Internal Revenue Service

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Date [redacted]

Surname [redacted]

Department of the Treasury

Washington, DC 20224

Contact Person: [redacted]

Telephone Number: [redacted]

In Reference to: [redacted]

Date: JAN 7 1999

Employer Identification Number: [redacted]

Dear Applicant:

We have considered your application for recognition of exemption from federal income tax under section 501(a) of the Internal Revenue Code as an organization described in section 501(c)(4). Based on the information submitted, we have concluded that you do not qualify for exemption under that section. The basis for our conclusion is set forth below.

FACTS

[redacted] ("Health Services") is a nonprofit organization that is tax-exempt under section 501(c)(3) of the Code. Health Services is the parent of a number of health care organizations, including your organization. On [redacted] you were incorporated under [redacted] law as a nonprofit corporation. According to your Bylaws, Health Services elects your Board of Directors.

In [redacted] you were licensed by [redacted] as a health maintenance organization ("HMO") to serve a five-county area, which is the primary area served by [redacted] ("Medical Center"), also a subsidiary of Health Services.

Your actual and projected enrollment is:

	Actual	Projected	Projected
Medical Center Employees	[redacted]	[redacted]	[redacted]
Small Employer Groups*	[redacted]	[redacted]	[redacted]
State and local government employers	[redacted]	[redacted]	[redacted]
Large Employer Groups**	[redacted]	[redacted]	[redacted]
Total	[redacted]	[redacted]	[redacted]

* Fewer than 50 employees
** 50 employees or more

[redacted]

You have applied for a Medicare license, which is now pending. You have been approved for Medicaid and are awaiting the rate structure to be furnished by [redacted].

You determine the fees you charge to your enrollees using a community rating methodology.

One of Health Services' subordinate organizations is [redacted] ("Physician Services"), which consists of a group of primary care physician practices. Physician Services has been recognized as exempt under section 501(c)(3) of the Code.

You obtain primary care physician services for your enrollees by contracting with independent physicians engaged in private practice and by contracting directly with the physicians employed by Physician Services. Under the Participating Physician Agreement, you compensate these primary care physicians on a fee-for-service basis plus a management fee of $[redacted] per member per month. The fee schedule is based on reasonable and customary fees and is not discounted. In addition, you do not withhold any portion of the fees you pay to your contracted primary care physicians.

On [redacted], you filed Form 1023 requesting recognition of exemption under section 501(c)(3) of the Code. On July [redacted] you withdrew this application and in lieu thereof, you submitted Form 1024, requesting recognition of exemption under section 501(c)(4).

LAW

Section 501(c)(4)

Section 501(c)(4) of the Code provides for the exemption from federal income taxation of civic leagues or organizations not organized for profit but operated exclusively for the promotion of social welfare, provided no part of the organization's net earnings inures to the benefit of any private shareholder or individual.

Section 1.501(a)-1(c) of the Income Tax Regulations defines the words "private shareholder or individual" as a person having a personal and private interest in the activities of the organization. Thus, exemption under section 501(c)(4) of the Code depends on an organization's ability to serve in some manner the general welfare of the community rather than providing benefits primarily to its members or to other interested parties.

[redacted]

Section 1.501(c)(4)-1(a)(1) of the regulations provides that an organization is described in section 501(c)(4) of the Code if (1) it is not organized or operated for profit and (2) it is operated exclusively for the promotion of social welfare. Section 1.501(c)(4)-1(a)(2)(i) of the regulations provides that an organization is operated exclusively for the promotion of social welfare if it is primarily engaged in promoting in some way the common good and general welfare of the people of the community.

Section 1.501(c)(4)-1(a)(2)(ii) of the regulations provides that an organization is not operated primarily for the promotion of social welfare if its primary activity is carrying on a business with the general public in a manner similar to organizations which are operated for profit.

