State of California
Office of Administrative Law

In re:
California Health Benefit Exchange

Regulatory Action:

Title 10, California Code of Regulations

Adopt sections: **6910, 6912, 6914, 6916, 6918, 6920, 6922**
Amend sections:
Repeal sections:

NOTICE OF APPROVAL OF EMERGENCY REGULATORY ACTION

Government Code Sections 11346.1 and 11349.6

OAL Matter Number: 2020-0430-02

OAL Matter Type: Emergency Readopt (EE)

This proposed emergency rulemaking action by the California Health Benefit Exchange readopts OAL File No. 2019-0927-05E that established the application process, eligibility and redetermination standards, and verification process for hardship and religious conscience exemptions.

OAL approves this emergency regulatory action pursuant to sections 11346.1 and 11349.6 of the Government Code.

This emergency regulatory action is effective on 5/11/2020.

Date: May 11, 2020

Lindsey S. McNeill
Attorney

For: Kenneth J. Pogue
Director

Original: Peter Lee, Executive Director
Copy: Faviola Ramirez-Adams

OAL REPORT TO THE PUBLISHER

OAL Matter Number	2020-0430-02
OAL Matter Type	Emergency Readopt (EE)
Agency Name	California Health Benefit Exchange
Title(s)	10
OAL Action	Approval
Date filed with Secretary of State	5/11/2020
Effective Date	5/11/2020
Custom History Note (if any)	"New article 13 (sections 6910-6922) and section refiled 5-11-2020 as a deemed emergency pursuant to Government Code section 100725(c); operative 5-11-2020 (Register 2020, No. **). A Certificate of Compliance must be transmitted to OAL by 1-1-2025 pursuant to Government Code section 100725 or emergency language will be repealed by operation of law on the following day."
Note to Publisher/Special Instructions (if any)	Please do not print the documents incorporated by reference in the CCR. Thank you!
Print Attachments?	○ Yes ◉ No ○ N/A
Changes in text from prior emergencies?	◉ Yes ○ No ○ N/A
Certificate of Compliance due date (if applicable)	1/1/2025
Expiration Date (if applicable)	1/2/2025
Reviewed by:	Lindsey S. McNeill lindsey.mcneill@oal.ca.gov, (916) 323-6820

STATE OF CALIFORNIA—OFFICE OF ADMINISTRATIVE LAW

NOTICE PUBLICATION/REGULATIONS SUBMISSION — EMERGENCY

(See instructions on reverse)

For use by Secretary of State only

STD. 400 (REV. 01-2013)

OAL FILE NUMBERS	NOTICE FILE NUMBER	REGULATORY ACTION NUMBER	EMERGENCY NUMBER
	Z-		2020-0430-02EE

For use by Office of Administrative Law (OAL) only

2020 APR 30 P 4:54

OFFICE OF ADMINISTRATIVE LAW

NOTICE | REGULATIONS

ENDORSED - FILED
In the office of the Secretary of State
of the State of California
MAY 11 2020
1:44PM

AGENCY WITH RULEMAKING AUTHORITY: California Health Benefit Exchange

AGENCY FILE NUMBER (If any):

A. PUBLICATION OF NOTICE (Complete for publication in Notice Register)

1. SUBJECT OF NOTICE | TITLE(S) | FIRST SECTION AFFECTED | 2. REQUESTED PUBLICATION DATE

3. NOTICE TYPE: ☐ Notice re Proposed Regulatory Action ☐ Other

4. AGENCY CONTACT PERSON | TELEPHONE NUMBER | FAX NUMBER (Optional)

OAL USE ONLY — ACTION ON PROPOSED NOTICE: ☐ Approved as Submitted ☐ Approved as Modified ☐ Disapproved/ Withdrawn | NOTICE REGISTER NUMBER | PUBLICATION DATE

B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1a. SUBJECT OF REGULATION(S): Hardship and Religious Conscience Exemptions Process

1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S): 2019-0927-05E; 2020-0408-05EE

2. SPECIFY CALIFORNIA CODE OF REGULATIONS TITLE(S) AND SECTION(S) (Including title 26, if toxics related)

SECTION(S) AFFECTED (List all section number(s) individually. Attach additional sheet if needed.)

ADOPT: 6910, 6912, 6914, 6916, 6918, 6920 and 6922

AMEND:

REPEAL:

TITLE(S): 10

3. TYPE OF FILING

- ☐ Regular Rulemaking (Gov. Code §11346)
- ☐ Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §§11349.3, 11349.4)
- ☐ Emergency (Gov. Code, §11346.1(b))
- ☐ Certificate of Compliance: The agency officer named below certifies that this agency complied with the provisions of Gov. Code §§11346.2-11347.3 either before the emergency regulation was adopted or within the time period required by statute.
- ☒ Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1)
- ☒ Emergency Readopt (Gov. Code, §11346.1(h))
- ☐ File & Print
- ☒ Other (Specify) Gov. Code, §100725(c) 5/8/20
- ☐ Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100) MM
- ☐ Print Only

4. ALL BEGINNING AND ENDING DATES OF AVAILABILITY OF MODIFIED REGULATIONS AND/OR MATERIAL ADDED TO THE RULEMAKING FILE (Cal. Code Regs. title 1, §44 and Gov. Code §11347.1)

5. EFFECTIVE DATE OF CHANGES (Gov. Code, §§ 11343.4, 11346.1(d); Cal. Code Regs., title 1, §100)

- ☐ Effective January 1, April 1, July 1, or October 1 (Gov. Code §11343.4(a))
- ☒ Effective on filing with Secretary of State
- ☐ §100 Changes Without Regulatory Effect
- ☐ Effective other (Specify) MM

6. CHECK IF THESE REGULATIONS REQUIRE NOTICE TO, OR REVIEW, CONSULTATION, APPROVAL OR CONCURRENCE BY, ANOTHER AGENCY OR ENTITY

- ☐ Department of Finance (Form STD. 399) (SAM §6660)
- ☐ Fair Political Practices Commission
- ☐ State Fire Marshal
- ☒ Other (Specify) Consultation with Franchise Tax Board pursuant to Government Code section 100725 5/8/20

7. CONTACT PERSON | TELEPHONE NUMBER | FAX NUMBER (Optional) | E-MAIL ADDRESS (Optional)

Faviola Adams | 916-284-5547 | | faviola.ramirez-adams@covered.ca

8. **I certify that the attached copy of the regulation(s) is a true and correct copy of the regulation(s) identified on this form, that the information specified on this form is true and correct, and that I am the head of the agency taking this action, or a designee of the head of the agency, and am authorized to make this certification.**

SIGNATURE OF AGENCY HEAD OR DESIGNEE: [signature] | DATE: 4/24/2020

TYPED NAME AND TITLE OF SIGNATORY: Peter V. Lee, Executive Director

For use by Office of Administrative Law (OAL) only

ENDORSED APPROVED
MAY 11 2020
Office of Administrative Law

LM
per agency
request
5/8/20

California Code of Regulations

Title 10. Investment

Chapter 12. California Health Benefit Exchange

Article 13. Hardship and Religious Conscience Exemptions Process Through the Exchange

Readopt Section 6910 with Amendments

§ 6910. Definitions and General Requirements.

(a) For purposes of this article, the following terms shall have the following meanings:

(1) "Applicant" means an individual who is seeking an exemption from the Minimum Essential Coverage Individual Mandate established in Title 24 of the Government Code or from the requirement to maintain minimum essential coverage under Section 5000A of the Internal Revenue Code (26 USC § 5000A) for the purpose of enrollment in a catastrophic plan through an application submitted to the Exchange.

(2) "Application filer" means an applicant, an individual who is liable for the Individual Shared Responsibility Penalty under Part 32 of Division 2 of the Revenue and Taxation Code or the shared responsibility payment under Section 5000A(b) of the Internal Revenue Code (26 USC § 5000A(b)) for an applicant, an authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for an applicant.

(3) "Certificate of exemption" is a certification attesting that the individual is exempt from the Minimum Essential Coverage Individual Mandate established in Title 24 of the Government Code or from the requirement to maintain minimum essential coverage under

section 5000A of the Internal Revenue Code (26 USC § 5000A) and the Individual Shared Responsibility Penalty imposed under Section 61010 of the Revenue and Taxation Code.

(4) "Exemption" means an exemption from the Minimum Essential Coverage Individual Mandate established in Title 24 of the Government Code and the Individual Shared Responsibility Penalty imposed under Section 61010 of the Revenue and Taxation Code or from the requirement to maintain minimum essential coverage under section 5000A of the Internal Revenue Code (26 USC § 5000A) for the purpose of enrollment in a catastrophic plan through an application submitted to the Exchange.

(5) "Household income" has the same meaning given the term in Section 5000A(c)(4)(B) of the Internal Revenue Code (26 USC § 5000A(c)(4)(B)) and in 26 CFR Section 1.5000A-1(d)(10) (December 26, 2013), hereby incorporated by reference.

(6) "Incarcerated" has the same meaning given the term in Section 6410 of Article 2 of this chapter.

(7) "Indian tribe" has the same meaning given the term in Section 6410 of Article 2 of this chapter.

(8) "Individual Shared Responsibility Penalty" has the same meaning given the term -in Section 61010 of the Revenue and Taxation Code.

(9) "Projected household income" means the household income that the applicant reasonably expects for the calendar year.

(10) <u>"Qualified Individual" means an individual who meets the eligibility standards for exemption through the Exchange, as specified in Section 6914.</u>

<u>(11)</u> "Required contribution" has the same meaning given the term in Section 5000A(e)(1)(B) of the Internal Revenue Code (26 USC § 5000A(e)(1)(B)).

~~(11)~~(12) "Tax filer" has the same meaning given the term in Section 6410 of Article 2 of this chapter. "Tax filer" also includes an individual who is required to make a return to the Franchise Tax Board in accordance with Section 18501 of the Revenue and Taxation Code.

(b) For purposes of this article, any attestation that an applicant is to provide under this article may be made by the application filer on behalf of the applicant.

(c) For purposes of this article, information obtained through electronic data sources, information provided by the applicant, or other information in the records of the Exchange shall be considered to be reasonably compatible with an applicant's attestation if the difference or discrepancy does not impact the applicant's eligibility for the exemption or exemptions for which the applicant applied.

(d) Information, including notices, forms, and applications, shall be provided to applicants in accordance with the accessibility and readability standards specified in Section 6452.

Note: Authority cited: Sections 100504 and 100725, Government Code. Reference: Sections 100502, 100705 and 100715, Government Code; Section 61010, Revenue and Taxation Code; 26 USC Section 5000A; 45 CFR Section 155.600.

Readopt Section 6912 with Amendments

§ 6912. Exemption Applications.

(a) The Exchange shall use an exemption application to collect the applicant's information necessary to determine the applicant's eligibility for religious conscience and hardship exemptions.

(b) To apply for a religious conscience or hardship exemption, an applicant or an application filer shall submit all information, documentation, and declarations required on the

application, as specified in subdivisions (c), (d), and (e) of this section, and shall sign and date the application.

(c) An applicant or an application filer shall provide the following information on the applicable exemption application:

(1) The applicant's full name (first, middle, if applicable, and last name).

(2) The applicant's home and mailing address, if different from home address, the applicant's county of residence and telephone number(s). For an applicant who does not have a home address, only a mailing address shall be provided.

(3) The applicant's email address, if the applicant chooses to get correspondence via email from the Exchange.

(4) The applicant's preferred written and spoken language.

(5) The applicant's date of birth.

