

Optional Benefit "D-2" =
Optional Benefit "D-3" =
Policy "E" =

Rider "E-1" =
Rider "E-2" =
Policy "F" =

Rider "F-1" =
Rider "F-2" =
Policy "G" =

Rider "G-1" =
Rider "G-2" =
Rider "G-3" =
Rider "G-4" =
Rider "G-5" =
Rider "G-6" =
Rider "G-7" =
Rider "G-8" =
Rider "G-9" =
Policy "H" =

Optional Benefit "H-1" =
Optional Benefit "H-2" =
Optional Benefit "H-3" =
Policy "I" =
Rider "I-1" =
Rider "I-2" =
Rider "I-3" =
Policy "J" =

Rider "J-1" =
Rider "J-2" =
Rider "J-3" =
Policy "K" =

Dear _____ :

This responds to your letter of April 28, 2006 requesting rulings on behalf of Taxpayer concerning whether certain insurance contracts ("Policies, Riders and Optional Benefits") constitute "permitted insurance," "permitted coverage" or "preventive care" within the meaning of section 223 of the Internal Revenue Code (the "Code"), so that employees who are covered by the Policies, Riders and Optional Benefits and who are

otherwise eligible to contribute to a Health Savings Account (“HSA”) remain eligible to make HSA contributions.

Taxpayer offers its eligible employees health and accident benefits, including an accident and health plan that is intended to qualify as a high deductible health plan (“HDHP”) within the meaning of section 223 of the Code. In addition to coverage under the HDHP, Taxpayer offers its eligible employees the opportunity to purchase the following Policies, Riders and Optional Benefits (none of which are HDHPs within the meaning of section 223):

Policy “A” is a group policy that pays a specified amount upon the first occurrence of most types of cancer, excluding skin cancer. Policy “A” covers up to specified amounts for comprehensive cancer treatment, including hospital confinement, drugs, diagnostic testing, in-hospital private nursing care, certain surgeries, ambulance transportation and hospice care. Policy “A” does not cover conditions or illnesses resulting from cancer or any other diseases.

Rider “A-1” is an optional rider to Policy “A” that covers hospitalization in intensive care and ambulance transportation to the intensive care unit for the treatment of cancer.

Rider “A-2” is an optional rider to Policy “A” that provides hospitalization benefits for the treatment of cancer up to a specified amount that increases progressively every year for the first five years Policy “A” and Rider “A-2” are in force.

Rider “A-3” is an optional rider to Policy “A” that provides a return of premium after Policy “A” is in force for five years. The amount to be returned is determined by a formula based on the individual’s age, the length of time the policy is in force and the amount of any claims paid under the policy.

Rider “A-4” is an optional rider to Policy “A” that provides hospital intensive care benefits up to a specified amount and ambulance transportation to the hospital intensive care unit for the treatment of cancer. Benefits are reduced by 50% when the covered person reaches age 70.

Rider “A-5” is an optional rider to Policy “A” that provides hospital intensive care benefits up to a specified amount and ambulance transportation to the hospital intensive care unit for the treatment of cancer. Benefits are reduced by 50% when the covered person reaches age 70. No benefits are paid if cancer or a specified disease is diagnosed within the Policy’s initial 30-day waiting period.

Policy “B” is a group policy that pays a specified amount upon the first occurrence of most types of cancer. Policy “B” covers certain aspects of cancer treatment including continuous hospital confinement and radiation/chemotherapy, up to specified amounts. Policy “B” does not cover conditions or illnesses resulting from cancer or from any other diseases.

Rider "B-1" is an optional rider to Policy "B" that covers hospitalization in intensive care and ambulance transportation to the intensive care unit for the treatment of cancer.

Rider "B-2" is an optional rider to Policy "B" that provides a return of premium after Policy "B" is in force for five years. The amount to be returned is determined by a formula based on the individual's age, the length of time the policy is in force and the amount of any claims paid under the policy.

Rider "B-3" is an optional rider to Policy "B" that provides hospital intensive care benefits up to a specified amount and ambulance transportation to the hospital intensive care unit for the treatment of cancer. Benefits are reduced by 50% when the covered person reaches age 70. No benefits are paid if cancer or a specified disease is diagnosed within the Policy's initial 30-day waiting period.