In general, social welfare must benefit the general community as a whole and organizations exempt under section 501(c)(4) of the Code must be operated primarily to promote social welfare. Certain social welfare organizations serve only the community as a whole (pure public benefit) while others benefit a particular group of people but still primarily serve community interests. However, in instances where an organization limits its benefits to members, the organization is generally considered not to be operated for social welfare purposes.

A number of rulings illustrate the distinction between organizations that serve the community and those that serve only their members or some other restricted class. See, e.g., Rev. Rul. 78-69, 1978-1 C.B. 156 (providing rush-hour bus service to members of the general public, where the bus service provided is subsidized by government and the regular bus service is not adequate or commercially available, constitutes a social welfare activity); and Rev. Rul. 78-429, 1978-2 C.B. 178 (an organization primarily promoted social welfare because it met a community need by operating an airport not otherwise available to the rural communities of the area). But see Rev. Rul. 75-199, 1975-1 C.B. 160 (an organization formed to provide sick and death benefits to members who are restricted to individuals of good moral character and health who belong to a particular ethnic group and reside in a stated geographical area provides only minor and incidental benefits to the community as a whole); and Rev. Rul. 55-311, 1955-1 C.B. 72 (providing bus service for a local association of employees, the membership of which is limited to employees of a particular corporation, is not a social welfare activity).

The distinction between "pure" public benefit and private benefit is illustrated by comparing Rev. Rul. 54-394, 1954-2 C.B. 131 (an organization does not primarily promote social welfare

[redacted]

where it provides television reception on a cooperative basis) with Rev. Rul. 62-167, 1962-2 C.B. 142 (an organization retransmitting TV signals for the benefit of the entire community qualifies as a social welfare organization). See also Rev. Rul. 80-206, 1980-2 C.B. 185, (an organization formed to promote the legal rights of all tenants in a particular community qualifies as a social welfare organization) and Rev. Rul. 73-306, 1973-2 C.B. 179 (a similar organization, formed to protect the rights of tenants in one particular rental complex, was not primarily promoting social welfare).

Another example of an organization benefiting only its members is Rev. Rul. 66-148, 1966-1 C.B. 143, in which the Service held that an organization formed to establish and maintain a system for water storage and distribution was exempt under section 501(c)(4) of the Code. Although it was a membership organization, its activities resulted in an increase in the level of underground water, which benefited the entire community, irrespective of membership.

Therefore, when the services furnished by an organization are beneficial to the community and available to all members of the community on an equal basis irrespective of membership, a social welfare objective will generally be found to exist. However, where an organization limits its services and benefits to its members, the organization is not ordinarily operated exclusively for the promotion of social welfare within the meaning of section 501(c)(4).

While a social welfare organization necessarily benefits private individuals in the process of benefiting the community as a whole, even when the benefits are confined to a particular group of individuals, the organization may be exempt if the general community derives a substantial benefit. Conversely, an organization that benefits a large number of people will not necessarily be organized for social welfare purposes within the meaning of section 501(c)(4) because numbers are not necessarily determinative of social welfare objectives. Social welfare is the wellbeing of persons as a community and classification depends upon the character -- as public or private -- of the benefits bestowed, of the beneficiary, and of the benefactor. See Commissioner v. Lake Forest, Inc., 305 F.2d 814 (4th Cir. 1962).

Therefore, the issue is whether the organization's activities result in so much private benefit as to preclude it from qualifying as a social welfare organization. The test in resolving this question with respect to exemption under section 501(c)(4) is "primarily," which, as used in the regulations,

means that some amount of private benefit may be permissible so long as the organization's activities remain primarily social welfare. This necessarily requires weighing the extent to which an organization's activities are social welfare activities versus those that result in a private benefit. An example of the balancing between public and private benefits is Rev. Rul. 72-102, 1972-1 C.B. 149. In this ruling, a homeowner's association formed by a developer to administer and enforce covenants for preserving the architecture and appearance of a housing development and to own and maintain common green areas, streets and sidewalks for the use of development residents was held to be exempt under section 501(c)(4) of the Code even though there existed some amount of private benefit to the developer and individual residents because these benefits were incidental to the benefit provided to the community as a whole.