(6) The applicant's Social Security Number or Individual Taxpayer Identification Number, if one has been issued to the applicant.

(7) The applicant's gender.

(8) For each individual included on the applicant's state tax return, including the applicant and the applicant's spouse or domestic partner, the individual's relationship to the applicant, the individual's full name, date of birth, Social Security Number or Individual Taxpayer Identification Number, if the individual has one, gender, and whether the individual wants an exemption.

(d) For a religious conscience exemption, as specified in Section 6914(b), an applicant or an application filer shall provide the following information on the religious conscience exemption application in addition to the information specified in subdivision (c) of this section:

(1) The year for which the applicant or any individual in the applicant's tax household is requesting the exemption.

(2) Whether the applicant or any individual in the applicant's tax household is a member of recognized religious sect or division described in section 1402(g)(1) of the Internal Revenue Code (26 USC § 1402(g)(1)) and adheres to the established tenets or teachings of such sect or division.

(3) Whether the applicant or any individual in the applicant's tax household has an approved IRS Form 4029 ("Application for Exemption from Social Security and Medicare Taxes and Waiver of Benefits") with required signatures. If so, a copy of the approved form shall be submitted with the application.

(4) Whether the applicant or any individual in the applicant's tax household is a member of a religious sect or division that is not described in Section 1402(g)(1) of the Internal Revenue Code (26 USC § 1402(g)(1)), relies solely on a religious method of healing, and the acceptance of medical health services would be inconsistent with the religious beliefs of the individual. If so, an attestation signed by the applicant that the member has not received medical health services during the preceding taxable year shall be submitted with the application.

(5) The full name and address of the religious sect or division the applicant or any individual in the applicant's tax household is a member of and the date they became a member.

(e) For a general hardship exemption, as specified in Section 6914(c), an applicant or an application filer shall provide the following information on the general hardship exemption application in addition to the information specified in subdivision (c) of this section:

(1) The type of hardship.

(2) The tax year for which the hardship exemption is requested.

(3) The start and end dates for the hardship ~~started and ended, or whether the hardship is ongoing~~.

(f) For an affordability hardship exemption, as specified in Section 6914(d), an applicant or an application filer shall provide the following information on the affordability hardship exemption application in addition to the information specified in subdivision (c) of this section:

(1) The year and months the applicant ~~or any individual in the applicant's tax household~~ requests the exemption.

(2) Whether the applicant ~~or any other individuals on the exemption application~~ has been offered employer-sponsored health coverage ~~and the name of such individuals~~.

(3) Documentation of the cost of the premium for the employer-sponsored coverage for the applicant and any covered family members and whether the employer-sponsored coverage meets the minimum value standards, specified in 45 CFR Section 156.145 (February 27, 2015), hereby incorporated by reference.

LM per agency request 5/8/20

(4) The applicant's projected household income from all sources for the year the applicant has requested the exemption, including tax-exempt foreign earned income and tax-exempt income from interest that the applicant receives or accrues during the taxable year, if any, and proof of such income. If self-employed, the amount of net income. The projected household income does not include income from child support payments, veteran's payments, and Supplemental Security Income/State Supplementary Payment (SSI/SSP).

(5) The applicant's expected type and amount of the tax deductions that the applicant is allowed to deduct from the applicant's taxable gross income when calculating the applicant's adjusted gross income on the applicant's federal income tax return.

(6) Whether the applicant intends to file federal and state income tax returns for the year for which the applicant is requesting coverage, and if so, the applicant's expected tax-filing status.

(7) Whether the applicant is enrolled in minimum essential coverage through any government sponsored programs, as defined in Section 5000A(f)(1)(A) of the Internal Revenue Code (26 USC § 5000A(f)(1)(A)), or is eligible for full-scope Medi-Cal or free Medicare Part A.

(8) The applicant's status as a U.S. Citizen or U.S. National, or the following information if the applicant is not a U.S. Citizen or U.S. National and attests to having lawful presence status:

(A) The applicant's immigration status;

(B) The applicant's immigration document type, identification number, country of issuance, expiration date, and the applicant's name as it appears on the document;

(C) Whether the applicant has lived in the U.S. since 1996; and

(D) Whether the applicant, or the applicant's spouse or parent, is a veteran or an active-duty member of the U.S. military.

(9) Whether the applicant is pregnant, and if so, the number of babies expected and the expected delivery date.

(10) Whether the applicant is 18 to 20 years old and a full-time student.

(11) Whether the applicant is 18 to 26 years old and lived in foster care on the applicant's 18th birthday or whether the applicant was in foster care and enrolled in Medicaid in any state.

(12) Whether the applicant is 18 years old or younger, and if so, the number of parents living with the applicant.

(13) Whether the applicant lives with at least one child under the age of 19 and is the primary person taking care of this child.

(14) Whether ~~anyone applying for an exemption on the application~~the applicant is incarcerated.

(15) Whether the applicant is a primary tax filer or a tax dependent. If the applicant is a tax dependent, the non-applicant primary tax filer shall provide the information in subdivision (f)(1) through (14) of this section, except for the information in subdivision (f)(8).

(16) For any other individuals seeking an exemption on the applicant's exemption application, all of the information in subdivision (f)(1) through (15) of this section.

(g) If the applicant designates an authorized representative, the applicant shall provide the authorized representative's name and address, and the applicant's signature authorizing the designated representative to act on the applicant's behalf for the exemption application, eligibility and enrollment, and appeals process, if applicable.

(h) An applicant or an application filer shall declare under penalty of perjury that the applicant or application filer:

(1) Understood all questions on the application and gave true and correct answers to the best of the applicant's or application filer's personal knowledge.

(2) Knows that if the applicant or application filer does not tell the truth on the exemption application, there may be a civil or criminal penalty for perjury pursuant to Penal Code Section 126.

(3) Knows that the information provided on the exemption application shall only be used for the purpose of determining exemption eligibility for the individuals listed on the application who are requesting an exemption, and that the Exchange shall keep such information private in accordance with the applicable federal and State privacy and security laws.

(4) Understands that the Exchange shall not discriminate against the applicant or anyone on the application because of race, color, national origin, religion, age, sex, sexual orientation, gender identity, or disability, and that the applicant may make a complaint of discrimination through the U.S. Department of Health and Human Services, Office for Civil Rights.

Note: Authority cited: Sections 100504 and 100725, Government Code. Reference: Sections 100502 and 100715, Government Code; 26 USC Section 5000A; 45 CFR Sections 155.605, ~~and~~ 155.610, and 156.145.

Readopt Section 6914 with Amendments

§ 6914. Eligibility Standards for Exemptions Through the Exchange.

(a) Except as specified in subdivisions (c) and (d) of this section, the Exchange shall determine an applicant eligible for and issue a certificate of exemption for ~~the~~ any month if the Exchange determines that the applicant meets the requirements for one or more of the exemptions described in this section for at least one day of the month.

(b) The Exchange shall proceed in accordance with the following process for a religious conscience exemption:

(1) The Exchange shall determine an applicant eligible for the religious conscience exemption for any month if, for that month, the applicant is either of the following:

(A) A member of a recognized religious sect or division described in section 1402(g)(1) of the Internal Revenue Code (26 USC § 1402(g)(1)) and adheres to the established tenets or teachings of such sect or division.

(B) A member of a religious sect or division that is not described in Section 1402(g)(1) of the Internal Revenue Code (26 USC § 1402(g)(1)), relies solely on a religious method of healing, the acceptance of medical health services would be inconsistent with the religious beliefs of the individual, and who includes an attestation that the individual has not received medical health

services during the preceding taxable year. For purposes of this paragraph, the term "medical health services" does not include routine dental, vision, and hearing services, midwifery services, vaccinations, necessary medical services provided to children, services required by law or by a third party, and other services as the Secretary of United States Department of Health and Human Services may provide in implementing Section 1311(d)(4)(H) of the federal Patient Protection and Affordable Care Act (42 USC § 18031(d)(4)(H)). An individual who claims this exemption, but received medical health services during the coverage year, shall lose eligibility for the religious conscience exemption.

(2) The Exchange shall grant a certificate of exemption to an applicant who meets the standard provided in subdivision (b)(1) of this section for a month on a continuing basis, until the last day of the month after the month of the individual's 21st birthday, or until such time that an individual reports that the individual no longer meets the standard provided in subdivision (b)(1) of this section, whichever comes first.

(3) If the Exchange granted a certificate of exemption for religious conscience to an applicant before reaching the age of 21, the Exchange shall send the applicant a notice upon reaching the age of 21 informing the applicant that the applicant must submit a new exemption application to maintain the certificate of exemption.

(4) The Exchange shall make an exemption in this category available prospectively or retrospectively.

(c) Except as specified in subparagraph (D) of paragraph (1) of this subdivision, ~~T~~the Exchange shall grant an exemption for general hardship to an applicant eligible for an exemption for at least the month before, the month or months during ~~which~~, and the month after a specific

event or circumstance, if the Exchange determines that the applicant meets at least one of the requirements specified in paragraph (1) of this subdivision.

(1) To qualify for a hardship exemption, the applicant or qualified individual shall meet at least one of the following criteria:

(A) The applicant experienced financial or domestic circumstances, including an unexpected natural or human-caused event, such that the applicant had a significant, unexpected increase in essential expenses that prevented the applicant from obtaining coverage under a QHP.;

(B) The expense of purchasing a QHP would have caused the applicant to experience serious deprivation of food, shelter, clothing, or other necessities.;

(C) The applicant has experienced other circumstances that prevented the applicant from obtaining coverage under a QHP. Such circumstances shall be determined by the Exchange on a case-by-case basis.

LM per agency request 5/6/20

(D) The qualified individual is an Indian eligible for services through an Indian health care provider, as defined in 42 CFR Section 447.51 (January 1, 2014), hereby incorporated by reference, and not otherwise eligible for an exemption under subdivision (c)(5) of Section 100705 of the Government Code, or an individual eligible for services through the Indian Health Service (IHS), in accordance with 25 USC Section 1680c(a), (b), or (d)(3). A qualified individual who meets the standards specified in this subparagraph shall be:

1. Deemed eligible for a hardship exemption without submitting an exemption application and obtaining a certificate of exemption through the Exchange; and

2. Exempt for a month on a continuing basis, until such time that the qualified individual no longer meets such standards.

(2) General hardship includes, but is not limited to, the following circumstances where the applicant:

(A) Experienced homelessness;

(B) Was evicted in the past six months, or is facing eviction or foreclosure;

(C) Received a shut-off notice from a utility company due to inability to pay the utility bills;

(D) Recently experienced domestic violence;

(E) Recently experienced the death of a close family member;

(F) Recently experienced a fire, flood, or other natural or human-caused disaster;

(G) Filed for bankruptcy in the last six months;

(H) Incurred unreimbursed medical expenses in the last 24 months that resulted in substantial debt;

(I) Recently experienced an unexpected increase in essential expenses or decrease in household income due to divorce or separation, unexpected or sudden disability, or caring for an ill, disabled, or aging family member;

(J) Is a child who has been determined ineligible for Medi-Cal and CHIP, and for whom a party other than the party who expects to claim the child as a tax dependent is required by court order to provide medical support. This exemption shall only be provided for the months during which the medical support order is in effect; or

(K) As a result of an eligibility appeals decision, is determined eligible for enrollment in a QHP or financial assistance through the Exchange for a period of time

during which the applicant was not enrolled in a QHP through the Exchange. This exemption shall only be provided for the period of time affected by the appeals decision.