Policy "C" is an individual policy that covers treatment up to specified amounts for the treatment of the first occurrence of cancer and certain other specified diseases. Policy "C" covered treatment benefits include hospital confinement, surgery, in-hospital private duty nursing, ambulance transportation and radiation/chemotherapy.

Rider "C-1" is an optional rider to Policy "C" that pays a specified amount upon the initial diagnosis of cancer.

Rider "C-2" is an optional rider to Policy "C" that pays a per diem amount for each day of confinement in the intensive care unit of a hospital up to 45 days, including ambulance transportation to the intensive care unit for the treatment of one of the specified diseases covered by Policy "C". Benefits are reduced by 50% when the covered person reaches age 70.

Rider "C-3" is an optional rider to Policy "C" that pays a per diem amount for each day of confinement in the intensive care unit of a hospital up to 45 days, including ambulance transportation to the intensive care unit, for the treatment of a specified disease covered by Policy "C". Benefits are reduced by 50% when the covered person reaches age 70. Rider "C-3" excludes such benefits if the specified disease is diagnosed within the Policy's initial 30-day waiting period.

Rider "C-4" is an optional rider to Policy "C" that pays up to specified amounts for treatment (such as hospital confinement and surgery) of the specified diseases covered by Policy "C".

Rider "C-5" is an optional rider to Policy "C" that pays a specified amount for the initial diagnosis of cancer. The specified amount increases progressively based on the length of time the rider and policy are in force and pays a surrender value if no cancer diagnosis occurs within the first five years of coverage. The rider terminates after 20 years, at which time the guaranteed value is paid.

Policy "D" is a group policy that pays up to a specified amount for the first occurrence of cancer and certain other specified diseases. Policy "D" coverage includes benefits for hospital confinement, surgery, in hospital private duty nursing, ambulance transportation, anesthesia, and radiation/chemotherapy.

Optional Benefit "D-1", a benefit that is optional to Policy "D", pays a specified amount upon the initial diagnosis of cancer, excluding skin cancer.

Optional Benefit "D-2", a benefit that is optional to Policy "D" pays a per diem amount for each day of confinement in the intensive care unit of a hospital up to 45 days, including a specified amount for ambulance transportation to the intensive care unit for the treatment of one of the specified diseases covered by Policy "D".

Optional Benefit "D-3", a benefit that is optional to Policy "D", covers up to a specified amount for certain cancer screening services, regardless of whether the covered individual is diagnosed with a specified disease. Covered cancer screening services include colonoscopy, chest X-ray and bone marrow testing.

Policy "E" is a group policy that pays a specified amount for treatment of a heart attack, heart disease or stroke. Policy "E" does not cover any disease, sickness or incapacity resulting from a heart attack, heart disease, or stroke. Benefits covered under Policy "E" include hospital confinement, drugs and in hospital private nursing.

Rider "E-1" is an optional rider to Policy "E" that pays a specified amount for the initial diagnosis of cancer, excluding skin cancer.

Rider "E-2" is an optional rider to Policy "E" that pays a per diem amount for confinement in an intensive care unit up to 45 days for the treatment of diseases specified in Policy "E" and ambulance transportation to the intensive care unit for the treatment of such diseases.

Policy "F" pays up to a specified amount for the initial diagnosis of a disease specified under the Policy.

Rider "F-1" is an optional rider to Policy "F" that pays a per diem amount for every day of hospital confinement for up to one year. Covered confinement may be for the treatment of a sickness or injury that is not a disease specified under Policy "F".

Rider "F-2" is an optional rider to Policy "F" that pays a specified amount for the initial diagnosis of certain types of cancer.

Policy "G" is a group hospital confinement indemnity policy that pays a specified amount for each day of hospital confinement up to a specified number of days, a specified

amount for each day of confinement in an intensive care unit, and a premium waiver during such period of hospital confinement.

Rider "G-1" is an optional rider to Policy "G" that pays a specified amount for treatment of a covered individual by a physician outside of a hospital up to a specified number of visits a year.

Rider "G-2" is an optional rider to Policy "G" that pays a per diem amount for treatment by a physician in a hospital, other than a surgeon, during hospital confinement.

Rider "G-3" is an optional rider to Policy "G" that pays a specified amount for medical or surgical treatment in an emergency room up to twice a year.

Rider "G-4" is an optional rider to Policy "G" that pays a specified amount for a surgical operation and anesthesia for surgery performed in a hospital or an ambulatory surgical center.