A similar analysis has been applied in the case of organizations exempt under section 501(c)(3) of the Code. Although an organization's operations may be deemed to be beneficial to the public, if it also serves private interests other than incidentally, it is not entitled to exemption under section 501(c)(3). The word "incidental" has both qualitative and quantitative connotations. To be qualitatively incidental, any private benefit must be a necessary concomitant of an activity which benefits the public at large; in other words, the benefit to the public cannot be achieved without necessarily benefiting certain private individuals. To be quantitatively incidental, any private benefit must be insubstantial measured in the context of the overall public benefit conferred by the activity.

Accordingly, exemption under section 501(c)(4) of the Code depends on an organization's ability to serve in some manner the general welfare of the community rather than providing benefits primarily to its members or to other interested parties. In addition, as explained below, for an organization to be exempt under section 501(c)(4), it must be in compliance with section 501(m).

In Rev. Rul. 86-98, 1986-2 C.B. 75, an individual practice association (IPA) sought recognition of exemption under section 501(c)(4) of the Code. The IPA's purpose was to arrange for the delivery of health service through written agreements negotiated with health maintenance organizations (HMOs). Its membership was limited to licensed physicians who were members of a specified county medical society. The IPA's primary activities were to serve as a bargaining agent for its members in dealing with HMOs and to perform the administrative claims services required by the agreements with the HMOs.

The IPA in this revenue ruling was akin to a billing and collection service and a collective bargaining representative negotiating on behalf of its member physicians with HMOs. The IPA did not provide access to medical care which would not have been available but for the establishment of the IPA, nor did it provide such care at fees below what was customarily and reasonably charged by the member physicians in their private practices. As a result, the Internal Revenue Service concluded that the IPA operated in a manner similar to organizations carried on for profit, the primary beneficiaries of which are its member physicians, rather than the community as a whole. Therefore, the Service held that it was not operated exclusively for the promotion of social welfare within the meaning of section 501(c)(4) of the Code.

Rev. Rul. 70-535, 1970-2 C.B. 117, describes an organization formed to provide management, development and consulting services for low and moderate income housing projects for a fee. The revenue ruling held that the organization did not qualify under section 501(c)(4) of the Code. The revenue ruling stated:

> Since the organization's primary activity is carrying on a business by managing low and moderate income housing projects in a manner similar to organizations operated for profit, the organization is not operated primarily for the promotion of social welfare. The fact that these services are being performed for tax exempt corporations does not change the business nature of the activity.

Section 501(m)

Section 501(m)(1) of the Code provides that an organization described in section 501(c)(3) or 501(c)(4) shall be exempt "only if no substantial part of its activities consists of providing commercial-type insurance." The legislative history indicates that this provision was intended, in part, to bar continued section 501(c)(4) exemption for Blue Cross/Blue Shield organizations, which had enjoyed such status for many years despite being in many respects indistinguishable from commercial health insurers. See H.R. Rep. No. 99-426, 99th Cong., 1st Sess. 662 - 6 (1986); 1986-3 C.B. (Vol. 2) 662 - 6. Consequently, where an organization's activities resemble those of commercial insurers, generally, section 501(m) would serve to deny exemption under section 501(c)(4), not only section 501(c)(3).

The legislative history of section 501(m) provides:

> For this purpose [section 501(m) of the Code], commercial-type insurance generally is any insurance of a type provided by commercial insurance companies.
>
> . . . .
>
> [C]ommercial-type insurance does not include arrangements that are not treated as insurance (i.e., in the absence of sufficient risk shifting and risk distribution for the arrangement to constitute insurance).13/
>
> 13/ See Helvering v. LeGierse, 312 U.S. 531 (1941).