(d) The Exchange shall determine an applicant eligible for a hardship exemption for a month or months during which the applicant, or another individual the applicant attests will be included in the applicant's tax household, is unable to afford coverage through the Exchange or an employer.

(1) Eligibility for this exemption shall be based on the applicant's projected household income for the taxable year.

(2) An individual cannot afford coverage in a month if the individual's required contribution, determined on an annual basis, for coverage for the month exceeds 8.3 percent of the individual's projected household income for the taxable year. An individual's projected household income shall include any amount of the required contribution made through a salary reduction arrangement that is excluded from gross income. An eligible employer-sponsored plan is only considered under subdivision (d)(3) of this section if it meets the minimum value standard described in 45 CFR Section 156.145.

(3) For an individual who is eligible to purchase coverage under an eligible employer-sponsored plan, the required contribution for coverage shall be determined as follows:

(A) The required contribution for an employee who is eligible to purchase coverage under an eligible employer-sponsored plan sponsored by the employee's employer is the portion of the annual premium that the employee would pay (whether through salary reduction or otherwise) for the lowest cost self-only coverage.

~~(4)~~(B) The required contribution for an individual who is eligible for coverage under an eligible employer-sponsored plan by reason of a relationship to an employee, is

the portion of the annual premium that the employee would pay (whether through salary reduction or otherwise) for the lowest cost family coverage that would cover the employee and all other individuals who are included in the employee's family who have not otherwise been granted an exemption through the Exchange.

(C) Nondiscriminatory wellness program incentives, within the meaning of 26 CFR Section 54.9802-1(f) (February 24, 2014), hereby incorporated by reference, offered by an eligible employer-sponsored plan that affect premiums are treated as earned in determining an employee's required contribution for purposes of affordability of an eligible employer-sponsored plan to the extent the incentives relate exclusively to tobacco use. Wellness program incentives that do not relate to tobacco use or that include a component unrelated to tobacco use are treated as not earned for this purpose. For purposes of this paragraph, the term "wellness program incentive" has the same meaning as the term "reward" in 26 CFR Section 54.9802-1(f)(1)(i).

~~(5)~~(4) The required contribution for an individual who is only eligible to purchase minimum essential coverage in the individual market is the annual premium for the lowest cost bronze plan available in the individual market through the Exchange serving the rating area in which the individual resides (without regard to whether the individual purchased a QHP though the Exchange), reduced by the maximum amount of any premium assistance for the taxable year determined as if the individual was covered for the entire taxable year by a QHP offered through the Exchange. All members of the individual's tax household who have not otherwise been granted an exemption through the Exchange and who are not treated as eligible to purchase coverage under an eligible employer-sponsored plan shall be included to determine the required contribution.

(5) In the case of plan years beginning in any calendar year after 2019, this subdivision shall be applied by substituting "8.3 percent" specified in subdivision (d)(2) of this section with an amount equal to 8 percent increased by the amount the United States Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for that period.

(6) The applicant shall apply for this exemption prior to the last date on which the applicant may enroll in a QHP through the Exchange for the month or months of a calendar year for which the exemption is requested.

(7) The Exchange shall make this exemption available prospectively and provide it for all remaining months in a coverage year, notwithstanding any change in an individual's circumstances.

Note: Authority cited: Sections 100504 and 100725, Government Code. Reference: Sections 100502, ~~and~~ 100705, 100715, and 100800, Government Code; 26 USC Sections 1402 and 5000A; 42 USC Section 13031; 26 CFR Sections 1.5000A-3 and 54.9802-1; 42 CFR Section 447.51; 45 CFR Sections 155.605 and 156.145.

Readopt Section 6916

§ 6916. Eligibility Process for Exemptions.

(a) The Exchange shall use the exemption applications described in Section 6912 to collect information necessary for determining eligibility for and granting certificates of exemption as described in Section 6914.

(b) If an individual submits the application specified in Section 6470 and then requests an exemption, the Exchange shall use the information collected for purposes of the eligibility determination for enrollment in a QHP and for insurance affordability programs in making the exemption eligibility determination. The Exchange shall not request duplicate information or

conduct repeat verifications to the extent that the Exchange finds that such information is still applicable and the standards for such verifications adhere to the standards specified in this article.

(c) The Exchange shall accept the exemption applications specified in Section 6912 from an application filer and shall provide the tools for the application filer to file the application through any of the following channels:

(1) The Exchange's Internet Web site;

(2) Facsimile; or

(3) Mail.

(d) The Exchange shall require an applicant who has a Social Security Number to provide such number to the Exchange. The Exchange shall not require an individual who is not seeking an exemption for oneself to provide a Social Security Number, except as specified in subdivision (e) of this section.

(e) The Exchange shall require an application filer to provide the Social Security Number of a tax filer who is not an applicant only if an applicant attests that the tax filer has a Social Security Number and filed a tax return for the year for which tax data would be utilized for verification of household income and family size for the hardship exemption as specified in Section 6914(d).

(f) The Exchange shall determine an applicant's eligibility for an exemption in accordance with the standards specified in Section 6914 and grant a certificate of exemption to any applicant determined eligible.

(g) The Exchange shall determine an applicant's eligibility for exemption within 30 calendar days from the date the Exchange receives the applicant's complete exemption application.

(h) The Exchange shall only accept an application for general hardship exemption described in Section 6914(c) during one of the three calendar years after the month or months during which the applicant attests that the hardship occurred.

(i) The Exchange shall provide a written notice to an applicant of any eligibility determination made in accordance with this article within five business days from the date of the eligibility determination. In the case of a determination that an applicant is eligible for an exemption, this notification shall also include the exemption certificate number for the purpose of tax administration. This notice shall comply with the general standards for Exchange notices specified in Section 6454.

(j) An individual shall retain the records that demonstrate receipt of the certificate of exemption and qualification for the underlying exemption. In the case of any factor of eligibility that is verified through use of the exception described in Section 6918(d)(3), the records that demonstrate qualification for the underlying exemption are the information submitted to the Exchange regarding the circumstances that warranted the use of the exception, as well as records of the Exchange decision to allow such exception.

(k) If an applicant submits an incomplete exemption application that does not include sufficient information for the Exchange to conduct a determination for eligibility of an exemption, the Exchange shall:

(1) Provide notice to the applicant indicating that information necessary to complete an eligibility determination is missing, specifying the missing information, and providing instructions on how to provide the missing information;

(2) Provide the applicant with a period of 30 calendar days from the date on which the notice described in paragraph (1) of this subdivision is sent to the applicant to provide the information needed to complete the application to the Exchange. The Exchange may extend this period for an applicant if the Exchange determines on a case-by-case basis that the applicant has demonstrated a good-faith effort to obtain the required information during the period;

(3) Not proceed with the applicant's eligibility determination during the period described in paragraph (2) of this subdivision; and

(4) Deny the exemption application, notify the applicant in writing that the Exchange cannot process the exemption application, and provide appeal rights to the applicant if the Exchange does not receive the requested information within the 30-day period specified in paragraph (2) of this subdivision.

Note: Authority cited: Sections 100504 and 100725, Government Code. Reference: Sections 100503 and 100715, Government Code; 45 CFR Section 155.610.

Readopt Section 6918 with Amendments

§ 6918. Verification Process Related to Eligibility for Exemptions Through the Exchange.

(a) The Exchange shall verify or obtain information as provided in this section in order to determine that an applicant is eligible for an exemption.

(b) For any applicant who requests an exemption based on religious conscience, the Exchange shall verify that the applicant meets the standards specified in Section 6914(b) in accordance with the following process:

(1) ~~Except as specified in paragraphs (2) and (3) of this subdivision, t~~The Exchange shall accept a copy of an approved IRS Form 4029 ("Application for Exemption from Social Security and Medicare Taxes and Waiver of Benefits") with required signatures ~~form~~ that reflects that the applicant is exempt from Social Security and Medicare taxes under Section 1402(g)(1) of the Internal Revenue Code (26 USC § 1402(g)(1)) without further verification.~~;~~

(2) Except as specified in paragraphs (3), (4) and (5) of this subdivision, the Exchange shall accept the applicant's attestation of membership in a religious sect or division~~, and shall~~ if the Exchange obtains the information necessary to verify that the religious sect or division to which the applicant attests membership is recognized by the Social Security Administration as an approved religious sect or division under Section 1402(g)(1) of the Internal Revenue Code (26 USC § 1402(g)(1))~~.~~;

(3) Except as specified in paragraph~~s~~ (4) of this subdivision:

per agency request 5/6/20

(A) ~~T~~the Exchange shall accept the applicant's attestation that the applicant is a member of a religious sect or division described in Section 6914(b)(1)(B) and that the individual has not received medical health services, as specified in Section 6914(b)(1)(B), during the preceding taxable year~~.~~; and

(B) The applicant shall provide documentation to the Exchange to demonstrate that such religious sect or division relies solely on a religious method of healing and that the acceptance of medical health services would be inconsistent with the religious beliefs of the applicant.

(4) If information provided by an applicant regarding the applicant's religious sect or division described in Section 6914(b)(1)(B) or the applicant's membership in ~~a~~ such religious sect or division is not reasonably compatible with other information provided by the individual

or in the Exchange's records, or if the Exchange is unable to verify the applicant's religious sect or division as specified in paragraph (2) of this subdivision, the Exchange shall follow the inconsistency procedures specified in subdivision (d) of this section.

per agency request 5/8/20

(5) Except as specified in paragraphs (1) and (3) of this subdivision, if an applicant attests to membership in a religious sect or division that cannot be verified by the Exchange ~~is not recognized by the Social Security Administration~~ as an approved religious sect or division under Section 1402(g)(1) of the Internal Revenue Code (26 USC § 1402(g)(1)), the Exchange shall provide the applicant with information regarding how the applicant's religious sect or division can pursue recognition under Section 1402(g)(1) of the Internal Revenue Code (26 USC § 1402(g)(1)). The Exchange shall determine the applicant ineligible for this exemption until the Exchange obtains information indicating that the religious sect or division has been approved.

per agency request 5/8/20

(c) For any applicant who requests an exemption based on a general hardship, as specified in subdivision (c)(2) of Section 6914, except for the circumstances described in subdivisions (c)(2)(A) and (c)(2)(D) of Section 6914, the applicant shall provide documentation to the Exchange to demonstrate that the applicant has experienced the hardship to which the applicant is attesting. For any applicant who requests a hardship exemption based on lack of affordable coverage, the Exchange shall verify ~~whether~~ the ~~applicant has experienced the~~ hardship to which the applicant is attesting in accordance with the following process:

(1) The Exchange shall verify the unavailability of affordable coverage through the procedures used to determine eligibility for APTC, including the procedures described in Section 6478, and the procedures used to verify eligibility for qualifying coverage in an eligible employer-sponsored plan, as specified in Section 6490.

(2) The Exchange shall accept an application filer's attestation for an applicant regarding eligibility for minimum essential coverage other than through an eligible employer-sponsored plan, instead of following the procedures specified in Section 6480.

(3) To the extent that the Exchange is unable to verify any of the information needed to determine an applicant's eligibility for an exemption based on hardship, the Exchange shall follow the procedures specified in subdivision (d) of this section.

(d) Except as otherwise specified in this article, for an applicant for whom the Exchange cannot verify information required to determine eligibility for an exemption, including but not limited to when electronic data is required in accordance with this article but data for individuals relevant to the eligibility determination for an exemption are not included in such data sources or when electronic data is required but it is not reasonably expected that data sources will be available within one day of the initial request to the data source, the Exchange shall follow the inconsistency process specified in Section 6492, except as specified in paragraphs (1) through (3) of this subdivision.

