential health benefits that is authorized by the Secretary of HHS for purposes of the prohibition on lifetime or annual dollar limits on essential health benefits.¹⁷

These final regulations clarify that limited-scope vision or dental benefits do

not have to be offered in connection with a separate offer of major medical or “primary” group health coverage under the plan, in order to meet the statutory criterion that such benefits are “otherwise not an integral part of the plan.” To meet this criterion, limited-scope vision or dental benefits can be provided without connection to a primary plan, or the limited-scope vision or dental benefits can be offered separately from the major medical or “primary” coverage under the plan (as described in these final regulations). Under the 2013 proposed regulations, in order to satisfy the statutory excepted benefits criterion that such benefits cannot otherwise be “an integral part of the plan,” participants must be able to decline coverage. These final regulations provide that this criterion is satisfied if participants may decline coverage or the claims for the benefits are administered under a contract separate from claims administration for any other benefits under the plan.

While coverage for long-term care benefits is not the focus of this rule, such benefits are also subject to the “not an integral part of a group health plan” standard in order to be classified as excepted benefits. Accordingly, the revisions discussed in this section of the preamble also apply to coverage of long-term care benefits.

B. Employee Assistance Programs

EAPs are typically programs offered by employers that can provide a wide-ranging set of benefits to address circumstances that might otherwise adversely affect employees’ work and health. Benefits may include referral services and short-term substance use disorder or mental health counseling, as well as financial counseling and legal services. They are typically available free of charge to employees and are often provided through third-party vendors. Benefits for medical care provided through an EAP would generally be considered group health plan coverage (and, therefore, minimum essential coverage), which would generally be subject to the HIPAA and Affordable Care Act market reform requirements (and could make individuals receiving

¹⁷See CMS, Frequently Asked Questions on Essential Health Benefits Bulletin, Q10 (February 17, 2012) <http://www.cms.gov/CCHIO/Resources/Files/Downloads/ehb-faq-508.pdf>.

benefits under an EAP ineligible to receive a premium tax credit under section 36B of the Code if they enroll in coverage under a QHP through the Exchange), unless the EAP meets the criteria for being excepted benefits.

Since enactment of the Affordable Care Act, various stakeholders have asked the Departments to treat EAPs as excepted benefits for reasons analogous to the arguments described above with respect to vision and dental benefits. Specifically, some employers represented that compliance with the prohibition on annual dollar limits could be problematic as such benefits are typically very limited, and that EAPs generally are intended to provide benefits in addition to those provided under other group health plans sponsored by employers. Moreover, consumer groups have represented that EAPs with very limited benefits, which may be the only coverage offered to employees, could make such employees ineligible to receive a premium tax credit under section 36B of the Code if they enroll in coverage under a QHP through the Exchange. At the same time, the Departments recognize that no universal definition exists for EAPs, and are concerned that employers not act to shift primary coverage to a separate “EAP plan,” exempt from the consumer protection provisions of title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code, including the mental health parity provisions.¹⁸

In guidance issued on September 13, 2013, the Departments stated their intent to amend the excepted benefits regulations with respect to EAPs.¹⁹ The guidance also provided transition relief, stating, “[u]ntil rulemaking is finalized, through at least 2014, the Departments will consider an employee assistance program or EAP to constitute excepted benefits only if the employee assistance program or EAP does not provide significant benefits in the

nature of medical care or treatment. For this purpose, employers may use a reasonable, good faith interpretation of whether an employee assistance program or EAP provides significant benefits in the nature of medical care or treatment.”

The 2013 proposed regulations set forth criteria for an EAP to qualify as excepted benefits beginning in 2015. Under the 2013 proposed regulations, benefits provided under EAPs are excepted if four criteria are met. First, the program cannot provide significant benefits in the nature of medical care. The Departments invited comments on how to define “significant.” For example, the Departments requested comments as to whether a program that provides no more than 10 outpatient visits for mental health or substance use disorder counseling, an annual wellness checkup, immunizations, and diabetes counseling, with no inpatient care benefits, should be considered to provide significant benefits in the nature of medical care.²⁰

The second proposed criterion for an EAP to constitute excepted benefits under the 2013 proposed regulations is that its benefits cannot be coordinated with benefits under another group health plan. The Departments outlined three conditions to meet this proposed criterion: (i) participants in the separate group health plan must not be required to exhaust benefits under the EAP (making the EAP a “gatekeeper”) before an individual is eligible for benefits under the other group health plan; (ii) participant eligibility for benefits under the EAP must not be dependent on participation in another group health plan; and (iii) benefits under the EAP must not be financed by another group health plan.

The third proposed criterion for an EAP to constitute excepted benefits under the 2013 proposed regulations is that no employee premiums or contributions be required to participate in the EAP. The

fourth proposed criterion is that there is no cost sharing under the EAP.

The criteria in the 2013 proposed regulations were intended to ensure that employers are able to continue offering EAPs as supplemental benefits to other coverage, and to ensure that in circumstances in which an EAP with limited benefits is the only coverage, or the only affordable coverage provided to an employee, that the coverage does not unreasonably disqualify an employee from potential eligibility to receive a premium tax credit under section 36B of the Code if the employee enrolls in coverage under a QHP through the Exchange. The Departments requested comments on whether the criteria proposed are sufficient to prevent the potential for abuse, including the evasion of compliance with the mental health parity provisions, and whether different or additional standards should be included.

The Departments received a number of comments relating to the treatment of EAPs as excepted benefits. While the comments generally supported treating EAPs as excepted benefits, there were many suggestions for clarifying or modifying the specific requirements in the 2013 proposed regulations for EAPs to constitute excepted benefits. In particular, many comments included suggestions for clarifying what is meant by significant benefits in the nature of medical care. Most of these comments raised concerns about the suggestion in the preamble to propose using numerical limits on the number of visits.

Some comments requested that EAPs be allowed to provide wellness and disease management programs, provided such programs do not provide significant benefits in the nature of medical care. However, treating wellness programs as excepted benefits by including them in an EAP would circumvent consumer protections contained in the statutory standards

¹⁸The mental health parity provisions are included in PHS Act section 2726, ERISA section 712, and Code section 9812. See also final regulations on mental health parity, published at 78 FR 68239 (November 13, 2013).

¹⁹See IRS Notice 2013–54 (available at <http://www.irs.gov/pub/irs-drop/n-13-54.pdf>) and DOL Technical Release 2013–03 (available at <http://www.dol.gov/ebsa/newsroom/tr13-03.html>), Q&A 9. See also CMS Insurance Standards Bulletin—Application of Affordable Care Act Provisions to Certain Healthcare Arrangements (available at <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cms-hra-notice-9-16-2013.pdf>).

²⁰Other examples of EAPs that do not provide significant benefits in the nature of medical care, discussed in IRS Notice 2004–50 Q&A–10 include (1) an EAP with benefits that consist primarily of free or low-cost confidential short-term counseling (which could address substance abuse, alcoholism, mental health or emotional disorders, financial or legal difficulties, and dependent care needs) to identify an employee’s problem that may affect job performance and, when appropriate, referrals to an outside organization, facility or program to assist the employee in resolving the problem; and (2) a wellness program that provides a wide-range of education and fitness services (also including sports and recreation activities, stress management, and health screenings) designed to improve the overall health of the employees and prevent illness, where any costs charged to the individual for participating in the services are separate from the individual’s coverage under the health plan.

for wellness programs under section 2705(j) of the PHS Act as enacted by the Affordable Care Act. This suggestion is not adopted in these final regulations.

Several comments opposed the prohibition in the 2013 proposed regulations on an EAP being financed by the other group health plan to qualify as excepted benefits. In particular, the comments noted that often the EAP and the group health plan are financed by a single payment or otherwise combined, and the requirement would result in disruptions of existing commercial arrangements. Moreover, these comments noted, the other requirements sufficiently protected against inappropriate coordination of the EAP benefits with the benefits of the other group health plan. In addition, there were a number of comments concerning EAPs that were beyond the scope of the 2013 proposed regulations.

After consideration of the comments, the Departments are finalizing the proposal, with one modification related to financing, described below.²¹ As with the 2013 proposed regulations, these final regulations provide that, for an EAP to constitute excepted benefits, the EAP must satisfy four requirements.