Rider "G-5" is an optional rider to Policy "G" that pays a specified amount for a covered individual's initial confinement to a hospital during a calendar year. This amount is in addition to the per diem amount for hospital confinement paid under Policy "G".

Rider "G-6" is an optional rider to Policy "G" that pays a per diem amount for each day that at home nursing care is required following a covered hospital confinement. Covered at home nursing care must be authorized by an attending physician.

Rider "G-7" is an optional rider to Policy "G" that pays a specified amount monthly upon receipt of written proof that the covered individual is totally disabled, has been disabled for 30 days and loses income due to such disability.

Rider "G-8" is an optional rider to Policy "G" that pays a specified amount monthly upon receipt of written proof that the covered individual is totally disabled due to cancer, a heart attack or stroke, has been disabled for 30 days and loses income due to such disability.

Rider "G-9" is an optional rider to Policy "G" that pays a specified amount for ambulance transportation to a hospital or emergency treatment center and, if treatment can not be obtained locally, a specified amount for non-local transportation.

Policy "H" is a group hospital confinement indemnity policy that pays a specified amount for each day of hospital confinement up to a specified number of days, a specified amount for each day of confinement in an intensive care unit, a premium waiver during hospital confinement, and a specified amount for initial hospital confinement. Additionally, Policy "H" pays a specified amount for a surgical operation performed in a hospital or ambulatory surgical center, anesthesia for such surgery, inpatient care by a physician other than the surgeon, medical or surgical care in an outpatient emergency

treatment center (limited to two visits a year), an outpatient emergency accident benefit, up to five visits a year for any reason for a physician's treatment outside of a hospital, at home nursing care during the period following hospital confinement, up to three ambulance trips a year to a hospital or emergency treatment center, and non-local transportation required for out-of-area treatment.

Optional benefit "H-1", a benefit that is optional to Policy "H", pays up to a specified amount for tests performed for the diagnosis of an injury or sickness suggested by symptoms of an injury or sickness outside of hospital confinement.

Optional benefit "H-2", a benefit that is optional to Policy "H", pays up to a specified amount for a routine physical examination or preventive screening services (e.g. bone marrow testing, colonoscopy, chest X-ray) outside of hospital confinement.

Optional Benefit "H-3", a benefit that is optional to Policy "H", covers up to a specified number of prescription drugs.

Policy "I" is an individual policy that pays a specified amount for covered losses sustained from an off-the-job accident resulting in accidental death or dismemberment within 90 days from the date of the accident. Policy "I" also pays a specified amount for hospital confinement, ambulance transportation, medical expenses and payment for total disability resulting from the accident. Policy "I" does not cover loss caused by sickness.

Rider "I-1" is an optional rider to Policy "I" that pays a specified amount per month for total disability resulting from sickness.

Rider "I-2" is an optional rider to Policy "I" that pays a specified amount for each day of hospital confinement due to sickness that does not result from an injury, regardless of whether the covered person is disabled as defined in Policy "I".

Rider "I-3" is an optional rider to Policy "I" that pays a specified amount for treatment by a physician outside of a hospital for any reason and regardless of whether the covered individual is disabled as defined in Policy "I".

Policy "J" is an individual policy that pays a specified amount for covered losses sustained from an on-the-job or off-the-job accident resulting in accidental death or dismemberment within 90 days from the date of the accident. Policy "J" also pays a specified amount for hospital confinement, ambulance transportation, medical expenses and payment for total disability resulting from the accident. Policy "J" does not cover loss caused by sickness.

Rider "J-1" is an optional rider to Policy "J" that pays a specified amount per month for total disability resulting from sickness.

Rider "J-2" is an optional rider to Policy "J" that pays a specified amount for each day of hospital confinement due to sickness that does not result from an injury, regardless of whether the covered person is disabled as defined in Policy "J".

Rider "J-3" is an optional rider to Policy "J" that pays a specified amount for treatment by a physician outside of a hospital for any reason and regardless of whether the covered individual is disabled as defined in Policy "J".

Policy "K" is an individual policy that pays a specified amount for covered losses sustained from an off-the-job accident resulting in accidental death or dismemberment within 90 days from the date of the accident. Policy "K" also pays a specified amount for hospital confinement, ambulance transportation, medical expenses and payment for total disability resulting from the accident. Policy "K" does not cover loss caused by sickness.