(1) During the 95-day period described in Section 6492(a)(2)(B), the Exchange shall not grant a certificate of exemption based on the information subject to this subdivision.

(2) If, after the period described in paragraph (1) of this subdivision, the Exchange remains unable to verify the attestation, the Exchange shall:

(A) Determine the applicant's eligibility for an exemption based on any information available from the data sources used in accordance with this article, if applicable, unless such applicant qualifies for the exception provided under paragraph (3) of this subdivision; and

(B) Notify the applicant of such determination in accordance with the notice requirements specified in Section 6916(i), including notice that the Exchange is unable to verify the attestation.

(3) For an applicant who does not have documentation with which to resolve the inconsistency through the process described in this subdivision because such documentation does not exist or is not reasonably available and for whom the Exchange is unable to otherwise resolve the inconsistency, the Exchange shall provide an exception, on a case-by-case basis, to accept an applicant's attestation as to the information which cannot otherwise be verified along with an explanation of circumstances as to why the applicant does not have documentation.

(e) The Exchange shall not require an applicant to provide information beyond the minimum necessary to support the eligibility process for exemptions as described in this article.

(f) The Exchange shall validate the applicant's Social Security Number in accordance with the following process:

(1) For any individual who provides a Social Security Number to the Exchange, the Exchange shall transmit the individual's Social Security Number and other identifying information to HHS, which will submit it to the Social Security Administration.

(2) To the extent that the Exchange is unable to validate an individual's Social Security Number through the Social Security Administration or the Social Security Administration indicates that the individual is deceased, the Exchange shall follow the inconsistency procedures specified in subdivision (d) of this section.

Note: Authority cited: Sections 100504 and 100725, Government Code. Reference: Sections 100503 and 100715, Government Code; 26 USC Section 1402; 45 CFR Section 155.615.

Readopt Section 6920

§ 6920. Eligibility Redeterminations for Exemptions During a Calendar Year.

(a) The Exchange shall redetermine the eligibility of an individual with an exemption granted by the Exchange if it receives and verifies new information reported by such an individual, except for the exemption described in Section 6914(d).

(b) An individual who has a certificate of exemption from the Exchange shall report any change with respect to the eligibility standards for the exemption as specified in Section 6914, except for the exemption described in Section 6914(d), to the Exchange within 30 days of such change through the channels available for the submission of an exemption application, as specified in Section 6916(c).

(c) The Exchange shall verify any information reported by an individual with a certificate of exemption in accordance with the processes specified in Section 6918 prior to using such information in an eligibility redetermination, and shall:

(1) Notify an individual in accordance with Section 6916(i) after redetermining the individual's eligibility based on a reported change; and

(2) Provide periodic electronic notifications regarding the requirements for reporting changes and an individual's opportunity to report any changes, to an individual who has a certificate of exemption for which changes must be reported in accordance with subdivision (b) of this section and who has elected to receive electronic notifications, unless the individual has declined to receive such notifications.

(d) The Exchange shall implement a change resulting from a redetermination under this section for the month or months after the month in which the redetermination occurs, such that a certificate that was provided for the month in which the redetermination occurs, and for prior months remains effective.

Note: Authority cited: Sections 100504 and 100725, Government Code. Reference: Sections 100503 and 100715, Government Code; 45 CFR Section 155.620.

Readopt Section 6922

§ 6922. Right to Appeal.

The Exchange shall include the notice of the right to appeal and instructions regarding how to file an appeal in accordance with Article 7 of this chapter in any eligibility determination and redetermination notice issued to the applicant in accordance with Sections 6916(i), 6916(k)(4), 6918(d)(2)(B) and 6920(c)(1).

Note: Authority cited: Sections 100504 and 100725, Government Code. Reference: Sections 100503, 100506, 100506.1 and 100506.2, Government Code; 45 CFR Section 155.635.

COVERED CALIFORNIA

April 22, 2020

DOCUMENTS INCORPORATED BY REFERENCE
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- 26 CFR Section 1.5000A-1(d)(10) (December 26, 2013)
- 26 CFR Section 54.9802-1(f) (February 24, 2014)
- 42 CFR Section 447.51 (January 1, 2014)
- 45 CFR Section 156.145 (February 27, 2015)

VM per agency request 5/9/20

§1.5000A-1 Maintenance of minimum essential coverage and liability for the shared responsibility payment.

(a) *In general.* For each month during the taxable year, a nonexempt individual must have minimum essential coverage or pay the shared responsibility payment. For a month, a nonexempt individual is an individual in existence for the entire month who is not an exempt individual described in §1.5000A-3.

(b) *Coverage under minimum essential coverage*—(1) *In general.* An individual has minimum essential coverage for a month in which the individual is enrolled in and entitled to receive benefits under a program or plan identified as minimum essential coverage in §1.5000A-2 for at least one day in the month.

(2) *Special rule for United States citizens or residents residing outside the United States or residents of territories.* An individual is treated as having minimum essential coverage for a month—

(i) If the month occurs during any period described in section 911(d)(1)(A) or section 911(d)(1)(B) that is applicable to the individual; or

(ii) If, for the month, the individual is a bona fide resident of a possession of the United States (as determined under section 937(a)).

(c) *Liability for shared responsibility payment*—(1) *In general.* A taxpayer is liable for the shared responsibility payment for a month for which—

(i) The taxpayer is a nonexempt individual without minimum essential coverage; or

(ii) A nonexempt individual for whom the taxpayer is liable under paragraph (c)(2) or (c)(3) of this section does not have minimum essential coverage.

(2) *Liability for dependents*—(i) *In general.* For a month when a nonexempt individual does not have minimum essential coverage, if the nonexempt individual is a dependent (as defined in section 152) of another individual for the other individual's taxable year including that month, the other individual is liable for the shared responsibility payment attributable to the dependent's lack of coverage. An individual is a dependent of a taxpayer for a taxable year if the individual satisfies the definition of dependent under section 152, regardless of whether the taxpayer claims the individual as a dependent on a Federal income tax return for the taxable year. If an individual may be claimed as a dependent by more than one taxpayer in the same calendar year, the taxpayer who properly claims the individual as a dependent for the taxable year is liable for the shared responsibility payment attributable to the individual. If more than one taxpayer may claim an individual as a dependent in the same calendar year but no one claims the individual as a dependent, the taxpayer with priority under the rules of section 152 to claim the individual as a dependent is liable for the shared responsibility payment for the individual.

(ii) *Special rules for dependents adopted or placed in foster care during the taxable year* —(A) *Taxpayers adopting an individual.* If a taxpayer adopts a nonexempt dependent (or accepts a nonexempt dependent who is an eligible foster child as defined in section 152(f)(1)(C)) during the taxable year and is otherwise liable for the nonexempt dependent under paragraph (c)(2)(i) of this section, the taxpayer is liable under paragraph (c)(2)(i) of this section for the nonexempt dependent only for the full months in the taxable year that follow the month in which the adoption or acceptance occurs.

(B) *Taxpayers placing an individual for adoption.* If a taxpayer who is otherwise liable for a nonexempt dependent under paragraph (c)(2)(i) of this section places (or, by operation of law, must place) the nonexempt dependent for adoption or foster care during the taxable year, the taxpayer is liable under paragraph (c)(2)(i) of this section for the nonexempt dependent only for the full months in the taxable year that precede the month in which the adoption or foster care placement occurs.

(C) *Examples.* The following examples illustrate the provisions of this paragraph (c)(2)(ii). In each example the taxpayer's taxable year is a calendar year.

Example 1. Taxpayers adopting a child. (i) E and F, married individuals filing a joint return, initiate proceedings for the legal adoption of a 2-year old child, G, in January 2016. On May 15, 2016, G becomes the adopted child (within the meaning of section 152(f)(1)(B)) of E and F, and resides with them for the remainder of 2016. Prior to the adoption, G resides with H, an unmarried individual, with H providing all of G's support. For 2016 G meets all requirements under section 152 to be E and F's dependent, and not H's dependent.

(ii) Under paragraph (c)(2) of this section, E and F are not liable for a shared responsibility payment attributable to G for January through May of 2016, but are liable for a shared responsibility payment attributable to G, if any, for June through December of 2016. H is not liable for a shared responsibility payment attributable to G for any month in 2016, because G is not H's dependent for 2016 under section 152.

Example 2. Taxpayers placing a child for adoption. (i) The facts are the same as *Example 1,* except the legal adoption occurs on August 15, 2016, and, for 2016, G meets all requirements under section 152 to be H's dependent, and not E and F's dependent.

(ii) Under paragraph (c)(2) of this section, H is liable for a shared responsibility payment attributable to G, if any, for January through July of 2016, but is not liable for a shared responsibility payment attributable to G for August through December of 2016. E and F are not liable for a shared responsibility payment attributable to G for any month in 2016, because G is not E and F's dependent for 2016 under section 152.

(3) *Liability of individuals filing a joint return.* Married individuals (within the meaning of section 7703) who file a joint return for a taxable year are jointly liable for any shared responsibility payment for a month included in the taxable year.

(d) *Definitions.* The definitions in this paragraph (d) apply to this section and §§1.5000A-2 through 1.5000A-5.

(1) *Affordable Care Act. Affordable Care Act* refers to the Patient Protection and Affordable Care Act, Public Law 111-148 (124 Stat. 119 (2010)), and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152 (124 Stat. 1029 (2010)), as amended.

(2) *Employee. Employee* includes former employees.

(3) *Exchange. Exchange* has the same meaning as in 45 CFR 155.20.

(4) *Family.* A taxpayer's family means the individuals for whom the taxpayer properly claims a deduction for a personal exemption under section 151 for the taxable year.

(5) *Family coverage. Family coverage* means health insurance that covers more than one individual.

(6) *Group health insurance coverage. Group health insurance coverage* has the same meaning as in section 2791(b)(4) of the Public Health Service Act (42 U.S.C. 300gg-91(b)(4)).

(7) *Group health plan. Group health plan* has the same meaning as in section 2791(a)(1) of the Public Health Service Act (42 U.S.C. 300gg-91(a)(1)).

(8) *Health insurance coverage. Health insurance coverage* has the same meaning as in section 2791(b)(1) of the Public Health Service Act (42 U.S.C. 300gg-91(b)(1)).

(9) *Health insurance issuer. Health insurance issuer* has the same meaning as in section 2791(b)(2) of the Public Health Service Act (42 U.S.C. 300gg-91(b)(2)).

(10) *Household income*—(i) *In general. Household income* means the sum of—

(A) A taxpayer's modified adjusted gross income; and

(B) The aggregate modified adjusted gross income of all other individuals who—

(*1*) Are included in the taxpayer's family under paragraph (d)(4) of this section; and

(*2*) Are required to file a Federal income tax return for the taxable year.

(ii) *Modified adjusted gross income. Modified adjusted gross income* means adjusted gross income (within the meaning of section 62) increased by—

(A) Amounts excluded from gross income under section 911; and

(B) Tax-exempt interest the taxpayer receives or accrues during the taxable year.

(11) *Individual market. Individual market* has the same meaning as in section 1304(a)(2) of the Affordable Care Act (42 U.S.C. 18024(a)(2)).

(12) *Large and small group market. Large group market* and *small group market* have the same meanings as in section 1304(a)(3) of the Affordable Care Act (42 U.S.C. 18024(a)(3)).

(13) *Month. Month* means calendar month.

(14) *Qualified health plan. Qualified health plan* has the same meaning as in section 1301(a) of the Affordable Care Act (42 U.S.C. 18021(a)).