The first requirement of the 2013 proposed regulations and these final regulations is that the EAP does not provide significant benefits in the nature of medical care. For this purpose, the amount, scope, and duration of covered services are taken into account. For example, an EAP that provides only limited, short-term outpatient counseling for substance use disorder services (without covering inpatient, residential, partial residential or intensive outpatient care) without requiring prior authorization or review for medical necessity does not provide significant benefits in the nature of medical care. At the same time, a program that provides disease management services (such as laboratory testing, counseling, and prescription drugs) for individuals with chronic conditions, such as diabetes, does provide significant benefits in the nature of medical care. The Departments may, through

guidance, provide additional clarification in the future regarding when a program provides significant benefits in the nature of medical care.

The second requirement of these final regulations is that for an EAP to constitute excepted benefits, its benefits cannot be coordinated with the benefits under another group health plan. This requirement has two elements: (1) participants in the other group health plan must not be required to use and exhaust benefits under the EAP (making the EAP a “gatekeeper”) before an individual is eligible for benefits under the other group health plan; and (2) participant eligibility for benefits under the EAP must not be dependent on participation in another group health plan. In response to comments, these final regulations do not include the requirement set forth in the 2013 proposed regulations that EAP benefits cannot be financed by another group health plan in order to qualify as excepted benefits.

The third requirement of the 2013 proposed regulations and these final regulations for EAPs to constitute excepted benefits is that no employee premiums or contributions may be required as a condition of participation in the EAP. Finally, as with the 2013 proposed regulations, the final regulations provide that an EAP that constitutes excepted benefits may not impose any cost-sharing requirements.

C. *Applicability Date and Reliance*

In the preamble to the 2013 proposed regulations, the Departments stated that, until rulemaking is finalized, through at least 2014, for purposes of enforcing the provisions of title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code, the Departments will consider dental and vision benefits, and EAP benefits, meeting the conditions of the 2013 proposed regulations to qualify as excepted benefits and that, to the extent final regulations or other guidance with respect to vision or dental benefits or EAPs is more restrictive on plans and issuers than the 2013 proposed regulations, the final regu-

lations or other guidance will not be effective prior to January 1, 2015. These final regulations apply to group health plans and group health insurance issuers for plan years beginning on or after January 1, 2015. They do not apply to health insurance issuers offering individual health insurance coverage. Until the applicability date of these final regulations, the Departments will consider dental and vision benefits and EAP benefits meeting the conditions of the 2013 proposed regulations or these final regulations to qualify as excepted benefits.

III. Economic Impact and Paperwork Burden

A. *Summary — Department of Labor and Department of Health and Human Services*

As stated above, these final regulations eliminate the requirement under the HIPAA regulations that participants pay an additional premium or contribution for limited-scope vision or dental benefits to qualify as excepted benefits, and set forth four requirements for an EAP to constitute excepted benefits.

B. *Executive Order 12866 — Department of Labor and Department of Health and Human Services*

OMB has determined that this regulatory action is significant within the meaning of section 3(f)(4) of the Executive Order, and the Departments accordingly provide the following assessment of its potential benefits and costs. The Departments expect the impact of these final regulations to be limited.

Specifically, with respect to vision and dental benefits, the final regulations allow group health plans to offer dental and vision benefits to employees without charging a premium or contribution. As stated earlier in the preamble, this eliminates a difference that would otherwise exist between insured and self-insured coverage. With respect to EAPs, the final regulations clarify the conditions that be must be sat-

²¹In the 2013 proposed regulations, the requirements regarding EAPs were proposed in paragraph (c)(3)(vii) of 26 CFR 54.9831-1, 29 CFR 2590.732, and 45 CFR 146.145. However, HHS regulations published on October 30, 2013 and effective December 30, 2013 redesignated 45 CFR 146.145(c) as paragraph (b) (78 FR at 65092). Additionally, because these regulations are finalizing only the requirements related to dental and vision benefits and EAP benefits, these final regulations have been renumbered so that the requirements regarding EAPs are now contained in paragraph (c)(3)(vi) of 26 CFR 54.9831-1 and 29 CFR 2590.732, and in paragraph (b)(3)(vi) of 45 CFR 146.145. As stated earlier in this preamble, the Departments also intend to publish regulations that address limited wraparound coverage in the future, taking into account the extensive comments received on this issue. Those provisions are intended to be codified in paragraph (c)(3)(vii) of 26 CFR 54.9831-1 and 29 CFR 2590.732, and in paragraph (b)(3)(vii) of 45 CFR 146.145.

ified for such benefits to constitute excepted benefits, which are not subject to the group market requirements under the PHS Act, ERISA, and the Code.

Some employers represented to the Departments that compliance with the Affordable Care Act presented challenges for their limited-scope vision and dental benefits and EAPs. The clarifications provided in these final regulations will benefit employees by ensuring continued access to these benefits. The Departments expect these final regulations to have some costs, but these costs will be limited because the Departments expect the primary result of the final regulations will be that employers providing limited-scope dental and vision and EAP benefits will continue to provide such benefits and that the number of employers who will begin providing such benefits for the first time will be small.

C. Regulatory Flexibility Act — Department of Labor and Department of Health and Human Services

The Regulatory Flexibility Act (5 U.S.C. 601 et seq.) (RFA) imposes certain requirements with respect to Federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 et seq.) and that are likely to have a significant economic impact on a substantial number of small entities. Unless an agency certifies that a proposed rule is not likely to have a significant economic impact on a substantial number of small entities, section 603 of RFA requires that the agency present an initial regulatory flexibility analysis at the time of the publication of the notice of proposed rulemaking describing the impact of the rule on small entities and seeking public comment on such impact. Small entities include small businesses, organizations and governmental jurisdictions.

For purposes of the RFA, the Departments continue to consider a small entity to be an employee benefit plan with fewer than 100 participants. The basis for this definition is found in section 104(a)(2) of the act, which permits the Secretary of Labor to prescribe simplified annual reports for pension plans that cover fewer than 100 participants. Pursuant to the au-

thority of section 104(a)(3), the Department of Labor has previously issued at 29 CFR 2520.104–20, 2520.104–21, 2520.104–41, 2520.104–46 and 2520.104b–10 certain simplified reporting provisions and limited exemptions from reporting and disclosure requirements for small plans, including unfunded or insured welfare plans covering fewer than 100 participants and satisfying certain other requirements.

Further, while some large employers may have small plans, in general small employers maintain most small plans. Thus, the Departments believe that assessing the impact of these final regulations on small plans is an appropriate substitute for evaluating the effect on small entities. The definition of small entity considered appropriate for this purpose differs, however, from a definition of small business that is based on size standards promulgated by the Small Business Administration (13 CFR 121.201) pursuant to the Small Business Act (15 U.S.C. 631 et seq.).

As noted above, the Departments expect the costs imposed by these regulations to be limited for those employers that provide dental, vision and EAP benefits, and that they will not affect employers who do not provide such benefits. The final regulations allow employers to decide based on their own costs and benefits what action to take. This is true for large and small plans alike. Accordingly, the Departments believe that these final regulations do not have a significant economic impact on a substantial number of small entities. Accordingly, pursuant to section 605(b) of the RFA, the Departments hereby certify that these final regulations will not have a significant economic impact on a substantial number of small entities.

D. Special Analyses—Department of the Treasury

For purposes of the Department of the Treasury it has been determined that these final regulations are not a significant regulatory action as defined in Executive Order 12866, as supplemented 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 these final regulations, and, because these final regulations do not impose a collection of information on small entities, a Regulatory Flexibility Analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required. Pursuant to section 7805(f) of the Code, these final regulations have been submitted to the Small Business Administration for comment on its impact on small business.

E. Unfunded Mandates Reform Act

For purposes of the Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1501 et seq.), as well as Executive Order 12875, these final regulations do not include any Federal mandate that may result in expenditures by State, local, or tribal governments, or the private sector, which may impose an annual burden of \$100 million adjusted for inflation since 1995.

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

Executive Order 13132 outlines fundamental principles of federalism. It requires adherence to specific criteria by Federal agencies in formulating and implementing policies that have “substantial direct effects” on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among the various levels of government. Federal agencies promulgating regulations 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 final regulation.

In the Departments’ view, the final regulations, by clarifying policy regarding certain excepted benefits options that can be designed by employers to support their employees, would provide more certainty to employers and others in the regulated community as well as States and political subdivisions regarding the treatment of such arrangements under the PHS Act, ERISA and the Code. Through the regular course of outreach the Departments normally engage in with officials of States (and political subdivisions), the Depart-

ments are aware of no special federalism implications presented by these final regulations. The Departments will continue to conduct regular outreach activities with States.