Staff of Joint Committee on Taxation, General Explanation of the Tax Reform Act of 1986, at 585 (Comm. Print 1987). See also, H.R. Rep. No. 99-426, 99th Cong., 1st Sess. 663 - 4 (1986); 1986-3 C.B. (Vol. 2) 663 - 4.

In reporting on technical corrections to Section 501(m) of the Code that were made in the Technical and Miscellaneous Revenue Act of 1988 ("TAMRA"), the Conference Committee stated:

> [T]he provision relating to organizations engaged in commercial-type insurance activities did not alter the tax-exempt status of health maintenance organizations (HMOs). HMOs provide physician services in a variety of practice settings primarily through physicians who are either employees or partners of the HMO or through contracts with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis). The conference committee clarifies that, in addition to the general exemption for health maintenance organizations, organizations that provide supplemental health maintenance organization-type services (such as dental or vision services) are not treated as providing commercial-type insurance if they operate in the same manner as a health maintenance organization.

H.R. Conf. Rep. No. 100-1104, 100th Cong., 2d Sess. II-9 (1988).

In Rev. Rul. 68-27, 1968-1 C.B. 315, an organization that issued medical service contracts to groups or individuals and furnished direct medical services to the subscribers by means of a salaried staff of medical personnel was held not to be an insurance company. In this revenue ruling, a medical clinic employed a staff of salaried physicians, nurses and technicians to provide a major portion of the contracted medical services. In the event the clinic had to treat a patient with an illness or injury, the patient was treated by the clinic's salaried staff, thereby incurring no significant additional costs. The revenue ruling concluded that any risk the clinic incurred was predominantly a normal business risk. The clinic's costs for its medical providers was fixed because the clinic paid its providers a salary. As a result, if a patient were to suffer a serious illness or injury, the clinic would not incur any substantial additional costs. Thus, the clinic's economic risk was fixed regardless of the presence or extent of any illness or injury.

In Jordan, Superintendent of Insurance v. Group Health Association, 107 F.2d 239 (1939) ("Jordan"), the U.S. Court of Appeals for the District of Columbia held that an HMO was not an insurance company. In this case, the HMO did not employ salaried physicians to provide medical services but paid contracted physicians a "fixed annual compensation, paid in monthly installments, not specific fees for each treatment or case." Jordan, at 242, ftnt. 7.

Neither the Internal Revenue Code nor the regulations define the term "insurance contract." Rev. Rul. 68-27, supra, citing Jordan, supra, defined an insurance contract as one that:

> [M]ust involve the element of shifting or assuming the risk of loss of the insured and must, therefore, be a contract under which the insurer is liable for a loss suffered by its insured.

Case law has defined "insurance contract," as a "contract whereby, for an adequate consideration, one party undertakes to indemnify another against loss from certain specified contingencies or peril. . . . [I]t is contractual security against possible anticipated loss." Epmeier v. U.S., 199 F.2d 508, 509-10 (7th Cir. 1952). See also, SEC v. Variable Life Annuity Life Ins. Co., 359 U.S. 65, 71 (1959); Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205, 211 (1979); Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 127 (1982); 1 Couch on Insurance 2d (Rev. ed), Sections 1:2, 1:3 (1984).

Moreover, case law has established that risk shifting and risk distribution are the fundamental characteristics of a contract of insurance. Helvering v. LeGierse, supra. In this case, the Supreme Court stated that "[h]istorically and commonly insurance involves risk-shifting and risk-distributing." 312 U.S. at 539.

Finally, the risk transferred must be a risk of economic loss. The risk for which insurance coverage is provided is an insurance risk; that is, it must occur fortuitously and must result in an economic loss to the insurer. Allied Fidelity Corp. v. Commissioner, 66 T.C. 1068 (1976); aff'd, 572 F.2d 1190 (7th Cir. 1978); cert. den., 439 U.S. 835 (1978). In this case, the Court of Appeals stated:

> . . . [T]he common definition for insurance is an agreement to protect the insured against a direct or indirect economic loss arising from a defined contingency whereby the insurer undertakes no present duty of performance but stands ready to assume the financial burden of any covered loss. 1 Couch on Insurance 2d 1:2 (1959). As the tax court below noted, an insurance contract contemplates a specified insurable hazard or risk with one party willing, in exchange for the payment of premiums, to agree to sustain economic loss resulting from the occurrence of the risk specified and, another party with an insurable interest in the insurable risk. It is important here to note that one of the essential features of insurance is this assumption of another's risk of economic loss. 1 Couch on Insurance 2d 1:3 (1959).