(15) *Rating area. Rating area* has the same meaning as in §1.36B-1(n).

(16) *Self-only coverage. Self-only coverage* means health insurance that covers one individual.

(17) *Shared responsibility family. Shared responsibility family* means, for a month, all nonexempt individuals for whom the taxpayer (and the taxpayer's spouse, if the taxpayer is married and files a joint return with the spouse) is liable for the shared responsibility payment under paragraph (c) of this section.

(18) *State. State* means each of the 50 states and the District of Columbia.

[T.D. 9632, 78 FR 53655, Aug. 30, 2013, as amended at 78 FR 78255, Dec. 26, 2013]

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Title 26 → Chapter I → Subchapter D → Part 54 → §54.9802-1

Title 26: Internal Revenue
PART 54—PENSION EXCISE TAXES

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§54.9802-1 Prohibiting discrimination against participants and beneficiaries based on a health factor.

(a) *Health factors.* (1) The term *health factor* means, in relation to an individual, any of the following health status-related factors:

(i) Health status;

(ii) Medical condition (including both physical and mental illnesses), as defined in §54.9801-2;

(iii) Claims experience;

(iv) Receipt of health care;

(v) Medical history;

(vi) Genetic information, as defined in §54.9802-3T.

(vii) Evidence of insurability; or

(viii) Disability.

(2) Evidence of insurability includes—

(i) Conditions arising out of acts of domestic violence; and

(ii) Participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities.

(3) The decision whether health coverage is elected for an individual (including the time chosen to enroll, such as under special enrollment or late enrollment) is not, itself, within the scope of any health factor. (However, under §54.9801-6, a plan must treat special enrollees the same as similarly situated individuals who are enrolled when first eligible.)

(b) *Prohibited discrimination in rules for eligibility*—(1) *In general.* (i) A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not establish any rule for eligibility (including continued eligibility) of any individual to enroll for benefits under the terms of the plan or group health insurance coverage that discriminates based on any health factor that relates to that individual or a dependent of that individual. This rule is subject to the provisions of paragraph (b)(2) of this section (explaining how this rule applies to benefits), paragraph (d) of this section (containing rules for establishing groups of similarly situated individuals), paragraph (e) of this section (relating to nonconfinement, actively-at-work, and other service requirements), paragraph (f) of this section (relating to wellness programs), and paragraph (g) of this section (permitting favorable treatment of individuals with adverse health factors).

(ii) For purposes of this section, rules for eligibility include, but are not limited to, rules relating to—

(A) Enrollment;

(B) The effective date of coverage;

(C) Waiting (or affiliation) periods;

(D) Late and special enrollment;

(E) Eligibility for benefit packages (including rules for individuals to change their selection among benefit packages);

(F) Benefits (including rules relating to covered benefits, benefit restrictions, and cost-sharing mechanisms such as coinsurance, copayments, and deductibles), as described in paragraphs (b)(2) and (3) of this section;

(G) Continued eligibility; and

(H) Terminating coverage (including disenrollment) of any individual under the plan.

(iii) The rules of this paragraph (b)(1) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan that is available to all employees who enroll within the first 30 days of their employment. However, employees who do not enroll within the first 30 days cannot enroll later unless they pass a physical examination.

(ii) *Conclusion.* In this *Example 1,* the requirement to pass a physical examination in order to enroll in the plan is a rule for eligibility that discriminates based on one or more health factors and thus violates this paragraph (b)(1).

Example 2. (i) *Facts.* Under an employer's group health plan, employees who enroll during the first 30 days of employment (and during special enrollment periods) may choose between two benefit packages: An indemnity option and an HMO option. However, employees who enroll during late enrollment are permitted to enroll only in the HMO option and only if they provide evidence of good health.

(ii) *Conclusion.* In this *Example 2,* the requirement to provide evidence of good health in order to be eligible for late enrollment in the HMO option is a rule for eligibility that discriminates based on one or more health factors and thus violates this paragraph (b)(1). However, if the plan did not require evidence of good health but limited late enrollees to the HMO option, the plan's rules for eligibility would not discriminate based on any health factor, and thus would not violate this paragraph (b)(1), because the time an individual chooses to enroll is not, itself, within the scope of any health factor.

Example 3. (i) *Facts.* Under an employer's group health plan, all employees generally may enroll within the first 30 days of employment. However, individuals who participate in certain recreational activities, including motorcycling, are excluded from coverage.

(ii) *Conclusion.* In this *Example 3,* excluding from the plan individuals who participate in recreational activities, such as motorcycling, is a rule for eligibility that discriminates based on one or more health factors and thus violates this paragraph (b)(1).

Example 4. (i) *Facts.* A group health plan applies for a group health policy offered by an issuer. As part of the application, the issuer receives health information about individuals to be covered under the plan. Individual *A* is an employee of the employer maintaining the plan. *A* and *A*'s dependents have a history of high health claims. Based on the information about *A* and *A*'s dependents, the issuer excludes *A* and *A*'s dependents from the group policy it offers to the employer.

(ii) *Conclusion.* See *Example 4* in 29 CFR 2590.702(b)(1) and 45 CFR 146.121(b)(1) for a conclusion that the exclusion by the issuer of *A* and *A*'s dependents from coverage is a rule for eligibility that discriminates based on one or more health factors and violates rules under 29 CFR 2590.702(b)(1) and 45 CFR 146.121(b)(1) similar to the rules under this paragraph (b)(1). (If the employer is a small employer under 45 CFR 144.103 (generally, an employer with 50 or fewer employees), the issuer also may violate 45 CFR 146.150, which requires issuers to offer all the policies they sell in the small group market on a guaranteed available basis to all small employers and to accept every eligible individual in every small employer group.) If the plan provides coverage through this policy and does not provide equivalent coverage for *A* and *A*'s dependents through other means, the plan violates this paragraph (b)(1).

(2) *Application to benefits*—(i) *General rule*—(A) Under this section, a group health plan is not required to provide coverage for any particular benefit to any group of similarly situated individuals.

(B) However, benefits provided under a plan must be uniformly available to all similarly situated individuals (as described in paragraph (d) of this section). Likewise, any restriction on a benefit or benefits must apply uniformly to all similarly situated individuals and must not be directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries (determined based on all the relevant facts and circumstances). Thus, for example, a plan may limit or exclude benefits in relation to a specific disease or condition, limit or exclude benefits for certain types of treatments or drugs, or limit or exclude benefits based on a determination of whether the benefits are experimental or not medically necessary, but only if the benefit limitation or exclusion applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. In addition, a plan or issuer may require the satisfaction of a deductible, copayment, coinsurance, or other cost-sharing requirement in order to obtain a benefit if the limit or cost-sharing requirement applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. In the case of a cost-sharing requirement, see also paragraph (b)(2)(ii) of this section, which permits variances in the application of a cost-sharing mechanism made available under a wellness program. (Whether any plan provision or practice with respect to benefits complies with this paragraph (b)(2)(i) does not affect whether the provision or practice is permitted under ERISA, the Affordable Care Act (including the requirements related to essential health benefits), the Americans With Disabilities Act, or any other law, whether State or Federal.)

(C) For purposes of this paragraph (b)(2)(i), a plan amendment applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries.

(D) The rules of this paragraph (b)(2)(i) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan applies a $10,000 annual limit on a specific covered benefit that is not an essential health benefit to each participant or beneficiary covered under the plan. The limit is not directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 1,* the limit does not violate this paragraph (b)(2)(i) because coverage of the specific, non-essential health benefit up to $10,000 is available uniformly to each participant and beneficiary under the plan and because the limit is applied uniformly to all participants and beneficiaries and is not directed at individual participants or beneficiaries.

Example 2. (i) *Facts.* A group health plan has a $500 deductible on all benefits for participants covered under the plan. Participant *B* files a claim for the treatment of AIDS. At the next corporate board meeting of the plan sponsor, the claim is discussed. Shortly thereafter, the plan is modified to impose a $2,000 deductible on benefits for the treatment of AIDS, effective before the beginning of the next plan year.

(ii) *Conclusion.* The facts of this *Example 2* strongly suggest that the plan modification is directed at *B* based on *B*'s claim. Absent outweighing evidence to the contrary, the plan violates this paragraph (b)(2)(i).

Example 3. (i) A group health plan applies for a group health policy offered by an issuer. Individual *C* is covered under the plan and has an adverse health condition. As part of the application, the issuer receives health information about the individuals to be covered, including information about *C*'s adverse health condition. The policy form offered by the issuer generally provides benefits for the adverse health condition that *C* has, but in this case the issuer offers the plan a policy modified by a rider that excludes benefits for *C* for that condition. The exclusionary rider is made effective the first day of the next plan year.

(ii) *Conclusion.* See *Example 3* in 29 CFR 2590.702(b)(2)(i) and 45 CFR 146.121(b)(2)(i) for a conclusion that the issuer violates rules under 29 CFR 2590.702(b)(2)(i) and 45 CFR 146.121(b)(2)(i) similar to the rules under this paragraph (b)(2)(i) because benefits for *C*'s condition are available to other individuals in the group of similarly situated individuals that includes *C* but are not available to *C*. Thus, the benefits are not uniformly available to all similarly situated individuals. Even though the exclusionary rider is made effective the first day of the next plan year, because the rider does not apply to all similarly situated individuals, the issuer violates the rules under 29 CFR 2590.702(b)(2)(i) and 45 CFR 146.121(b)(2)(i). If the plan provides coverage through this policy and does not provide equivalent coverage for *C* through other means, the plan violates this paragraph (b)(2)(i).

Example 4. (i) *Facts.* A group health plan has a $2,000 lifetime limit for the treatment of temporomandibular joint syndrome (TMJ). The limit is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 4,* the limit does not violate this paragraph (b)(2)(i) because $2,000 of benefits for the treatment of TMJ are available uniformly to all similarly situated individuals and a plan may limit benefits covered in relation to a specific disease or condition if the limit applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries. (However, applying a lifetime limit on TMJ may violate PHS Act section 2711 and its implementing regulations, if TMJ coverage is an essential health benefit, depending on the essential health benefits benchmark plan as defined in 45 CFR 156.20. This example does not address whether the plan provision is permissible under any other applicable law, including PHS Act section 2711 or the Americans with Disabilities Act.)

Example 5. (i) *Facts.* A group health plan applies a $2 million lifetime limit on all benefits. However, the $2 million lifetime limit is reduced to $10,000 for any participant or beneficiary covered under the plan who has a congenital heart defect.

(ii) *Conclusion.* In this *Example 5,* the lower lifetime limit for participants and beneficiaries with a congenital heart defect violates this paragraph (b)(2)(i) because benefits under the plan are not uniformly available to all similarly situated individuals and the plan's lifetime limit on benefits does not apply uniformly to all similarly situated individuals. Additionally, this plan provision is prohibited under PHS Act section 2711 and its implementing regulations because it imposes a lifetime limit on essential health benefits.