G. Congressional Review Act

These final regulations are subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 et seq.), and will be transmitted to the Congress and to the Comptroller General for review in accordance with such provisions.

IV. Statutory Authority

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

The Department of Labor regulations are adopted pursuant to the authority contained in 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 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. 3765; Public Law 110–460, 122 Stat. 5123; Secretary of Labor’s Order 1–2011, 77 FR 1088 (January 9, 2012).

The Department of Health and Human Services regulations are 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.

29 CFR Part 2590

Continuation coverage, Disclosure, Employee benefit plans, Group health plans, Health care, Health insurance, Medical child support, Reporting and recordkeeping requirements.

45 CFR Part 146

Health care, Health insurance, Reporting and recordkeeping requirements, and State regulation of health insurance.

John Dalrymple
Deputy Commissioner for Services and Enforcement, Internal Revenue Service.

Approved September 25, 2014.

Mark J. Mazur
Assistant Secretary of the Treasury
(Tax Policy).

Signed this 25th day of September, 2014.

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

Dated: _____

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

Dated: _____

Sylvia Burwell,
Secretary, Department of Health and
Human Services.

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Accordingly, 26 CFR Part 54 is 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. * * *

Section 54.9831–1 is also issued under 26 U.S.C. 9833; * * *

Par. 2. Section 54.9831–1 is amended by revising paragraphs (c)(3)(i) and (c)(3)(ii), and adding paragraph (c)(3)(vi), to read as follows:

§ 54.9831–1 *Special rules relating to group health plans.*

* * * * *

(c) * * *

(3) * * *

(i) *In general.* Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan as described in paragraph (c)(3)(ii) of this section. In addition, ben-

efits provided under a health flexible spending arrangement are excepted benefits if they satisfy the requirements of paragraph (c)(3)(v) of this section. Furthermore, benefits provided under an employee assistance program are excepted benefits if they satisfy the requirements of paragraph (c)(3)(vi) of this section.

(ii) *Not an integral part of a group health plan.* For purposes of this paragraph (c)(3), benefits are not an integral part of a group health plan (whether the benefits are provided through the same plan, a separate plan, or as the only plan offered to participants) if either paragraph (c)(3)(ii)(A) or (B) are satisfied.

(A) Participants may decline coverage. For example, a participant may decline coverage if the participant can opt out of the coverage upon request, whether or not there is a participant contribution required for the coverage.

(B) Claims for the benefits are administered under a contract separate from claims administration for any other benefits under the plan.

* * * * *

(vi) *Employee assistance programs.* Benefits provided under employee assistance programs are excepted if they satisfy all of the requirements of this paragraph (c)(3)(vi).

(A) The program does not provide significant benefits in the nature of medical care. For this purpose, the amount, scope and duration of covered services are taken into account.

(B) The benefits under the employee assistance program are not coordinated with benefits under another group health plan, as follows:

(1) Participants in the other group health plan must not be required to use and exhaust benefits under the employee assistance program (making the employee assistance program a gatekeeper) before an individual is eligible for benefits under the other group health plan; and

(2) Participant eligibility for benefits under the employee assistance program must not be dependent on participation in another group health plan.

(C) No employee premiums or contributions are required as a condition of participation in the employee assistance program.

(D) There is no cost sharing under the employee assistance program.

* * * * *

Part III. Administrative, Procedural, and Miscellaneous

Guidance on Pension Funding Stabilization under the Highway and Transportation Funding Act of 2014 (HATFA)

Notice 2014-53

I. PURPOSE

This notice provides guidance on the changes to the funding stabilization rules for single-employer pension plans under the Internal Revenue Code (Code) and the Employee Retirement Income Security Act of 1974 (ERISA)¹ that were made by section 2003 of the Highway and Transportation Funding Act of 2014 (HATFA), Pub. L. No. 113-159, which was enacted on August 8, 2014.

II. BACKGROUND

Section 430 specifies the minimum funding requirements that generally apply to single-employer defined benefit pension plans pursuant to § 412. Section 430(h)(2) specifies interest rates that are used for purposes of calculating the minimum required contribution. The interest rates that are used for this purpose are a set of three segment rates described in § 430(h)(2)(C)(i), (ii) and (iii), or, alternatively, a full yield curve described in § 430(h)(2)(D)(i).

Section 430(h)(2)(C)(iv), which was added by the Moving Ahead for Progress in the 21st Century Act of 2012 (MAP-21), Pub. L. No. 112-141, provides that each of the three segment rates described in § 430(h)(2)(C)(i), (ii) and (iii) for a plan year is adjusted as necessary to fall within a specified range that is determined based on an average of the corresponding segment rates for the 25-year period ending on September 30 of the calendar year preceding the first day of that plan year. For plan years beginning in 2012, each segment rate is adjusted so that it is no less than 90% and no more than 110% of the corresponding 25-year average segment

rate. Under § 430(h)(2)(C)(iv)(II) as in effect prior to its modification by HATFA, this range was scheduled to gradually increase for later plan years, so that the segment rates for plan years beginning after 2015 would have been no less than 70% and no more than 130% of the corresponding 25-year average segment rates.

Notice 2012-61, 2012-42 I.R.B. 479, provides guidance regarding the changes to the minimum funding requirements and related rules made by MAP-21. Notice 2012-61 includes general guidance relating to the application of the modified segment rates (referred to in Notice 2012-61 and this notice as the MAP-21 segment rates), measurements for which the modified segment rates do not apply, transition issues, elections, reporting, and other issues.

HATFA extends the period during which the narrowest range around the 25-year average segment rates applies for purposes of determining the segment rates that are used to apply §§ 430 and 436. Under the modifications to § 430(h)(2)(C)(iv) made by HATFA, for plan years beginning in 2012 through 2017, each segment rate is adjusted so that it is no less than 90% and no more than 110% of the corresponding 25-year average segment rate. For later plan years, this range is scheduled to gradually increase, so that the segment rates for plan years beginning after 2020 are no less than 70% and no more than 130% of the corresponding 25-year average segment rates. The segment rates as modified by HATFA are referred to in this notice as the HATFA segment rates.

Section 436 sets forth a series of limitations on the accrual and payment of benefits under an underfunded plan. These limitations are applied during a plan year based on the plan's adjusted funding target attainment percentage (AFTAP). Section 2003(c) of HATFA provides that the limitation on interest rates based on the corresponding 25-year average segment rates does not apply for purposes of § 436(d)(2) (relating to limitations on ac-

celerated benefit distributions for a plan sponsored by an employer in bankruptcy).

Section 2003(e)(1) of HATFA provides that the modifications to § 430(h)(2)(C)(iv) apply with respect to plan years beginning after December 31, 2012. Under section 2003(e)(2) of HATFA, a plan sponsor can elect not to have the modifications to § 430 apply to any plan year beginning in 2013, either for all purposes or solely for purposes of determining the plan's AFTAP for that plan year (which is used to apply the benefit restrictions under § 436).

This notice provides guidance on certain issues relating to HATFA. Notice 2012-61 continues to apply except to the extent the statutory provisions have changed.

III. ELECTION TO DEFER USE OF HATFA SEGMENT RATES UNTIL THE 2014 PLAN YEAR

This section III sets forth the procedures for elections made pursuant to section 2003(e)(2) of HATFA that relate to a plan year beginning in 2013.

A. Procedure for electing to defer use of HATFA segment rates

Except as provided in section III.B of this notice (which provides for a deemed election to defer the use of the HATFA segment rates for purposes of both §§ 430 and 436 based on the filing of Form 5500 under some circumstances), a plan sponsor elects to defer the use of the HATFA segment rates, either for all purposes or solely for purposes of § 436, until the first plan year beginning on or after January 1, 2014, by providing written notice to the enrolled actuary for the plan and to the plan administrator. The notice must specify the name of the plan, employer identification number and plan number, and whether the use of the HATFA segment rates is deferred for all purposes or only for determination of the AFTAP used to apply benefit restrictions under § 436.

The election described in this section III.A is irrevocable, and must be made no

¹Under section 101 of Reorganization Plan No. 4 of 1978 (43 FR 47713) and section 3002(c) of ERISA, the Secretary of the Treasury has interpretive jurisdiction over the subject matter addressed in this notice for purposes of ERISA, as well as the Code. Thus, the provisions of this notice pertaining to §§ 430 and 436 of the Code also apply for purposes of sections 303 and 206(g) of ERISA.

later than the later of: (1) the deadline for filing the Form 5500, Form 5500–SF or Form 5500–EZ (including extensions) for the plan year beginning in 2013; or (2) December 31, 2014.