RULINGS REQUESTED

You have requested a ruling that employees who are otherwise eligible to contribute to an HSA, remain eligible individuals as defined in section 223(c)(1) if they are also covered by any Policy, Rider, or Optional Benefit.

LAW AND ANALYSIS

Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173 added section 223 to the Code to permit eligible individuals to establish HSAs for taxable years beginning after December 31, 2003.

Section 223(a) allows a deduction for the taxable year of an amount equal to the aggregate amount paid in cash during such taxable year by or on behalf of an individual to an HSA. The legislative history of section 223 states that "eligible individuals for HSAs are individuals who are covered by a high deductible health plan and no other health plan that is not a high deductible health plan." The legislative history also states that, "[a]n individual with other coverage in addition to a high deductible health plan is still eligible for an HSA if such other coverage is certain permitted insurance or permitted coverage." H.R. Conf. Rep. No. 391, 108th Cong., 1st Sess. 841 (2003).

Section 223(c)(1) requires that for an individual to be an "eligible individual", the individual must be covered under a High Deductible Health Plan (HDHP).

Section 223(c)(2)(A) defines an HDHP as a health plan that satisfies certain requirements with respect to minimum annual deductibles and maximum annual out-of-pocket expenses. Generally, an HDHP may not provide benefits for any year until the deductible for that year is satisfied.

Section 223(c)(1)(B) provides that in addition to coverage under an HDHP, an eligible individual may have certain additional coverage including "permitted insurance" and other specified coverage ("permitted coverage"). Section 223(c)(3)(B) defines "permitted insurance" as insurance for a specified disease or illness. Section 223(c)(3)(C) defines "permitted insurance" as insurance that pays a fixed amount per day (or other period) of hospitalization. Section 223(c)(1)(B)(ii) defines "permitted coverage" as coverage for accidents, disability, dental care, vision care or long-term care (whether through insurance or otherwise). See also Notice 2004-2, Q&A – 6, 2004-1 C.B. 269.

Section 223(c)(2)(C) provides a safe harbor for the absence of a preventive care deductible, or a preventive care deductible below the minimum annual deductible. That section states, "[a] plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care ..." Notice 2004-23, 2004-1 C.B. 725 provides that preventive care for purposes of section 223(c)(2)(C) includes screening services for cancer and heart and vascular diseases.

Notice 2004-2, 2004-1 C.B. 269 provides that an "eligible individual means, with respect to any month, any individual who: (1) is covered under an HDHP on the first day of such month; (2) is not also covered by any other health plan that is not an HDHP (with certain exceptions for plans providing certain limited types of coverage); (3) is not entitled to benefits under Medicare (generally, has not yet reached age 65); and (4) may not be claimed as a dependent on another person's tax return.

Notice 2004-50 provides that an "eligible individual" who is covered by an HDHP may also be covered "for any benefit provided by permitted insurance" under section 223(c)(1)(B)(i). Because section 223(c)(3)(B) provides that the term "permitted insurance" includes "insurance for a specified disease or illness," an "eligible individual" may be covered by an HDHP and also by permitted insurance for one or more specific diseases or illnesses, such as cancer, diabetes, asthma or congestive heart failure, as long as the principal health coverage is provided by the HDHP. Notice 2004-50, 2004-2 C.B. 196; Rev. Rul. 2004-45, 2004-1 C.B. 971.

Accordingly, based on the representations made and authorities cited above, we conclude as follows:

Policy "A" constitutes a specified disease or illness policy within the meaning of section 223(c)(3)(B) of the Code. An individual who is otherwise an "eligible individual" as defined by section 223(c)(1) of the Code remains an "eligible individual" if covered under Policy "A".

Rider "A-1", Rider "A-2", Rider "A-3", Rider "A-4" and Rider "A-5" constitute specified disease or illness policies within the meaning of section 223(c)(3)(B) of the Code. An individual who is otherwise an "eligible individual" as defined by section 223(c)(1) of the

Code remains an “eligible individual” if covered under Rider “A-1”, Rider “A-2”, Rider “A-3”, Rider “A-4” and Rider “A-5”.

Policy “B” constitutes a specified disease or illness policy within the meaning of section 223(c)(3)(B) of the Code. An individual who is otherwise an “eligible individual” as defined by section 223(c)(1) of the Code remains an “eligible individual” if covered under Policy “B”.