Example 6. (i) *Facts.* A group health plan limits benefits for prescription drugs to those listed on a drug formulary. The limit is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 6,* the exclusion from coverage of drugs not listed on the drug formulary does not violate this paragraph (b)(2)(i) because benefits for prescription drugs listed on the formulary are uniformly available to all similarly situated individuals and because the exclusion of drugs not listed on the formulary applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

Example 7. (i) *Facts.* Under a group health plan, doctor visits are generally subject to a $250 annual deductible and 20 percent coinsurance requirement. However, prenatal doctor visits are not subject to any deductible or coinsurance requirement. These rules are applied uniformly to all similarly situated individuals and are not directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 7,* imposing different deductible and coinsurance requirements for prenatal doctor visits and other visits does not violate this paragraph (b)(2)(i) because a plan may establish different deductibles or coinsurance requirements for different services if the deductible or coinsurance requirement is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

(ii) *Exception for wellness programs.* A group health plan may vary benefits, including cost-sharing mechanisms (such as a deductible, copayment, or coinsurance), based on whether an individual has met the standards of a wellness program that satisfies the requirements of paragraph (f) of this section.

(iii) *Specific rule relating to source-of-injury exclusions*—(A) If a group health plan generally provides benefits for a type of injury, the plan may not deny benefits otherwise provided for treatment of the injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions). This rule applies in the case of an injury resulting from a medical condition even if the condition is not diagnosed before the injury.

(B) The rules of this paragraph (b)(2)(iii) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan generally provides medical/surgical benefits, including benefits for hospital stays, that are medically necessary. However, the plan excludes benefits for self-inflicted injuries or injuries sustained in connection with attempted suicide. Because of depression, Individual *D* attempts suicide. As a result, *D* sustains injuries and is hospitalized for treatment of the injuries. Under the exclusion, the plan denies *D* benefits for treatment of the injuries.

(ii) *Conclusion.* In this *Example 1,* the suicide attempt is the result of a medical condition (depression). Accordingly, the denial of benefits for the treatments of *D*'s injuries violates the requirements of this paragraph (b)(2)(iii) because the plan provision excludes benefits for treatment of an injury resulting from a medical condition.

Example 2. (i) *Facts.* A group health plan provides benefits for head injuries generally. The plan also has a general exclusion for any injury sustained while participating in any of a number of recreational activities, including bungee jumping. However, this exclusion does not apply to any

injury that results from a medical condition (nor from domestic violence). Participant *E* sustains a head injury while bungee jumping. The injury did not result from a medical condition (nor from domestic violence). Accordingly, the plan denies benefits for *E*'s head injury.

(ii) *Conclusion.* In this *Example 2,* the plan provision that denies benefits based on the source of an injury does not restrict benefits based on an act of domestic violence or any medical condition. Therefore, the provision is permissible under this paragraph (b)(2)(iii) and does not violate this section. (However, if the plan did not allow *E* to enroll in the plan (or applied different rules for eligibility to *E*) because *E* frequently participates in bungee jumping, the plan would violate paragraph (b)(1) of this section.)

(c) *Prohibited discrimination in premiums or contributions*—(1) *In general*—(i) A group health plan may not require an individual, as a condition of enrollment or continued enrollment under the plan, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual (described in paragraph (d) of this section) enrolled in the plan based on any health factor that relates to the individual or a dependent of the individual.

(ii) Discounts, rebates, payments in kind, and any other premium differential mechanisms are taken into account in determining an individual's premium or contribution rate. (For rules relating to cost-sharing mechanisms, see paragraph (b)(2) of this section (addressing benefits).)

(2) *Rules relating to premium rates*—(i) *Group rating based on health factors not restricted under this section.* Nothing in this section restricts the aggregate amount that an employer may be charged for coverage under a group health plan. But *see* §54.9802-3T(b), which prohibits adjustments in group premium or contribution rates based on genetic information.

(ii) *List billing based on a health factor prohibited.* However, a group health plan may not quote or charge an employer (or an individual) a different premium for an individual in a group of similarly situated individuals based on a health factor. (But see paragraph (g) of this section permitting favorable treatment of individuals with adverse health factors.)

(iii) *Examples.* The rules of this paragraph (c)(2) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan and purchases coverage from a health insurance issuer. In order to determine the premium rate for the upcoming plan year, the issuer reviews the claims experience of individuals covered under the plan. The issuer finds that Individual F had significantly higher claims experience than similarly situated individuals in the plan. The issuer quotes the plan a higher per-participant rate because of F's claims experience.

(ii) *Conclusion.* See *Example 1* in 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) for a conclusion that the issuer does not violate the provisions of 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) similar to the provisions of this paragraph (c)(2) because the issuer blends the rate so that the employer is not quoted a higher rate for F than for a similarly situated individual based on F's claims experience. (However, those examples conclude that if the issuer used genetic information in computing the group rate, it would violate 29 CFR 2590.702-1(b) or 45 CFR 146.122(b).)

Example 2. (i) *Facts.* Same facts as *Example 1,* except that the issuer quotes the employer a higher premium rate for *F,* because of *F*'s claims experience, than for a similarly situated individual.

(ii) *Conclusion.* See *Example 2* in 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) for a conclusion that the issuer violates provisions of 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) similar to the provisions of this paragraph (c)(2). Moreover, even if the plan purchased the policy based on the quote but did not require a higher participant contribution for *F* than for a similarly situated individual, see *Example 2* in 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) for a conclusion that the issuer would still violate 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) (but in such a case the plan would not violate this paragraph (c)(2)).

(3) *Exception for wellness programs.* Notwithstanding paragraphs (c)(1) and (2) of this section, a plan may vary the amount of premium or contribution it requires similarly situated individuals to pay based on whether an individual has met the standards of a wellness program that satisfies the requirements of paragraph (f) of this section.

(d) *Similarly situated individuals.* The requirements of this section apply only within a group of individuals who are treated as similarly situated individuals. A plan may treat participants as a group of similarly situated individuals separate from beneficiaries. In addition, participants may be treated as two or more distinct groups of similarly situated individuals and beneficiaries may be treated as two or more distinct groups of similarly situated individuals in accordance with the rules of this paragraph (d). Moreover, if individuals have a choice of two or more benefit packages, individuals choosing one benefit package may be treated as one or more groups of similarly situated individuals distinct from individuals choosing another benefit package.

(1) *Participants.* Subject to paragraph (d)(3) of this section, a plan may treat participants as two or more distinct groups of similarly situated individuals if the distinction between or among the groups of participants is based on a bona fide employment-based classification consistent with the employer's usual business practice. Whether an employment-based classification is bona fide is determined on the basis of all the relevant facts and circumstances. Relevant facts and circumstances include whether the employer uses the classification for purposes independent of qualification for health coverage (for example, determining eligibility for other employee benefits or determining other terms of employment). Subject to paragraph (d)(3) of this section, examples of classifications that, based on all the relevant facts and circumstances, may be bona fide include full-time versus part-time status, different geographic location, membership in a collective bargaining unit, date of hire, length of service, current employee versus former employee status, and different occupations. However, a classification based on any health factor is not a bona fide employment-based classification, unless the requirements of paragraph (g) of this section are satisfied (permitting favorable treatment of individuals with adverse health factors).

(2) *Beneficiaries*—(i) Subject to paragraph (d)(3) of this section, a plan may treat beneficiaries as two or more distinct groups of similarly situated individuals if the distinction between or among the groups of beneficiaries is based on any of the following factors:

(A) A bona fide employment-based classification of the participant through whom the beneficiary is receiving coverage;

(B) Relationship to the participant (for example, as a spouse or as a dependent child);

(C) Marital status;

(D) With respect to children of a participant, age or student status; or

(E) Any other factor if the factor is not a health factor.

(ii) Paragraph (d)(2)(i) of this section does not prevent more favorable treatment of individuals with adverse health factors in accordance with paragraph (g) of this section.

(3) *Discrimination directed at individuals.* Notwithstanding paragraphs (d)(1) and (2) of this section, if the creation or modification of an employment or coverage classification is directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries, the classification is not permitted under this paragraph (d), unless it is permitted under paragraph (g) of this section (permitting favorable treatment of individuals with adverse health factors). Thus, if an employer modified an employment-based classification to single out, based on a health factor, individual participants and beneficiaries and deny them health coverage, the new classification would not be permitted under this section.

(4) *Examples.* The rules of this paragraph (d) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan for full-time employees only. Under the plan (consistent with the employer's usual business practice), employees who normally work at least 30 hours per week are considered to be working full-time. Other employees are considered to be working part-time. There is no evidence to suggest that the classification is directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 1,* treating the full-time and part-time employees as two separate groups of similarly situated individuals is permitted under this paragraph (d) because the classification is bona fide and is not directed at individual participants or beneficiaries.

Example 2. (i) *Facts.* Under a group health plan, coverage is made available to employees, their spouses, and their children. However, coverage is made available to a child only if the child is under age 26 (or under age 29 if the child is continuously enrolled full-time in an institution of higher learning (full-time students)). There is no evidence to suggest that these classifications are directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this Example 2, treating spouses and children differently by imposing an age limitation on children, but not on spouses, is permitted under this paragraph (d). Specifically, the distinction between spouses and children is permitted under paragraph (d)(2) of this section and is not prohibited under paragraph (d)(3) of this section because it is not directed at individual participants or beneficiaries. It is also permissible to treat children who are under age 26 (or full-time students under age 29) as a group of similarly situated individuals separate from those who are age 26 or older (or age 29 or older if they are not full-time students) because the classification is permitted under paragraph (d)(2) of this section and is not directed at individual participants or beneficiaries.

Example 3. (i) *Facts.* A university sponsors a group health plan that provides one health benefit package to faculty and another health benefit package to other staff. Faculty and staff are treated differently with respect to other employee benefits such as retirement benefits and leaves of absence. There is no evidence to suggest that the distinction is directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 3,* the classification is permitted under this paragraph (d) because there is a distinction based on a bona fide employment-based classification consistent with the employer's usual business practice and the distinction is not directed at individual participants and beneficiaries.

Example 4. (i) *Facts.* An employer sponsors a group health plan that is available to all current employees. Former employees may also be eligible, but only if they complete a specified number of years of service, are enrolled under the plan at the time of termination of employment, and are continuously enrolled from that date. There is no evidence to suggest that these distinctions are directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 4,* imposing additional eligibility requirements on former employees is permitted because a classification that distinguishes between current and former employees is a bona fide employment-based classification that is permitted under this paragraph (d), provided that it is not directed at individual participants or beneficiaries. In addition, it is permissible to distinguish between former employees who satisfy the service requirement and those who do not, provided that the distinction is not directed at individual participants or beneficiaries. (However, former employees who do not satisfy the eligibility criteria may, nonetheless, be eligible for continued coverage pursuant to a COBRA continuation provision or similar State law.)

Example 5. (i) *Facts.* An employer sponsors a group health plan that provides the same benefit package to all seven employees of the employer. Six of the seven employees have the same job title and responsibilities, but Employee *G* has a different job title and different responsibilities. After *G* files an expensive claim for benefits under the plan, coverage under the plan is modified so that employees with *G*'s job title receive a different benefit package that includes a higher deductible than in the benefit package made available to the other six employees.

(ii) *Conclusion.* Under the facts of this *Example 5,* changing the coverage classification for *G* based on the existing employment classification for *G* is not permitted under this paragraph (d) because the creation of the new coverage classification for *G* is directed at *G* based on one or more health factors.

(e) *Nonconfinement and actively-at-work provisions*—(1) *Nonconfinement provisions*—(i) *General rule.* Under the rules of paragraphs (b) and (c) of this section, a plan may not establish a rule for eligibility (as described in paragraph (b)(1)(ii) of this section) or set any individual's premium or contribution rate based on whether an individual is confined to a hospital or other

health care institution. In addition, under the rules of paragraphs (b) and (c) of this section, a plan may not establish a rule for eligibility or set any individual's premium or contribution rate based on an individual's ability to engage in normal life activities, except to the extent permitted under paragraphs (e)(2)(ii) and (3) of this section (permitting plans, under certain circumstances, to distinguish among employees based on the performance of services).