Risk shifting occurs when a person facing the possibility of an economic loss transfers some or all of the financial consequences of the loss to the insurer. Rev. Rul. 88-72, 1988-2 C.B. 31, clarified by Rev. Rul. 89-61, 1989-1 C.B. 75.

Risk distribution refers to the operation of the statistical phenomenon known as the "law of large numbers." When additional statistically independent risk exposure units are insured, an insurance company's potential total loss increases, as does the uncertainty regarding the amount of that loss. As the uncertainty regarding the company's total loss increases, however, there is an increase in the predictability of the insurance company's average loss. Due to this increase in the predictability of average loss, there is a downward trend in the

amount of capital that the company needs per risk unit to remain at a given level of solvency. See Rev. Rul. 89-61, supra.

In Rev. Rul. 77-316, 1977-2 C.B. 53, a domestic parent corporation and its domestic subsidiaries paid amounts designated as "insurance premiums" to a wholly-owned foreign "insurance" subsidiary. This subsidiary was organized to insure property and casualty risks of only the parent and its subsidiaries. The "insurance" subsidiary did not accept risks from any other companies. The parent paid "premiums" at commercial rates. Because there was no economic shifting or distributing of risks of loss with respect to the risks borne by the subsidiary, this ruling held:

> [T]he insuring parent corporation and its domestic subsidiaries, and the wholly-owned "insurance" subsidiary, although separate corporate entities, represent one economic family with the result that those who bear the ultimate economic burden of loss are the same persons who suffer the loss. To the extent that the risks of loss are not retained in their entirety by . . . or reinsured with . . . insurance companies that are unrelated to the economic family of insureds, there is no risk-shifting or risk-distributing, and no insurance. . . .

In Rev. Rul. 78-338, 1978-2 C.B. 107, a domestic corporation paid premiums to a foreign insurance company that was owned by the taxpayer and 30 other unrelated corporations. No shareholder owned a controlling interest in the foreign company. The foreign company provided "insurance" only to its shareholders and their subsidiaries and affiliates. The bylaws prohibited any shareholder's individual risk coverage from exceeding five percent of the total risks "insured" by the foreign company. All "premiums" were determined on a fair market value basis. This revenue ruling held that because the taxpayer and the other "insured" shareholders were not economically related, the economic risk of loss could be shifted and distributed among the shareholders who comprised the insured group.

[redacted]

RATIONALE

Section 501(c)(4)

Open Enrollment

Exemption under section 501(c)(4) of the Code depends on an organization serving the general welfare of the community rather than providing benefits solely to its members or to parties in control of the organization. Section 1.501(c)(4)-1(a) of the regulations provides that an organization is operated exclusively for the promotion of social welfare if it is primarily engaged in promoting in some way the common good and general welfare of the people of the community. Social welfare is the well being of persons as a community. Commissioner v. Lake Forest, Inc., supra. Thus, organizations that primarily serve the community as a whole rather than their members or some other restricted class satisfy the requirements of the regulations. See Rev. Rul. 80-.206, supra; Rev. Rul. 78-429, supra; Rev. Rul. 78-69, supra; Rev. Rul. 62-167, supra.

On the other hand, organizations that primarily serve their members or some other restricted class rather than the community as a whole do not satisfy this requirement. See Rev. Rul. 75-199, supra; Rev. Rul. 73-306, supra; Rev. Rul. 54-394.