B. Deemed election to defer use of the HATFA segment rates for purposes of both §§ 430 and 436 through filing of Form 5500, Form 5500–SF or Form 5500–EZ

With respect to a plan year beginning in 2013, if, on or before December 31, 2014, the Form 5500, Form 5500–SF or Form 5500–EZ is filed and the Schedule SB reflects the MAP–21 segment rates, then an election to defer use of the HATFA segment rates for purposes of both §§ 430 and 436 until the first plan year beginning on or after January 1, 2014 is deemed made. If an election is deemed made pursuant to this section III.B, the election is permitted to be revoked by filing, no later than December 31, 2014, an amended Form 5500, Form 5500–SF, or Form 5500–EZ² for the plan year, with a revised Schedule SB that reflects the use of the HATFA segment rates. Alternatively, the deemed election is permitted to be revoked by either providing written notice of the revocation (which includes the name of the plan, employer identification number and plan number) to the enrolled actuary for the plan and to the plan administrator or by making the election described in section III.A of this notice to defer the use of HATFA segment rates only for purposes of § 436, but only if (1) a copy of the notice of the revocation or of the election is e-mailed to the Pension Benefit Guaranty Corporation (PBGC) at revoke.deemed.HATFA.election@pbgc.gov on or before December 31, 2014 (including in the subject line of the e-mail the plan sponsor’s employer identification number, the plan number, and the name of the plan), and (2) at the time of the revocation of the deemed election, the plan sponsor is not a debtor in a case under title 11, United States Code, or similar federal or state law. If the plan sponsor revokes the deemed election using this alternative method, then an amended Form 5500, Form 5500–SF, or Form 5500–EZ for the

plan year must be filed no later than the date on which Form 5500, Form 5500–SF or Form 5500–EZ is timely filed for the following plan year, and the revised Schedule SB must reflect the use of the HATFA segment rates.

If the plan sponsor revokes the deemed election, the plan sponsor can also elect to defer use of the HATFA segment rates only for purposes of § 436 under the rules of section III.A of this notice. An election that is deemed made pursuant to this section III.B is irrevocable if it is not revoked in the time and manner set forth in this section III.B.

IV. SECTION 430 ELECTIONS AND REDESIGNATIONS AVAILABLE FOR THE 2013 PLAN YEAR

This section IV sets forth rules regarding elections and designations relating to the minimum funding requirements applicable to the plan for the plan year beginning in 2013. Any action otherwise permitted in this section IV is not permitted to the extent it (1) would result in the imposition of benefit restrictions under § 436 for the plan year beginning in 2013 or 2014 that would otherwise not be imposed, or (2) would result in an unpaid minimum required contribution for any plan year beginning before 2014. The procedural and timing rules governing the acts permitted under this section IV are in section IV.E of this notice.

A. Reversal of an election to reduce funding balances

A plan sponsor is permitted to elect to reverse all or part of any election under § 1.430(f)–1(e) to reduce the plan’s funding standard carryover balance or prefunding balance as of the first day of a plan year beginning in 2013 if (i) the HATFA segment rates apply for purposes of determining the minimum required contribution for that plan year, and (ii) the reduction election was made on or before September 30, 2014. It is expected that the regulations under § 430(f) will be revised to permit this exception to the general rule that any election to reduce the plan’s

funding standard carryover balance or prefunding balance is irrevocable.

Under § 1.436–1(a)(5), there may have been deemed elections to reduce the funding standard carryover balance or prefunding balance to avoid or remove benefit restrictions under § 436 for the plan year beginning in 2013. If the HATFA segment rates are applied retroactively for purposes of § 436 for a plan year beginning in 2013, the election to reverse a reduction under this section IV.A also applies to such a deemed election that was made in conjunction with a certification of the plan’s AFTAP for the plan year. However, any reduction election that was made to avoid or remove benefit restrictions under § 436 during the period before the date of the original AFTAP certification for the 2013 plan year cannot be reversed even if the HATFA segment rates apply retroactively for purposes of § 436 for the plan year. This is because the AFTAP based on the HATFA segment rates will not apply to that portion of the plan year and therefore the reversal of any reduction election that was made to avoid or remove benefit restrictions under § 436 during that period would result in the imposition of new restrictions.

B. Late elections to add excess contributions for the 2013 plan year to the prefunding balance

If the HATFA segment rates apply for purposes of determining the minimum required contribution for a plan year beginning in 2013, the plan sponsor is permitted to make (or increase) the election under § 1.430(f)–1(b)(1)(ii) to add excess contributions for that plan year to the plan’s prefunding balance as of the first day of the following plan year. It is expected that the regulations under § 430(f) will be revised to permit this extension of time to make this election.

C. Redesignation of a section 436 contribution

If the HATFA segment rates are applied retroactively for purposes of § 436 for a plan year beginning in 2013, any section 436 contribution within the meaning of § 1.436–1(j)(7) that was made in connection with the certified AFTAP for

²Schedule SB is not required to be filed for plans for which Form 5500–EZ is filed and certain plans for which Form 5500–SF is filed. For these plans, the Schedule SB must be completed (including being signed by the enrolled actuary) and delivered to the plan administrator, who must retain it. With respect to these plans, references in section III.B of this notice to the filing of an amended Form 5500, Form 5500–SF, or Form 5500–EZ with a revised Schedule SB are applied by substituting the completion and delivery of the revised Schedule SB for the filing of the amended form.

that plan year is applied toward the minimum required contribution for that plan year to the extent the contribution is no longer required to avoid or remove the benefit restriction. However, no change is permitted with respect to section 436 contributions that were made in connection with a presumed AFTAP before the AFTAP was certified for the plan year.

D. Redesignation of a contribution originally designated for 2013

Despite the general position of the IRS that a contribution designated for a particular plan year cannot be redesignated to apply for another plan year after the Schedule SB is filed, the plan sponsor may choose to redesignate all or a portion of a contribution that was originally designated as applying to the plan year beginning in 2013 to apply to a plan year that begins in 2014. This rule applies only to contributions made after the end of the 2013 plan year and on or before September 30, 2014 and applies only if the original designation is on a Schedule SB for the 2013 plan year that is filed on or before December 31, 2014.³

E. Procedural and timing rules

Any reversal of an election, election made after the generally applicable deadline, or redesignation of contributions under this section IV is made by the plan sponsor by providing written notification to the plan's enrolled actuary and plan administrator, and must be made no later than the last day of the plan year beginning in 2014. The written notification must specify the name of the plan, the employer identification number and plan number, and must set forth the relevant details, including the specific dollar amount involved. A conditional or formula-based election does not satisfy this requirement.

V. REPORTING REQUIREMENTS IF THE HATFA SEGMENT RATES APPLY TO THE 2013 PLAN YEAR

With respect to the plan year beginning in 2013, if the plan uses the segment rates and the plan sponsor has not elected to defer the use of the HATFA segment rates in accordance with section III.A or III.B of this notice, then the Schedule SB for

that plan year must reflect the use of the HATFA segment rates.

VI. APPLICATION OF § 436 AND RELATED RULES FOR A PLAN YEAR BEGINNING AFTER DECEMBER 31, 2012 AND BEFORE OCTOBER 1, 2014

This notice provides special rules relating to the application of the benefit restrictions under § 436 and related rules for a plan year beginning after December 31, 2012 and before October 1, 2014 for a plan for which the modifications made by HATFA to § 430(h)(2)(C)(iv) are applied for purposes of determining the plan's AFTAP for the plan year. A plan year to which this section VI applies is referred to in this section VI as an applicable plan year.

A. Presumptions apply based on prior year AFTAP

The benefit restrictions under § 436 for an applicable plan year are applied based on the presumed AFTAP before the date, if any, that the AFTAP is certified for that applicable plan year. Thus, the application of the HATFA segment rates does not affect the application of the presumption rules under § 436(h) for the first plan year for which those rates apply to the plan for purposes of § 436 (but affects the application of those presumption rules for the subsequent plan year).

B. Rules if first certification uses HATFA segment rates

If the first AFTAP certification for an applicable plan year (which may be a range certification pursuant to § 1.436-1(h)(4)(ii)) is made using the HATFA segment rates, the benefit restrictions under § 436 apply based on that AFTAP in accordance with the rules of §§ 1.436-1(g) and (h).