(ii) *Examples.* The rules of this paragraph (e)(1) are illustrated by the following examples:

Example 1. (i) *Facts.* Under a group health plan, coverage for employees and their dependents generally becomes effective on the first day of employment. However, coverage for a dependent who is confined to a hospital or other health care institution does not become effective until the confinement ends.

(ii) *Conclusion.* In this *Example 1,* the plan violates this paragraph (e)(1) because the plan delays the effective date of coverage for dependents based on confinement to a hospital or other health care institution.

Example 2. (i) *Facts.* In previous years, a group health plan has provided coverage through a group health insurance policy offered by Issuer *M.* However, for the current year, the plan provides coverage through a group health insurance policy offered by Issuer *N.* Under Issuer *N*'s policy, items and services provided in connection with the confinement of a dependent to a hospital or other health care institution are not covered if the confinement is covered under an extension of benefits clause from a previous health insurance issuer.

(ii) *Conclusion.* See *Example 2* in 29 CFR 2590.702(e)(1) and 45 CFR 146.121(e)(1) for a conclusion that Issuer *N* violates provisions of 29 CFR 2590.702(e)(1) and 45 CFR 146.121(e)(1) similar to the provisions of this paragraph (e)(1) because the group health insurance coverage restricts benefits based on whether a dependent is confined to a hospital or other health care institution that is covered under an extension of benefits from a previous issuer. See *Example 2* in 29 CFR 2590.702(e)(1) and 45 CFR 146.121(e)(1) for the additional conclusions that under State law Issuer *M* may also be responsible for providing benefits to such a dependent; and that in a case in which Issuer *N* has an obligation under 29 CFR 2590.702(e)(1) or 45 CFR 146.121(e)(1) to provide benefits and Issuer *M* has an obligation under State law to provide benefits, any State laws designed to prevent more than 100% reimbursement, such as State coordination-of-benefits laws, continue to apply.

(2) *Actively-at-work and continuous service provisions*—(i) *General rule*—(A) Under the rules of paragraphs (b) and (c) of this section and subject to the exception for the first day of work described in paragraph (e)(2)(ii) of this section, a plan may not establish a rule for eligibility (as described in paragraph (b)(1)(ii) of this section) or set any individual's premium or contribution rate based on whether an individual is actively at work (including whether an individual is continuously employed), unless absence from work due to any health factor (such as being absent from work on sick leave) is treated, for purposes of the plan, as being actively at work.

(B) The rules of this paragraph (e)(2)(i) are illustrated by the following examples:

Example 1. (i) *Facts.* Under a group health plan, an employee generally becomes eligible to enroll 30 days after the first day of employment. However, if the employee is not actively at work on the first day after the end of the 30-day period, then eligibility for enrollment is delayed until the first day the employee is actively at work.

(ii) *Conclusion.* In this *Example 1,* the plan violates this paragraph (e)(2) (and thus also violates paragraph (b) of this section). However, the plan would not violate paragraph (e)(2) or (b) of this section if, under the plan, an absence due to any health factor is considered being actively at work.

Example 2. (i) *Facts.* Under a group health plan, coverage for an employee becomes effective after 90 days of continuous service; that is, if an employee is absent from work (for any reason) before completing 90 days of service, the beginning of the 90-day period is measured from the day the employee returns to work (without any credit for service before the absence).

(ii) *Conclusion.* In this Example 2, the plan violates this paragraph (e)(2) (and thus also paragraph (b) of this section) because the 90-day continuous service requirement is a rule for eligibility based on whether an individual is actively at work. However, the plan would not violate this paragraph (e)(2) or paragraph (b) of this section if, under the plan, an absence due to any health factor is not considered an absence for purposes of measuring 90 days of continuous service. (In addition, any eligibility provision that is time-based must comply with the requirements of PHS Act section 2708 and its implementing regulations.)

(ii) *Exception for the first day of work*—(A) Notwithstanding the general rule in paragraph (e)(2)(i) of this section, a plan may establish a rule for eligibility that requires an individual to begin work for the employer sponsoring the plan (or, in the case of a multiemployer plan, to begin a job in covered employment) before coverage becomes effective, provided that such a rule for eligibility applies regardless of the reason for the absence.

(B) The rules of this paragraph (e)(2)(ii) are illustrated by the following examples:

Example 1. (i) *Facts.* Under the eligibility provision of a group health plan, coverage for new employees becomes effective on the first day that the employee reports to work. Individual *H* is scheduled to begin work on August 3. However, *H* is unable to begin work on that day because of illness. *H* begins working on August 4, and *H*'s coverage is effective on August 4.

(ii) *Conclusion.* In this *Example 1,* the plan provision does not violate this section. However, if coverage for individuals who do not report to work on the first day they were scheduled to work for a reason unrelated to a health factor (such as vacation or bereavement) becomes effective on the first day they were scheduled to work, then the plan would violate this section.

Example 2. (i) *Facts.* Under a group health plan, coverage for new employees becomes effective on the first day of the month following the employee's first day of work, regardless of whether the employee is actively at work on the first day of the month. Individual *J* is scheduled to begin work on March 24. However, *J* is unable to begin work on March 24 because of illness. *J* begins working on April 7 and *J*'s coverage is effective May 1.

(ii) *Conclusion.* In this *Example 2,* the plan provision does not violate this section. However, as in *Example 1,* if coverage for individuals absent from work for reasons unrelated to a health factor became effective despite their absence, then the plan would violate this section.

(3) *Relationship to plan provisions defining similarly situated individuals*—(i) Notwithstanding the rules of paragraphs (e)(1) and (2) of this section, a plan may establish rules for eligibility or set any individual's premium or contribution rate in accordance with the rules relating to similarly situated individuals in paragraph (d) of this section. Accordingly, a plan may distinguish in rules for eligibility under the plan between full-time and part-time employees, between permanent and temporary or seasonal employees, between current and former employees, and between employees currently performing services and employees no longer performing services for the employer, subject to paragraph (d) of this section. However, other Federal or State laws (including the COBRA continuation provisions and the Family and Medical Leave Act of 1993) may require an employee or the employee's dependents to be offered coverage and set limits on the premium or contribution rate even though the employee is not performing services.

(ii) The rules of this paragraph (e)(3) are illustrated by the following examples:

Example 1. (i) *Facts.* Under a group health plan, employees are eligible for coverage if they perform services for the employer for 30 or more hours per week or if they are on paid leave (such as vacation, sick, or bereavement leave). Employees on unpaid leave are treated as a separate group of similarly situated individuals in accordance with the rules of paragraph (d) of this section.

(ii) *Conclusion.* In this *Example 1,* the plan provisions do not violate this section. However, if the plan treated individuals performing services for the employer for 30 or more hours per week, individuals on vacation leave, and individuals on bereavement leave as a group of similarly situated individuals separate from individuals on sick leave, the plan would violate this paragraph (e) (and thus also would violate paragraph (b) of this section) because groups of similarly situated individuals cannot be established based on a health factor (including the taking of sick leave) under paragraph (d) of this section.

Example 2. (i) *Facts.* To be eligible for coverage under a bona fide collectively bargained group health plan in the current calendar quarter, the plan requires an individual to have worked 250 hours in covered employment during the three-month period that ends one month before the beginning of the current calendar quarter. The distinction between employees working at least 250 hours and those working less than 250 hours in the earlier three-month period is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries.

(ii) *Conclusion.* In this *Example 2,* the plan provision does not violate this section because, under the rules for similarly situated individuals allowing full-time employees to be treated differently than part-time employees, employees who work at least 250 hours in a three-month period can be treated differently than employees who fail to work 250 hours in that period. The result would be the same if the plan permitted individuals to apply excess hours from previous periods to satisfy the requirement for the current quarter.

Example 3. (i) *Facts.* Under a group health plan, coverage of an employee is terminated when the individual's employment is terminated, in accordance with the rules of paragraph (d) of this section. Employee *B* has been covered under the plan. *B* experiences a disabling illness that prevents *B* from working. *B* takes a leave of absence under the Family and Medical Leave Act of 1993. At the end of such leave, *B* terminates employment and consequently loses coverage under the plan. (This termination of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation.)

(ii) *Conclusion.* In this *Example 3,* the plan provision terminating *B*'s coverage upon *B*'s termination of employment does not violate this section.

Example 4. (i) *Facts.* Under a group health plan, coverage of an employee is terminated when the employee ceases to perform services for the employer sponsoring the plan, in accordance with the rules of paragraph (d) of this section. Employee *C* is laid off for three months. When the layoff begins, *C*'s coverage under the plan is terminated. (This termination of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation coverage.)

(ii) *Conclusion.* In this *Example 4,* the plan provision terminating *C*'s coverage upon the cessation of *C*'s performance of services does not violate this section.

(f) *Nondiscriminatory wellness programs—in general.* A wellness program is a program of health promotion or disease prevention. Paragraphs (b)(2)(ii) and (c)(3) of this section provide exceptions to the general prohibitions against discrimination based on a health factor for plan provisions that vary benefits (including cost-sharing mechanisms) or the premium or contribution for similarly situated individuals in connection with a wellness program that satisfies the requirements of this paragraph (f).

(1) *Definitions.* The definitions in this paragraph (f)(1) govern in applying the provisions of this paragraph (f).

(i) *Reward.* Except where expressly provided otherwise, references in this section to an individual obtaining a reward include both obtaining a reward (such as a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism, an additional benefit, or any financial or other incentive) and avoiding a penalty (such as the absence of a premium surcharge or other financial or nonfinancial disincentive). References in this section to a plan providing a reward include both providing a reward (such as a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism, an additional benefit, or any financial or other incentive) and imposing a penalty (such as a surcharge or other financial or nonfinancial disincentive).

(ii) *Participatory wellness programs.* If none of the conditions for obtaining a reward under a wellness program is based on an individual satisfying a standard that is related to a health factor (or if a wellness program does not provide a reward), the wellness program is a participatory wellness program. Examples of participatory wellness programs are:

(A) A program that reimburses employees for all or part of the cost for membership in a fitness center.

(B) A diagnostic testing program that provides a reward for participation in that program and does not base any part of the reward on outcomes.

(C) A program that encourages preventive care through the waiver of the copayment or deductible requirement under a group health plan for the costs of, for example, prenatal care or well-baby visits. (Note that, with respect to non-grandfathered plans, §54.9815-2713T requires benefits for certain preventive health services without the imposition of cost sharing.)

(D) A program that reimburses employees for the costs of participating, or that otherwise provides a reward for participating, in a smoking cessation program without regard to whether the employee quits smoking.

(E) A program that provides a reward to employees for attending a monthly, no-cost health education seminar.

(F) A program that provides a reward to employees who complete a health risk assessment regarding current health status, without any further action (educational or otherwise) required by the employee with regard to the health issues identified as part of the assessment. (*See also* §54.9802-3T for rules prohibiting collection of genetic information.)

(iii) *Health-contingent wellness programs.* A health-contingent wellness program is a program that requires an individual to satisfy a standard related to a health factor to obtain a reward (or requires an individual to undertake more than a similarly situated individual based on a health factor in order to obtain the same reward). A health-contingent wellness program may be an activity-only wellness program or an outcome-based wellness program.