Persons who generally experience difficulty in obtaining affordable health care services or health care insurance (e.g., the poor, the elderly, unemployed individuals, individuals whose employers do not offer health insurance, and employees of small employer groups), are considered to be "medically underserved." An organization that arranges for the provision of health care services for one or more groups of medically underserved persons is considered to be primarily engaged in promoting the common good and general welfare of the people of the community.

A substantial portion of your enrollment consists of persons who are generally considered to be medically underserved, i.e., employees in small employer groups, and in the future, may also include Medicare and Medicaid beneficiaries. Thus, your enrollment is open to medically underserved persons in the community.

Community Rating

To qualify for exemption under section 501(c)(4) of the Code an organization must promote the common good and general welfare of the community as a whole. To accomplish this, the services provided by the organization must be available to the community

as a whole and generally affordable by the members of the community. In the case of the services of an HMO, the premiums charged must be reasonably priced. Where the HMO determines its premiums under a community rating methodology, rather than an experience rating methodology, premiums are generally lower because the premiums are based on the health care experience of the community, not a high utilization group.

You have stated that you determine the fees you charge to your enrollees based on a community rating methodology.

Community Control

When an organization's board of directors is comprised of independent persons who broadly represent the community, the organization is more likely to provide significant benefit to the community rather than to its members or to some other restricted group. See, e.g., Rev. Rul. 69-545, 1969-2 C.B. 117 (control of a hospital by a board of trustees comprised of "independent civic leaders" was a significant fact in determining whether the hospital operates to benefit the community as a whole rather than private interests).

The members of your Board of Directors are elected by Health Services, which is exempt under section 501(c)(3) of the Code. Therefore, your Board of Directors is presumed to be a community board.

Private Inurement and Private Benefit

Section 501(c)(4) and the regulations thereunder require that an organization engage in activities that primarily benefit the community rather than the private interests of the organization's members or some other restricted group. Furthermore, section 501(c)(4) specifically prohibits private inurement.

There is no evidence to indicate that your activities are likely to result in private inurement or impermissible private benefit.

In conclusion, because you will be operated primarily for the benefit of the community as a whole, you will satisfy the requirements of section 501(c)(4) of the Code .

Section 501(m)

Under section 501(m)(1) of the Code, an organization that otherwise qualifies for exemption under section 501(c)(3) or

section 501(c)(4) is precluded from exemption if a substantial part of its activities consists of providing commercial-type insurance.

When individuals enroll in an HMO and pay the HMO fixed premiums, the HMO agrees that it will furnish health care services to treat their injuries and illnesses. Under this arrangement, enrollees protect themselves against the risk that they would suffer economic loss from having to pay for health care services that are necessary because of injuries or illnesses. By enrolling in an HMO, individuals shift their risk of economic loss to the HMO.

For an HMO that operates on a staff model basis, the HMO assumes the financial risk associated with furnishing medical services. Since a staff model HMO pays physicians on a salaried basis, it does not incur additional fees when its employed physicians treat its enrollees. Therefore, the risk the HMO assumes is predominantly a normal business risk of an organization engaged in furnishing medical services on a fixed-price basis, rather than an insurance risk. Rev. Rul. 68-27, supra.

On the other hand, a non-staff model HMO that does not pay its physicians on a fixed-price basis assumes a financial risk that is greater than a normal business risk associated with its obligation to furnish medical services to its enrollees. Therefore, this obligation constitutes a contract of insurance.

An HMO that compensates its non-employee physicians on a fixed fee basis is treated the same as a staff model HMO that pays its physicians on a salaried basis because the HMO has transferred to its physicians a substantial portion of its financial risk associated with its obligation to furnish medical services to its enrollees. The remaining risk is only the normal business risk associated with operating the HMO.

For example, an HMO that pays its contracted physicians almost exclusively fixed monthly fees based on the number of enrollees ("capitated fees") transfers to these physicians a substantial portion of its financial risk associated with its obligation to furnish medical services to its enrollees. Therefore, the remaining risk is only the normal business risk associated with operating the HMO.