Rider “B-1”, Rider “B-2” and Rider “B-3” constitute specified disease or illness policies within the meaning of section 223(c)(3)(B) of the Code. An individual who is otherwise an “eligible individual” as defined by section 223(c)(1) of the Code remains an “eligible individual” if covered under Rider “B-1”, Rider “B-2” or Rider “B-3”.

Policy “C” constitutes a specified disease or illness policy within the meaning of section 223(c)(3)(B) of the Code. An individual who is otherwise an “eligible individual” as defined by section 223(c)(1) of the Code remains an “eligible individual” if covered under Policy “C”.

Rider “C-1”, Rider “C-2”, Rider “C-3”, Rider “C-4” and Rider “C-5” constitute specified disease or illness policies within the meaning of section 223(c)(3)(B) of the Code. An individual who is otherwise an “eligible individual” as defined by section 223(c)(1) of the Code remains an “eligible individual” if covered under Rider “C-1”, Rider “C-2”, Rider “C-3”, Rider “C-4” or Rider “C-5”.

Policy “D” constitutes a specified disease or illness policy within the meaning of section 223(c)(3)(B) of the Code. An individual who is otherwise an “eligible individual” as defined by section 223(c)(1) of the Code remains an “eligible individual” if covered under Policy “D”.

Optional Benefit “D-1” and Optional Benefit “D-2” constitute specified disease or illness policies within the meaning of section 223(c)(3)(B) of the Code. An individual who is otherwise an “eligible individual” as defined by section 223(c)(1) of the Code remains an “eligible individual” if covered under Optional Benefit “D-1” or Optional Benefit “D-2”.

Optional Benefit “D-3” constitutes preventive care for purposes of section 223(c)(2)(c) of the Code. An individual who is otherwise an “eligible individual” as defined by section 223(c)(1) of the Code remains an “eligible individual” if covered under Optional Benefit “D-3”.

Policy “E” constitutes a specified disease or illness policy within the meaning of section 223(c)(3)(B) of the Code. An individual who is otherwise an “eligible individual” as defined by section 223(c)(1) of the Code remains an “eligible individual” if covered under Policy “E”.

Rider “E-1” and Rider “E-2” constitute specified disease or illness policies within the meaning of section 223(c)(3)(B) of the Code. An individual who is otherwise an “eligible individual” as defined by section 223(c)(1) of the Code remains an “eligible individual” if covered under Rider “E-1” or Rider “E-2” .

Policy “F” constitutes a specified disease or illness policy within the meaning of section 223(c)(3)(B) of the Code. An individual who is otherwise an “eligible individual” as defined by section 223(c)(1) of the Code remains an “eligible individual” if covered under Policy “F”.

Rider “F-1” constitutes insurance paying a fixed amount per day (or other period) of hospitalization within the meaning of section 223(c)(3)(C) of the Code. An individual who is otherwise an “eligible individual” as defined by section 223(c)(1) of the Code remains an “eligible individual” if covered under Rider “F-1”.

Rider “F-2” constitutes a specified disease or illness policy within the meaning of section 223(c)(3)(B) of the Code. An individual who is otherwise an “eligible individual” as defined by section 223(c)(1) of the Code remains an “eligible individual” if covered under Rider “F-2”.

Policy “G” constitutes insurance paying a fixed amount per day (or other period) of hospitalization within the meaning of section 223(c)(3)(C) of the Code. An individual who is otherwise an “eligible individual” as defined by section 223(c)(1) of the Code remains an “eligible individual” if covered under Policy “G”.

Rider “G-1”, Rider “G-2”, Rider “G-3”, Rider “G-4”, Rider “G-5”, and Rider “G-6” do not constitute permitted coverage, permitted insurance or preventative care under section 223 of the Code. An individual who is covered under Policy “G” and also covered by Rider “G-1”, Rider “G-2”, Rider “G-3”, Rider “G-4”, Rider “G-5”, or Rider “G-6” is not an “eligible individual” under section 223 of the Code.

Rider “G-7” and Rider “G-8” constitute permitted accident or disability coverage within the meaning section 223(c)(1)(B)(ii) of the Code. An individual who is otherwise an “eligible individual” as defined by section 223(c)(1) of the Code remains an “eligible individual” if covered under Rider “G-7” or Rider “G-8”.

Rider “G-9” does not constitute permitted coverage, permitted insurance or preventative care under section 223 of the Code. An individual who is covered under Policy “G” and also covered by Rider “G-9” is not an “eligible individual” under section 223 of the Code.