C. Rules if first certification uses MAP-21 segment rates

If, on or before September 30, 2014, the AFTAP for an applicable plan year is certified using the MAP-21 segment rates, the AFTAP for that applicable plan year must be determined using the HATFA segment rates. If the change in the AFTAP using the HATFA segment rates rather than the MAP-21 segment rates results in

a material change to the AFTAP, then the AFTAP must be recertified. In such a case, the plan sponsor can choose to apply any resulting change in the application of the benefit restrictions under § 436 either (i) prospectively, as described in section VI.D of this notice or (ii) retroactively to the date that the AFTAP was originally certified, as described in section VI.E of this notice. If the HATFA segment rates are applied to determine the certified AFTAP for the plan year beginning in 2013, then the option to apply any change in the application of § 436 as a result of recertification of the AFTAP using the HATFA segment rates prospectively is not available for the plan year beginning in 2014. For the first plan year for which the HATFA segment rates apply for purposes of § 436, if the AFTAP using the HATFA segment rates is certified before the end of the plan year, then in the absence of an affirmative election to apply the changes retroactively as described in section VI.E of this notice, the plan sponsor will be treated as having elected to apply any changes prospectively as described in section VI.D of this notice. All plan operations and elections must be consistent with this choice of whether to apply the AFTAP using the HATFA segment rates retroactively or prospectively, and any plan operations that were inconsistent with this choice must be corrected as described in section VI.G of this notice.

If any AFTAP certification for an applicable plan year using the MAP-21 segment rates is made after September 30, 2014, then the rules regarding a change in the AFTAP set forth in § 1.436-1(h)(4)(iii) and (iv) apply with respect to the determination of the AFTAP for that plan year that must be made using the HATFA segment rates.

D. Prospective application of change in benefit restrictions reflecting HATFA segment rates

If the AFTAP is certified for an applicable plan year using the MAP-21 segment rates, then any subsequent change to that certification (including a certification based on the HATFA segment rates) is subject to the rules regarding a change in

³With respect to a plan for which the Schedule SB need not be filed, as described in footnote 2 of this notice, the reference to filing of the Schedule SB is replaced by the completion and delivery of the Schedule SB.

the AFTAP set forth in § 1.436–1(h)(4)(iii) and (iv).

Section 1.436–1(h)(4)(iii) sets forth rules relating to changes in certified AFTAPs and provides a special rule that deems a change in the AFTAP attributable to certain events as “immaterial,” even if the change would otherwise be a material change. The effect of having an event for which the change in AFTAP is deemed immaterial is that a plan administrator can reflect the event on a prospective basis beginning with the date of the event, provided that the AFTAP is recertified as soon as practicable thereafter. It is expected that § 1.436–1(h)(4)(iii)(C) will be amended to provide that additional events can be added to the list of deemed immaterial events in guidance of general applicability.

If (1) on or before September 30, 2014, the AFTAP is certified for an applicable plan year using the MAP–21 segment rates, (2) a certification for that applicable year is subsequently made using the HATFA segment rates, and (3) the plan sponsor does not choose to apply any change in those restrictions retroactively as described in section VI.E of this notice; then the change in AFTAP attributable to the use of the HATFA segment rates for an applicable plan year under this section VI.D is treated as a deemed immaterial change. The date of the event is October 1, 2014 (or the date of the revised AFTAP certification, if earlier). Accordingly, if the plan sponsor chooses to apply any changes in the § 436 restrictions prospectively for an applicable plan year as described in this section VI.D, any change in benefit restrictions resulting from the updated AFTAP determination using the HATFA segment rates must be effective as of the earlier of (1) October 1, 2014, or (2) the date the AFTAP for the applicable plan year is recertified using the HATFA segment rates.

The requirement that the AFTAP be recertified to reflect the HATFA segment rates as soon as practicable after the event giving rise to the deemed immaterial change will not be satisfied if the recertification occurs later than December 31, 2014.

E. Retroactive application of change in benefit restrictions reflecting HATFA segment rates

If (1) on or before September 30, 2014, the AFTAP is certified for an applicable plan year using the MAP–21 segment rates, (2) a certification for that applicable plan year is subsequently made using the HATFA segment rates, and (3) the plan sponsor elects to apply the AFTAP determined using the HATFA segment rates retroactively as described in this section VI.E; then the operations of the plan must be conformed to that updated AFTAP for the period beginning when the AFTAP for the plan year was originally certified. In addition, if the HATFA segment rates apply for purposes of determining the AFTAP for the plan year beginning in 2013, then operations of the plan during the plan year beginning in 2014 must be conformed to apply the rules of § 1.436–1(g) and (h) using the redetermined 2013 AFTAP as the AFTAP for the preceding plan year, during the period beginning on the first day of the plan year beginning in 2014 and ending when the AFTAP for that plan year was originally certified.

F. Reversal of an election to reduce funding balances and redesignation of section 436 contributions for the 2014 plan year

Sections IV.A and IV.C of this notice permit the reversal of an election to reduce a funding balance and the redesignation of a section 436 contribution for an applicable plan year beginning in 2013. Under this section VI.F, a reversal of an election made on or before October 1, 2014 to reduce a funding balance or a redesignation of a section 436 contribution made on or before October 1, 2014 is permitted for the plan year beginning in 2014.

Any reversal of an election or redesignation of a section 436 contribution under this section VI.F is not permitted to the extent it would result in the imposition of benefit restrictions under § 436 for the plan year beginning in 2014 that would otherwise not be imposed. Accordingly, if the plan year beginning in 2014 is the first applicable plan year, any reduction election that was made to avoid or remove benefit restrictions under § 436 during the period before the date of the original AFTAP certification for that plan year cannot be reversed. This is because the AFTAP based on the HATFA segment rates will not apply to that portion of the

plan year and therefore the reversal of any reduction election that was made to avoid or remove benefit restrictions under § 436 during that period would result in the imposition of new restrictions. Similarly, if the plan year beginning in 2014 is the first applicable plan year, no change is permitted with respect to section 436 contributions that were made in connection with a presumed AFTAP before the AFTAP was certified for the plan year.

G. Corrections

Once a plan’s AFTAP for an applicable plan year has been certified using the HATFA segment rates, the plan administrator must take any corrective actions necessary to conform plan operations to this certified AFTAP, if applying this certified AFTAP would have changed the application of the § 436 restrictions for the period (1) beginning with the date of the immaterial event described in section VI.D of this notice (if the AFTAP certification applying the HATFA segment rates applies prospectively under section VI.D) or (2) beginning with the date the AFTAP for the year was first certified, as applicable (if the AFTAP certification applying the HATFA segment rates applies retroactively under section VI.E). If the plan year beginning in 2013 is an applicable plan year, the period for potential correction also includes the period during the 2014 plan year before the AFTAP for that plan year beginning in 2014 was originally certified.

If the corrective actions described in this section VI.G are taken to reflect the application of the new certified AFTAP, then the plan’s operations are treated as having been consistent with the provisions of the plan document relative to the requirements of § 436. For this purpose, the provisions of the Employee Plans Compliance Resolution System (EPCRS), as set forth in Rev. Proc. 2013–12, 2013–4 I.R.B. 313, apply, except that a plan is eligible for self-correction under sections 7, 8, and 9 of Rev. Proc. 2013–12 without regard to the requirements of sections 4.03 (requiring a favorable IRS determination letter) and 4.04 (requiring certain established practices and procedures) of that revenue procedure.

Consistent with § 1.436–1(a)(4)(iii), if unpredictable contingent event benefits due to an event occurring during a plan

year beginning in 2013 or 2014 are not permitted to be paid because of restrictions under § 436(b), but are later permitted to be paid as a result of a new certification of the AFTAP for the plan year reflecting the HATFA segment rates, then those unpredictable contingent event benefits must become payable, retroactive to the period those benefits would have been payable under the terms of the plan (other than plan terms implementing the requirements of § 436(b)).

Consistent with § 1.436-1(a)(4)(iv), if a plan amendment with an effective date during a plan year beginning in 2013 or 2014 does not take effect because of the limitations of § 436(c), but is later permitted to take effect as a result of a new certification of the AFTAP for the plan year reflecting the HATFA segment rates, then the plan amendment must automatically take effect as of the first day of that plan year (or, if later, the original effective date of the amendment).

For any prohibited payment that was not permitted to be paid during a plan year beginning in 2013 or 2014 because of the restrictions under § 436(d), but is permitted to be paid as a result of a new certification of the AFTAP reflecting the HATFA segment rates, the plan has taken adequate corrective action if it makes the prohibited payment available to participants or beneficiaries who would have been eligible for the prohibited payment (including a prohibited payment that is available on a restricted basis under § 436(d)(3)) on or after the dates described in the first paragraph of this section VI.G.