Similarly, an HMO that pays its contracted physicians almost exclusively fees-for-service under a fee schedule that represents a meaningful discount from the physicians' usual and customary charges ("discounted fee-for-service") and withholds from these

payments a significant percent of the fees otherwise payable, pending compliance with periodic budget or utilization standards transfers to these physicians, in effect, a substantial portion of its financial risk associated with its obligation to furnish medical services to its enrollees. Therefore, the remaining risk is only the normal business risk associated with operating the HMO. In return for accepting discounted fees, the physicians are assured of a flow of patients from the HMO. It is a common commercial practice for vendors of goods or providers of services to accept lower prices or fees in return for greater sales.

On the other hand, when an HMO pays its contracted physicians on a fee-for-service basis that is not discounted and where no significant portion of the fees has been withheld, the HMO does not transfer to these physicians its financial risk associated with its obligation to furnish medical services to its enrollees. Thus, the HMO retains the financial risk associated with its obligation to furnish medical services to its enrollees. This financial risk constitutes a contract of insurance.

You do not operate as a staff model HMO. Instead, you contract with independent physicians in private practice and with physicians employed by the Medical Center to provide health care services to your enrollees. Under Rev. Rul. 68-27, supra, and Jordan, supra, the contract with your enrollees to arrange for the provision of health care services in return for a fixed fee constitutes a contract of insurance.

Under the Participating Physician Agreement, you compensate physicians on a fee-for-service basis that is based on reasonable and customary fees and is not discounted. In addition, you do not withhold any portion of the fees you pay.

Under this fee-for-service compensation arrangement with participating physicians, you have not transferred to these physicians a substantial portion of your financial risk associated with your obligation to furnish medical services to your enrollees. Therefore, you retain the financial risk associated with your obligation to furnish medical services to your enrollees. This financial risk constitutes a contract of insurance. See Rev. Rul. 68-27.

Since this health insurance is the same type of health insurance as that which is offered by commercial insurance companies, it is "commercial-type" insurance under section 501(m)(1) of the Code. Therefore, even though you otherwise qualify for exemption under section 501(c)(4) of the Code, you are precluded from qualifying for exemption by section 501(m)(1).

[redacted]

CONCLUSION

Accordingly, you do not qualify for exemption as an organization described in section 501(c)(4) of the Code and you must file federal income tax returns.

Contributions to you are not deductible under section 170 of the Code.

You have the right to protest this ruling if you believe it is incorrect. To protest, you should submit a statement of your views, with a full explanation of your reasoning. This statement, signed by one of your officers, must be submitted within 30 days from the date of this letter. You also have a right to a conference in this office after your statement is submitted. You must request the conference, if you want one, when you file your protest statement. If you are to be represented by someone who is not one of your officers, that person will need to file a proper power of attorney and otherwise qualify under our Conference and Practices Requirements.

If we do not hear from you within 30 days, this ruling will become final and copies will be forwarded to the Ohio EP/EO key district office. Thereafter, any questions about your federal income tax status should be addressed to that office, either by calling 877-829-5500 (a toll free number) or sending correspondence to: Internal Revenue Service, EP/EO Customer Service, P.O. Box 2508, Cincinnati, OH 45201.

When sending additional letters to us with respect to this case, you will expedite their receipt by using the following address:

Internal Revenue Service
[redacted]
1111 Constitution Ave, N.W.
Washington, D.C. 20224

For your convenience, our FAX number is [redacted] or [redacted]. [redacted] E-Mail address is: [redacted].irs.gov

If you have any questions, please contact the person whose name and telephone number are shown in the heading of this letter.

[redacted]

In accordance with the Power of Attorney currently on file with the Internal Revenue Service, we are sending a copy of this letter to your authorized representative.

Sincerely
Marvin Friedlander

Marvin Friedlander
Chief, Exempt Organizations
Technical Branch 1