Policy “H” does not constitute permitted coverage, permitted insurance or preventative care under section 223 of the Code. An individual covered by Policy “H” is not an “eligible individual” under section 223 of the Code.

Although Optional Benefit “H-1” constitutes preventive care for purposes of section 223(c)(2)(c) of the Code, because the individual is also covered by Policy “H”, the individual is not an “eligible individual” under section 223 of the Code.

Although Optional Benefit “H-2” constitutes preventive care for purposes of section 223(c)(2)(c) of the Code, because the individual is also covered by Policy “H”, the individual is not an “eligible individual” as defined by section 223 of the Code.

Optional Benefit “H-3” does not constitute permitted coverage, permitted insurance or preventative care under section 223 of the Code. An individual covered by Optional Benefit “H-3” is not an “eligible individual” under section 223 of the Code.

Policy “I” is permitted accident coverage within the meaning of section 223(c)(1)(B)(ii). An individual who is otherwise an “eligible individual” as defined by section 223(c)(1) of the Code remains an “eligible individual” if covered under Policy “I”.

Rider “I-1” is permitted accident coverage within the meaning of section 223(c)(1)(B)(ii). An individual who is otherwise an “eligible individual” as defined by section 223(c)(1) of the Code remains an “eligible individual” if covered under Rider “I-1”.

Rider “I-2” constitutes insurance paying a fixed amount per day (or other period) of hospitalization within the meaning of section 223(c)(3)(C) of the Code. An individual who is otherwise an “eligible individual” as defined by section 223(c)(1) of the Code remains an “eligible individual” if covered under Rider “I-2”.

Rider “I-3” does not constitute permitted coverage, permitted insurance or preventative care under section 223 of the Code. An individual who is covered under Policy “I” and also covered by Rider “I-3” is not an “eligible individual” under section 223 of the Code.

Policy “J” is permitted accident coverage within the meaning of section 223(c)(1)(B)(ii). An individual who is otherwise an “eligible individual” as defined by section 223(c)(1) of the Code remains an “eligible individual” if covered under Policy “J”.

Rider “J-1” is permitted accident coverage within the meaning of section 223(c)(1)(B)(ii). An individual who is otherwise an “eligible individual” as defined by section 223(c)(1) of the Code remains an “eligible individual” if covered under Rider “J-1”.

Rider “J-2” constitutes insurance paying a fixed amount per day (or other period) of hospitalization within the meaning of section 223(c)(3)(C) of the Code. An individual who is otherwise an “eligible individual” as defined by section 223(c)(1) of the Code remains an “eligible individual” if covered under Rider “J-2”.

Rider “J-3” does not constitute permitted coverage, permitted insurance or preventative care under section 223 of the Code. An individual who is covered under Policy “J” and also covered by Rider “J-3” is not an “eligible individual” under section 223 of the Code.

Policy "K" is permitted accident coverage within the meaning of section 223(c)(1)(B)(ii). An individual who is otherwise an "eligible individual" as defined by section 223(c)(1) of the Code remains an "eligible individual" if covered under Policy "K".

If an individual is covered by any Policy, Rider, or Optional Benefit that does not meet the requirements of permitted coverage, permitted insurance or preventative care under section 223 of the Code, the individual is not an "eligible individual". Thus, for example, even though an individual is covered by a Policy that satisfies the requirements of permitted coverage, permitted insurance or preventative care, but the individual is also covered by a Rider or Optional Benefit that does not satisfy the requirements for permitted coverage, permitted insurance or preventative care, the individual is not eligible to contribute to an HSA. Conversely, if the Policy does not meet the requirements for permitted coverage, permitted insurance or preventative care, the individual is not an eligible individual for purposes of section 223(c)(1) of the Code, whether or not the individual is covered by Riders or Optional Benefits that do satisfy the requirements.

No opinion is expressed or implied concerning the tax consequences of any of the Policies, Riders or Optional Benefits under any other provision of the Code or regulations other than those specifically stated herein.

This ruling is directed only to the Taxpayer who requested it. Section 6110(k)(3) of the Code provides that it may not be used or cited as precedent.

In accordance with the Power of Attorney on file with this office, a copy of this letter is being sent to your authorized representatives.

Sincerely,

Harry Beker, Chief
Health & Welfare Branch
Office of Division Counsel/Associate
Chief Counsel (Tax Exempt
& Government Entities)