For any accruals that were not permitted to accrue during a plan year beginning in 2013 or 2014 because of restrictions under § 436(e), but are permitted to accrue as a result of a new certification of the AFTAP reflecting the HATFA segment rates, the plan has taken adequate corrective action if it restores benefits that accrue during the period that begins on the date described in the first paragraph of this section VI.G.

In the case of a participant or beneficiary who, as a result of any of the changes described in this section VI.G is entitled to increased benefits, to benefits payable at a special early retirement date, or to benefits payable in a different form of payment (and who elects such different

form of payment, with spousal consent, if applicable), the required correction is to provide the benefit payments in the increased amount or other form of payment commencing with a new prospective annuity starting date. However, if payments have already commenced, the correction is to provide the participant with (1) future benefit payments that are paid in the same manner and amount as if the participant had begun receiving the corrected payment at his or her original annuity starting date, and (2) a make-up for past underpayments. The make-up for past underpayments is equal to the aggregate difference between the past payments actually received and the amounts that would have been received had the benefit commenced in the correct form of payment at the participant's original annuity starting date, plus interest to the date of the correction (in accordance with EPCRS), and may be paid as either (i) a single-sum payment, or (ii) an actuarially equivalent increase in the amount of future benefit payments.

VII. PAPERWORK REDUCTION ACT

The collections of information contained in this notice 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 1545-2095.

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 notice are in sections III, IV, and VI of this notice. The collections of information are required to implement the application of the funding relief under section 2003 of HATFA. The collections of information are mandatory for those plan sponsors making various elections when applying the amendments made by HATFA to a plan and any plan sponsor of a plan for which the 2014 AFTAP was certified using MAP-21 segment rates.

For the collections in section III of this notice (relating to the election and possible amendment of Schedule SB for the 2013 plan year), the estimated total number of respondents is 39,600 plans. The estimated annual burden per respondent

varies from 15 minutes to 1 hour and 45 minutes, depending on individual circumstances, with an estimated average of 23 minutes. The estimated total annual reporting and/or recordkeeping burden is 15,200 hours.

For the collections in sections IV and VI of this notice (relating to elections regarding the application of benefit restrictions under § 436), the estimated total number of respondents is 37,000 plans. The estimated annual burden per respondent varies from 15 minutes to 45 minutes, depending on individual circumstances, with an estimated average of 37 minutes. The estimated total annual reporting and/or recordkeeping burden is 22,800 hours.

Estimates of the annualized cost to respondents are not relevant, because each collection of information in this notice is a one-time collection.

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 § 6103.

VIII. DRAFTING INFORMATION

The principal authors of this notice are Tonya B. Manning and Carolyn E. Zimmerman of the Employee Plans, Tax Exempt and Government Entities Division. For further information regarding this notice, please contact the Employee Plans taxpayer assistance answering service at 1-877-829-5500 (a toll free number) or e-mail Ms. Manning or Ms. Zimmerman at RetirementPlanQuestions@irs.gov.

Extension of Replacement Period for Livestock Sold on Account of Drought

Notice 2014-60

SECTION 1. PURPOSE

This notice provides guidance regarding an extension of the replacement period under § 1033(e) of the Internal Revenue Code for livestock sold on account of drought in specified counties.

SECTION 2. BACKGROUND

.01 *Nonrecognition of Gain on Involuntary Conversion of Livestock.* Section 1033(a) generally provides for nonrecognition of gain when property is involuntarily converted and replaced with property that is similar or related in service or use. Section 1033(e)(1) provides that a sale or exchange of livestock (other than poultry) held by a taxpayer for draft, breeding, or dairy purposes in excess of the number that would be sold following the taxpayer's usual business practices is treated as an involuntary conversion if the livestock is sold or exchanged solely on account of drought, flood, or other weather-related conditions.

.02 *Replacement Period.* Section 1033(a)(2)(A) generally provides that gain from an involuntary conversion is recognized only to the extent the amount realized on the conversion exceeds the cost of replacement property purchased during the replacement period. If a sale or exchange of livestock is treated as an involuntary conversion under § 1033(e)(1) and is solely on account of drought, flood, or other weather-related conditions that result in the area being designated as eligible for assistance by the federal government, § 1033(e)(2)(A) provides that the replacement period ends four years after the close of the first taxable year in which any part of the gain from the conversion is realized. Section 1033(e)(2)(B) provides that the Secretary may extend this replacement period on a regional basis for such additional time as the Secretary determines appropriate if the weather-related conditions that resulted in the area being designated as eligible for assistance by the federal government continue for more than three years. Section 1033(e)(2) is effective for any taxable year with respect to which the due date (without regard to extensions) for a taxpayer's return is after December 31, 2002.

SECTION 3. EXTENSION OF REPLACEMENT PERIOD UNDER § 1033(e)(2)(B)

Notice 2006-82, 2006-2 C.B. 529, provides for extensions of the replacement period under § 1033(e)(2)(B). If a sale or exchange of livestock is treated as an involuntary conversion on account of

drought and the taxpayer's replacement period is determined under § 1033(e)(2)(A), the replacement period will be extended under § 1033(e)(2)(B) and Notice 2006-82 until the end of the taxpayer's first taxable year ending after the first drought-free year for the applicable region. For this purpose, the first drought-free year for the applicable region is the first 12-month period that (1) ends August 31; (2) ends in or after the last year of the taxpayer's 4-year replacement period determined under § 1033(e)(2)(A); and (3) does not include any weekly period for which exceptional, extreme, or severe drought is reported for any location in the applicable region. The applicable region is the county that experienced the drought conditions on account of which the livestock was sold or exchanged and all counties that are contiguous to that county.

A taxpayer may determine whether exceptional, extreme, or severe drought is reported for any location in the applicable region by reference to U.S. Drought Monitor maps that are produced on a weekly basis by the National Drought Mitigation Center. U.S. Drought Monitor maps are archived at <http://droughtmonitor.unl.edu/mapsanddata/maparchive.aspx>.

In addition, Notice 2006-82 provides that the Internal Revenue Service will publish in September of each year a list of counties, districts, cities, boroughs, census areas or parishes (hereinafter "counties") for which exceptional, extreme, or severe drought was reported during the preceding 12 months. Taxpayers may use this list instead of U.S. Drought Monitor maps to determine whether exceptional, extreme, or severe drought has been reported for any location in the applicable region.

The Appendix to this notice contains the list of counties for which exceptional, extreme, or severe drought was reported during the 12-month period ending August 31, 2014. Under Notice 2006-82, the 12-month period ending on August 31, 2014, is not a drought-free year for an applicable region that includes any county on this list. Accordingly, for a taxpayer who qualified for a 4-year replacement period for livestock sold or exchanged on account of drought and whose replacement period is scheduled to expire at the

end of 2014 (or, in the case of a fiscal year taxpayer, at the end of the taxable year that includes August 31, 2014), the replacement period will be extended under § 1033(e)(2) and Notice 2006-82 if the applicable region includes any county on this list. This extension will continue until the end of the taxpayer's first taxable year ending after a drought-free year for the applicable region.

SECTION 4. DRAFTING INFORMATION

The principal author of this notice is Andrew Braden of the Office of Associate Chief Counsel (Income Tax & Accounting). For further information regarding this notice contact Mr. Braden on (202) 317-4725 (not a toll-free number).

APPENDIX

Alabama

County of Henry.

Alaska

Boroughs of Denali, Fairbanks North Star. Census Areas of Southeast Fairbanks, Yukon-Koyukuk.

Arizona

Counties of Apache, Cochise, Coconino, Gila, Graham, Greenlee, La Paz, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, Yuma.

Arkansas

Counties of Arkansas, Ashley, Bradley, Calhoun, Chicot, Clark, Cleveland, Columbia, Dallas, Desha, Drew, Grant, Hempstead, Howard, Jefferson, Lafayette, Lee, Lincoln, Little River, Lonoke, Miller, Monroe, Nevada, Ouachita, Phillips, Prairie, Pulaski, Sevier, Union.

California

Counties of Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Los Angeles, Madera, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Orange, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tulare, Tuolumne, Ventura, Yolo, Yuba.

Colorado

Counties of Alamosa, Arapahoe, Archuleta, Baca, Bent, Chaffee, Cheyenne, Conejos, Costilla, Crowley, Custer, Dolores, Douglas, Eagle, Elbert, El Paso, Fremont, Garfield, Gunnison, Hinsdale, Huerfano, Jackson, Jefferson, Kiowa, Kit Carson, La Plata, Las Animas, Lincoln, Logan, Mesa, Mineral, Moffat, Montezuma, Montrose, Otero, Ouray, Park, Phillips, Prowers, Pueblo, Rio Blanco, Rio Grande, Routt, Saguache, San Juan, San Miguel, Sedgwick, Teller, Weld, Yuma.

Florida

County of Jackson.

Georgia

Counties of Atkinson, Baker, Berrien, Brooks, Calhoun, Clay, Clinch, Coffee, Colquitt, Cook, Decatur, Dougherty, Early, Echols, Grady, Irwin, Lanier, Lowndes, Miller, Mitchell, Randolph, Seminole, Thomas, Tift, Ware.

Hawaii

Counties of Hawaii, Kalawao, Maui.

Idaho

Counties of Ada, Adams, Bannock, Bingham, Blaine, Boise, Bonneville, Butte, Camas, Canyon, Caribou, Cassia, Clark, Custer, Elmore, Franklin, Fremont, Gem, Gooding, Idaho, Jefferson, Jerome, Lemhi, Lincoln, Madison, Minidoka, Oneida, Owyhee, Payette, Power, Twin Falls, Valley, Washington.

Illinois

Counties of Adams, Bureau, Carroll, Champaign, Christian, De Witt, Douglas, Fulton, Hancock, Henderson, Henry, Knox, Lee, Logan, McDonough, McLean, Macon, Marshall, Mason, Menard, Mercer, Moultrie, Ogle, Peoria, Piatt, Putnam, Rock Island, Sangamon, Shelby, Stark, Tazewell, Warren, Whiteside, Woodford.

Iowa

Counties of Adair, Adams, Appanoose, Audubon, Benton, Boone, Buena Vista, Calhoun, Carroll, Cass, Cedar, Clarke, Clinton, Crawford, Dallas, Davis, Des Moines, Greene, Guthrie, Hamilton, Hardin, Harrison, Henry, Humboldt, Ida, Iowa, Jackson, Jasper, Jefferson, Johnson, Jones, Keokuk, Lee, Linn, Louisa, Lucas, Madison, Mahaska, Marion, Marshall, Mills, Monroe, Montgomery, Muscatine, Pocahontas, Polk, Pottawattamie, Poweshiek, Sac, Scott, Shelby, Story, Tama, Union, Van Buren, Wapello, Warren, Washington, Webster, Wright.

Kansas

Counties of Allen, Anderson, Barber, Barton, Bourbon, Butler, Chase, Chautauqua, Cherokee, Cheyenne, Clark, Clay, Cloud, Coffey, Comanche, Cowley, Crawford, Decatur, Dickinson, Edwards, Elk, Ellis, Ellsworth, Finney, Ford, Franklin, Geary, Gove, Graham, Grant, Gray, Greeley, Greenwood, Hamilton, Harper, Harvey, Haskell, Hodgeman, Jewell, Kearny, Kingman, Kiowa, Labette, Lane, Lincoln, Logan, Lyon, McPherson, Marion, Marshall, Meade, Mitchell, Montgomery, Morris, Morton, Neosho, Ness, Norton, Osage, Osborne, Ottawa, Pawnee, Phillips, Pratt, Rawlins, Reno, Republic, Rice, Rooks, Rush, Russell, Saline, Scott, Sedgwick, Seward, Sheridan, Sherman, Smith, Stafford, Stanton, Stevens, Sumner, Thomas, Trego, Wabaunsee, Wallace, Washington, Wichita, Wilson, Woodson.

Louisiana

Parishes of Acadia, Allen, Ascension, Assumption, Avoyelles, Beauregard, Bienville, Bossier, Caddo, Calcasieu, Caldwell, Cameron, Claiborne, De Soto, East Carroll, East Feliciana, Evangeline, Franklin, Grant, Iberia, Iberville, Jackson, Jefferson Davis, Lafayette, La Salle, Lincoln, Madison, Morehouse, Natchitoches, Ouachita, Pointe Coupee, Rapides, Red River, Richland, Sabine, Saint Landry, Saint Martin, Saint Mary, Tensas, Union, Vermilion, Vernon, Webster, West Carroll, West Feliciana, Winn.

Minnesota

Counties of Anoka, Benton, Brown, Chippewa, Chisago, Cottonwood, Dakota, Goodhue, Hennepin, Houston, Isanti, Jackson, Kanabec, Kandiyohi, Lyon, McLeod, Martin, Meeker, Mille Lacs, Murray, Nobles, Olmsted, Pope, Ramsey, Redwood, Renville, Sherburne, Stearns, Swift, Wabasha, Washington, Watonwan, Winona, Wright.

Mississippi

Counties of Attala, Bolivar, Calhoun, Carroll, Choctaw, Coahoma, Grenada, Hinds, Holmes, Humphreys, Issaquena, Leake, Leflore, Madison, Montgomery, Neshoba, Oktibbeha, Panola, Quitman, Rankin, Scott, Sharkey, Sunflower, Tallahatchie, Tunica, Warren, Washington, Webster, Winston, Yalobusha, Yazoo.

Missouri

Counties of Adair, Andrew, Barton, Buchanan, Caldwell, Carroll, Chariton,

Clark, Clay, Clinton, Daviess, DeKalb, Gentry, Grundy, Harrison, Jasper, Knox, Lewis, Linn, Livingston, Macon, Marion, Mercer, Monroe, Newton, Nodaway, Putnam, Randolph, Ray, Saline, Schuyler, Scotland, Shelby, Sullivan, Worth.

Montana

Counties of Beaverhead, Big Horn, Broadwater, Carbon, Gallatin, Granite, Jefferson, Madison, Missoula, Powell, Ravalli, Silver Bow.

Nebraska

Counties of Antelope, Arthur, Banner, Blaine, Boone, Box Butte, Boyd, Brown, Buffalo, Butler, Cass, Cedar, Chase, Cherry, Cheyenne, Cuming, Custer, Dakota, Dawes, Dawson, Deuel, Dixon, Dodge, Douglas, Dundy, Franklin, Frontier, Furnas, Gage, Garden, Garfield, Gosper, Grant, Greeley, Hall, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Jefferson, Kearney, Keith, Keya Paha, Kimball, Knox, Lancaster, Lincoln, Logan, Loup, McPherson, Madison, Merrick, Morrill, Nance, Perkins, Phelps, Pierce, Platte, Red Willow, Rock, Sarpy, Saunders, Scotts Bluff, Seward, Sheridan, Sherman, Sioux, Stanton, Thayer, Thomas, Thurston, Valley, Washington, Wayne, Webster, Wheeler.

Nevada

Carson City. Counties of Churchill, Clark, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Pershing, Storey, Washoe, White Pine.

New Mexico

Counties of Bernalillo, Catron, Chaves, Cibola, Colfax, Curry, DeBaca, Dona Ana, Eddy, Grant, Guadalupe, Harding, Hidalgo, Lea, Lincoln, Los Alamos, Luna, McKinley, Mora, Otero, Quay, Rio Arriba, Roosevelt, Sandoval, San Juan, San Miguel, Santa Fe, Sierra, Socorro, Taos, Torrance, Union, Valencia.

North Dakota

Counties of Barnes, Foster, Griggs, Kidder, LaMoure, Logan, Stutsman, Wells.

Oklahoma

Counties of Alfalfa, Atoka, Beaver, Beckham, Blaine, Bryan, Caddo, Canadian, Carter, Choctaw, Cimarron, Cleveland, Comanche, Cotton, Craig, Creek, Custer, Delaware, Dewey, Ellis, Garfield, Garvin, Grady, Grant, Greer, Harmon, Harper, Hughes, Jackson, Jefferson, Johnston, Kay, Kingfisher, Kiowa, Lincoln, Logan, Love, McClain, McCurtain, Major,

Marshall, Mayes, Murray, Noble, Nowata, Okfuskee, Oklahoma, Okmulgee, Osage, Ottawa, Pawnee, Payne, Pontotoc, Pottawatomie, Pushmataha, Roger Mills, Rogers, Seminole, Stephens, Texas, Tillman, Tulsa, Wagoner, Washington, Washita, Woods, Woodward.

Oregon

Counties of Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Multnomah, Polk, Union, Wasco, Washington, Yamhill.

South Dakota

Counties of Bennett, Brown, Clark, Codington, Day, Deuel, Fall River, Grant, Hamlin, Marshall, Roberts, Shannon, Spink, Todd.

Texas

Counties of Anderson, Andrews, Angelina, Aransas, Archer, Armstrong, Atascosa, Austin, Bailey, Bandera, Bastrop, Baylor, Bee, Bell, Bexar, Blanco, Borden, Bosque, Bowie, Brazoria, Brazos, Brewster, Briscoe, Brooks, Brown, Burleson, Burnet, Caldwell, Calhoun, Callahan, Cameron, Camp, Carson, Cass, Castro, Chambers, Cherokee, Childress, Clay, Cochran, Coke, Coleman, Collin, Collingsworth, Colorado, Comal, Comanche, Concho, Cooke, Coryell, Cottle, Crane, Crockett, Crosby, Dallam, Dallas, Dawson, Deaf Smith, Delta, Denton, DeWitt, Dickens, Dimmit, Donley, Duval, Eastland, Ector, Edwards, Ellis, El Paso, Erath, Falls, Fannin, Fayette, Fisher, Floyd, Foard, Fort Bend, Franklin, Freestone, Frio, Gaines, Galveston, Garza, Gillespie, Glasscock, Goliad, Gonzales, Gray, Grayson, Gregg, Grimes, Guadalupe, Hale, Hall, Hamilton, Hansford, Hardeman, Hardin, Harris, Harrison, Hartley, Haskell, Hays, Hemphill, Henderson, Hidalgo, Hill, Hockley, Hood, Hopkins, Houston, Howard, Hudspeth, Hunt, Hutchinson, Irion, Jack, Jackson, Jasper, Jefferson, Jim Hogg, Jim Wells, Johnson, Jones, Karnes, Kaufman, Kendall, Kenedy, Kent, Kerr, Kimble, King, Kinney, Kleberg, Knox, Lamar, Lamb, Lampasas, La Salle, Lavaca, Lee, Leon, Liberty, Limestone, Lipscomb, Live Oak, Llano, Lubbock, Lynn, McCulloch, McLennan, McMullen, Madison, Marion, Martin, Mason, Matagorda, Maverick, Medina, Menard, Midland, Milam, Mills, Mitchell, Montague, Montgomery, Moore, Morris,

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Utah

Counties of Beaver, Box Elder, Cache, Carbon, Daggett, Davis, Duchesne, Emery, Garfield, Grand, Iron, Juab, Kane, Millard, San Juan, Sanpete, Summit, Tooele, Uintah, Utah, Wasatch, Washington, Wayne, Weber.

Washington

County of Adams, Benton, Chelan, Clark, Cowlitz, Douglas, Ferry, Franklin, Grant, Grays Harbor, Jefferson, King, Kitsap, Kittitas, Lewis, Lincoln, Mason, Okanogan, Pacific, Pierce, Skamania, Stevens, Thurston, Wahkiakum, Walla Walla, Yakima.

Wisconsin

Counties of Adams, Buffalo, Chippewa, Clark, Columbia, Crawford, Dunn, Eau Claire, Jackson, Juneau, La Crosse, Monroe, Pepin, Pierce, Polk, Richland, Saint Croix, Sauk, Trempealeau, Vernon, Wood.

Wyoming

Counties of Albany, Big Horn, Campbell, Carbon, Converse, Fremont, Goshen, Hot Springs, Johnson, Lincoln, Natrona, Niobrara, Park, Platte, Sheridan, Sublette, Sweetwater, Uinta, Washakie, Weston.

Per Capita Payments from Proceeds of Settlements of Indian Tribal Trust Cases

Notice 2014–61

BACKGROUND

Notice 2013–1, 2013–3 IRB 281, provides guidance on the federal tax treatment

of per capita payments that members of Indian tribes receive from proceeds of certain settlements of tribal trust cases between the United States and those Indian tribes. Additional tribes have settled tribal trust cases against the United States since publication of Notice 2013–1. This notice provides an updated Appendix that reflects the additional settlement agreements.

EFFECT ON OTHER DOCUMENTS

Notice 2013–1 Appendix is modified and superseded.

FURTHER INFORMATION

For further information regarding this notice, please contact Telly Meier at phone number (202) 317-8494 (not a toll-free number).

Appendix

Tribes That Have Entered into Settlement Agreements of Tribal Trust Cases

1. Assiniboine and Sioux Tribes of the Fort Peck Reservation
2. Bad River Band of Lake Superior Chippewa Indians
3. Blackfeet Tribe of the Blackfeet Indian Reservation
4. Bois Forte Band of Chippewa
5. Cachil Dehe Band of Wintun Indians of the Colusa Rancheria
6. Chippewa Cree Tribe of the Rocky Boy's Reservation
7. Coeur d'Alene Tribe
8. Confederated Salish and Kootenai Tribes
9. Confederated Tribes of Siletz Indians
10. Confederated Tribes of the Colville Reservation
11. Confederated Tribes of the Goshute Reservation
12. Crow Creek Sioux Tribe
13. Eastern Shawnee Tribe of Oklahoma
14. Hualapai Indian Tribe
15. Iowa Tribe of Kansas and Nebraska
16. Kaibab Band of Paiute Indians of Arizona
17. Kickapoo Tribe of Kansas
18. Lac Courte Oreilles Band of Lake Superior Chippewa Indians

- 19. Lac du Flambeau Band of Lake Superior Chippewa Indians
- 20. Leech Lake Band of Ojibwe
- 21. Lower Brule Sioux Tribe
- 22. Makah Indian Tribe of the Makah Reservation
- 23. Mescalero Apache Tribe
- 24. Minnesota Chippewa Tribe
- 25. Nez Perce Tribe
- 26. Nooksack Indian Tribe
- 27. Northern Cheyenne Tribe of Indians
- 28. Omaha Tribe of Nebraska
- 29. Passamaquoddy Tribe of Maine
- 30. Pawnee Nation
- 31. Prairie Band of Potawatomi Nation
- 32. Pueblo of Zia
- 33. Quechan Tribe of the Fort Yuma Reservation
- 34. Red Cliff Band of Lake Superior Chippewa Indians
- 35. Rincon Luiseño Band of Indians
- 36. Rosebud Sioux Tribe
- 37. Round Valley Indian Tribes
- 38. Salt River Pima-Maricopa Indian Community
- 39. Santee Sioux Tribe of Nebraska
- 40. Sault Ste. Marie Tribe
- 41. Shoshone-Bannock Tribes of the Fort Hall Reservation
- 42. Soboba Band of Luiseno Indians
- 43. Spirit Lake Dakota Nation
- 44. Spokane Tribe of Indians
- 45. Standing Rock Sioux Tribe
- 46. Stillaguamish Tribe of Indians
- 47. Summit Lake Paiute Tribe
- 48. Swinomish Indian Tribal Community
- 49. Te-Moak Tribe of Western Shoshone Indians
- 50. Tohono O'odham Nation
- 51. Tulalip Tribes
- 52. Tule River Indian Tribe
- 53. Ute Indian Tribe of the Uintah and Ouray Reservation
- 54. Ute Mountain Ute Tribe
- 55. Winnebago Tribe of Nebraska
- 56. Qawalangin Tribe of Unalaska
- 57. Tlingit & Haida Tribes of Alaska
- 58. Northwestern Band of Shoshone Indians
- 59. Hoopa Valley Tribe
- 60. Ak-Chin Indian Community
- 61. Oglala Sioux Tribe
- 62. Yoruk Tribe
- 63. Cheyenne River Sioux Tribe
- 64. Paiute-Shoshone Indians of the Bishop Community of the Bishop Colony
- 65. Seminole Nation of Oklahoma
- 66. Otoe-Missouria Tribe of Oklahoma
- 67. Samish Indian Nation
- 68. Tonkawa Tribe of Indians of Oklahoma
- 69. Yakama Nation
- 70. Miami Tribe of Oklahoma
- 71. Shoshone Indian Tribe and the Northern Arapahoe Indian Tribe of the Wind River Reservation
- 72. Pueblo of Laguna
- 73. Navajo Nation
- 74. Caddo Nation of Oklahoma

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 sub-

stance 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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¹A cumulative list of all revenue rulings, revenue procedures, Treasury decisions, etc., published in Internal Revenue Bulletins 2014–01 through 2014–26 is in Internal Revenue Bulletin 2014–26, dated June 30, 2014.

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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
TC	Tax Convention
TD	Treasury Decision
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Internal Revenue Service

Washington, DC 20224

Official Business
Penalty for Private Use, \$300

INTERNAL REVENUE BULLETIN

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