(iv) *Activity-only wellness programs.* An activity-only wellness program is a type of health-contingent wellness program that requires an individual to perform or complete an activity related to a health factor in order to obtain a reward but does not require the individual to attain or maintain a specific health outcome. Examples include walking, diet, or exercise programs, which some individuals may be unable to participate in or complete (or have difficulty participating in or completing) due to a health factor, such as severe asthma, pregnancy, or a recent surgery. *See* paragraph (f)(3) of this section for requirements applicable to activity-only wellness programs.

(v) *Outcome-based wellness programs.* An outcome-based wellness program is a type of health-contingent wellness program that requires an individual to attain or maintain a specific health outcome (such as not smoking or attaining certain results on biometric screenings) in order to obtain a reward. To comply with the rules of this paragraph (f), an outcome-based wellness program typically has two tiers. That is, for individuals who do not attain or maintain the specific health outcome, compliance with an educational program or an activity may be offered as an alternative to achieve the same reward. This alternative pathway, however, does not mean that the overall program, which has an outcome-based component, is not an outcome-based wellness program. That is, if a measurement, test, or screening is used as part of an initial standard and individuals who meet the standard are granted the reward, the program is considered an outcome-based wellness program. For example, if a wellness program tests individuals for specified medical conditions or risk factors (including biometric screening such as testing for high cholesterol, high blood pressure, abnormal body mass index, or high glucose level) and provides a reward to individuals identified as within a normal or healthy range for these medical conditions or risk factors, while requiring individuals who are identified as outside the normal or healthy range (or at risk) to take additional steps (such as meeting with a health coach, taking a health or fitness course, adhering to a health improvement action plan, complying with a walking or exercise program, or complying with a health care provider's plan of care) to obtain the same reward, the program is an outcome-based wellness program. *See* paragraph (f)(4) of this section for requirements applicable to outcome-based wellness programs.

(2) *Requirement for participatory wellness programs.* A participatory wellness program, as described in paragraph (f)(1)(ii) of this section, does not violate the provisions of this section only if participation in the program is made available to all similarly situated individuals, regardless of health status.

(3) *Requirements for activity-only wellness programs.* A health-contingent wellness program that is an activity-only wellness program, as described in paragraph (f)(1)(iv) of this section, does not violate the provisions of this section only if all of the following requirements are satisfied:

(i) *Frequency of opportunity to qualify.* The program must give individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year.

(ii) *Size of reward.* The reward for the activity-only wellness program, together with the reward for other health-contingent wellness programs with respect to the plan, must not exceed the applicable percentage (as defined in paragraph (f)(5) of this section) of the total cost of employee-only coverage under the plan. However, if, in addition to employees, any class of dependents (such as spouses, or spouses and dependent children) may participate in the wellness program, the reward must not exceed the applicable percentage of the total cost of the coverage in which an employee and any dependents are enrolled. For purposes of this paragraph (f)(3)(ii), the cost of coverage is determined based on the total amount of employer and employee contributions towards the cost of coverage for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage.

(iii) *Reasonable design.* The program must be reasonably designed to promote health or prevent disease. A program satisfies this standard if it has a reasonable chance of improving the health of, or preventing disease in, participating individuals,

and it is not overly burdensome, is not a subterfuge for discriminating based on a health factor, and is not highly suspect in the method chosen to promote health or prevent disease. This determination is based on all the relevant facts and circumstances.

(iv) *Uniform availability and reasonable alternative standards.* The full reward under the activity-only wellness program must be available to all similarly situated individuals.

(A) Under this paragraph (f)(3)(iv), a reward under an activity-only wellness program is not available to all similarly situated individuals for a period unless the program meets both of the following requirements:

(*1*) The program allows a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

(*2*) The program allows a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

(B) While plans and issuers are not required to determine a particular reasonable alternative standard in advance of an individual's request for one, if an individual is described in either paragraph (f)(3)(iv)(A)(*1*) or (*2*) of this section, a reasonable alternative standard must be furnished by the plan or issuer upon the individual's request or the condition for obtaining the reward must be waived.

(C) All the facts and circumstances are taken into account in determining whether a plan or issuer has furnished a reasonable alternative standard, including but not limited to the following:

(*1*) If the reasonable alternative standard is completion of an educational program, the plan or issuer must make the educational program available or assist the employee in finding such a program (instead of requiring an individual to find such a program unassisted), and may not require an individual to pay for the cost of the program.

(*2*) The time commitment required must be reasonable (for example, requiring attendance nightly at a one-hour class would be unreasonable).

(*3*) If the reasonable alternative standard is a diet program, the plan or issuer is not required to pay for the cost of food but must pay any membership or participation fee.

(*4*) If an individual's personal physician states that a plan standard (including, if applicable, the recommendations of the plan's medical professional) is not medically appropriate for that individual, the plan or issuer must provide a reasonable alternative standard that accommodates the recommendations of the individual's personal physician with regard to medical appropriateness. Plans and issuers may impose standard cost sharing under the plan or coverage for medical items and services furnished pursuant to the physician's recommendations.

(D) To the extent that a reasonable alternative standard under an activity-only wellness program is, itself, an activity-only wellness program, it must comply with the requirements of this paragraph (f)(3) in the same manner as if it were an initial program standard. (Thus, for example, if a plan or issuer provides a walking program as a reasonable alternative standard to a running program, individuals for whom it is unreasonably difficult due to a medical condition to complete the walking program (or for whom it is medically inadvisable to attempt to complete the walking program) must be provided a reasonable alternative standard to the walking program.) To the extent that a reasonable alternative standard under an activity-only wellness program is, itself, an outcome-based wellness program, it must comply with the requirements of paragraph (f)(4) of this section, including paragraph (f)(4)(iv)(D).

(E) If reasonable under the circumstances, a plan or issuer may seek verification, such as a statement from an individual's personal physician, that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy, the otherwise applicable standard of an activity-only wellness program. Plans and issuers may seek verification with respect to requests for a reasonable alternative standard for which it is reasonable to determine that medical judgment is required to evaluate the validity of the request.

(v) *Notice of availability of reasonable alternative standard.* The plan or issuer must disclose in all plan materials describing the terms of an activity-only wellness program the availability of a reasonable alternative standard to qualify for the reward (and, if applicable, the possibility of waiver of the otherwise applicable standard), including contact information for obtaining a reasonable alternative standard and a statement that recommendations of an individual's personal physician will be accommodated. If plan materials merely mention that such a program is available, without describing its terms, this disclosure is not required. Sample language is provided in paragraph (f)(6) of this section, as well as in certain examples of this section.

(vi) *Example.* The provisions of this paragraph (f)(3) are illustrated by the following example:

Example. (i) *Facts.* A group health plan provides a reward to individuals who participate in a reasonable specified walking program. If it is unreasonably difficult due to a medical condition for an individual to participate (or if it is medically inadvisable for an individual to attempt to participate), the plan will waive the walking program requirement and provide the reward. All materials describing the terms of the walking program disclose the availability of the waiver.

(ii) *Conclusion.* In this *Example,* the program satisfies the requirements of paragraph (f)(3)(iii) of this section because the walking program is reasonably designed to promote health and prevent disease. The program satisfies the requirements of paragraph (f)(3)(iv) of this section because the reward under the program is available to all similarly situated individuals. It accommodates individuals for whom it is unreasonably difficult to participate in the walking program due to a medical condition (or for whom it would be medically inadvisable to attempt to participate) by providing them with the reward even if they do not participate in the walking program (that is, by waiving the condition). The plan also complies with the disclosure requirement of paragraph (f)(3)(v) of this section. Thus, the plan satisfies paragraphs (f)(3)(iii), (iv), and (v) of this section.

(4) *Requirements for outcome-based wellness programs.* A health-contingent wellness program that is an outcome-based wellness program, as described in paragraph (f)(1)(v) of this section, does not violate the provisions of this section only if all of the following requirements are satisfied:

(i) *Frequency of opportunity to qualify.* The program must give individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year.

(ii) *Size of reward.* The reward for the outcome-based wellness program, together with the reward for other health-contingent wellness programs with respect to the plan, must not exceed the applicable percentage (as defined in paragraph (f)(5) of this section) of the total cost of employee-only coverage under the plan. However, if, in addition to employees, any class of dependents (such as spouses, or spouses and dependent children) may participate in the wellness program, the reward must not exceed the applicable percentage of the total cost of the coverage in which an employee and any dependents are enrolled. For purposes of this paragraph (f)(4)(ii), the cost of coverage is determined based on the total amount of employer and employee contributions towards the cost of coverage for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage.

(iii) *Reasonable design.* The program must be reasonably designed to promote health or prevent disease. A program satisfies this standard if it has a reasonable chance of improving the health of, or preventing disease in, participating individuals, and it is not overly burdensome, is not a subterfuge for discriminating based on a health factor, and is not highly suspect in the method chosen to promote health or prevent disease. This determination is based on all the relevant facts and circumstances. To ensure that an outcome-based wellness program is reasonably designed to improve health and does not act as a subterfuge for underwriting or reducing benefits based on a health factor, a reasonable alternative standard to qualify for the reward must be provided to any individual who does not meet the initial standard based on a measurement, test, or screening that is related to a health factor, as explained in paragraph (f)(4)(iv) of this section.

(iv) *Uniform availability and reasonable alternative standards.* The full reward under the outcome-based wellness program must be available to all similarly situated individuals.

(A) Under this paragraph (f)(4)(iv), a reward under an outcome-based wellness program is not available to all similarly situated individuals for a period unless the program allows a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual who does not meet the initial standard based on the measurement, test, or screening, as described in this paragraph (f)(4)(iv).

(B) While plans and issuers are not required to determine a particular reasonable alternative standard in advance of an individual's request for one, if an individual is described in paragraph (f)(4)(iv)(A) of this section, a reasonable alternative standard must be furnished by the plan or issuer upon the individual's request or the condition for obtaining the reward must be waived.

(C) All the facts and circumstances are taken into account in determining whether a plan or issuer has furnished a reasonable alternative standard, including but not limited to the following:

(*1*) If the reasonable alternative standard is completion of an educational program, the plan or issuer must make the educational program available or assist the employee in finding such a program (instead of requiring an individual to find such a program unassisted), and may not require an individual to pay for the cost of the program.

(*2*) The time commitment required must be reasonable (for example, requiring attendance nightly at a one-hour class would be unreasonable).

(*3*) If the reasonable alternative standard is a diet program, the plan or issuer is not required to pay for the cost of food but must pay any membership or participation fee.

(*4*) If an individual's personal physician states that a plan standard (including, if applicable, the recommendations of the plan's medical professional) is not medically appropriate for that individual, the plan or issuer must provide a reasonable alternative standard that accommodates the recommendations of the individual's personal physician with regard to medical

appropriateness. Plans and issuers may impose standard cost sharing under the plan or coverage for medical items and services furnished pursuant to the physician's recommendations.

(D) To the extent that a reasonable alternative standard under an outcome-based wellness program is, itself, an activity-only wellness program, it must comply with the requirements of paragraph (f)(3) of this section in the same manner as if it were an initial program standard. To the extent that a reasonable alternative standard under an outcome-based wellness program is, itself, another outcome-based wellness program, it must comply with the requirements of this paragraph (f)(4), subject to the following special rules:

(*1*) The reasonable alternative standard cannot be a requirement to meet a different level of the same standard without additional time to comply that takes into account the individual's circumstances. For example, if the initial standard is to achieve a BMI less than 30, the reasonable alternative standard cannot be to achieve a BMI less than 31 on that same date. However, if the initial standard is to achieve a BMI less than 30, a reasonable alternative standard for the individual could be to reduce the individual's BMI by a small amount or small percentage, over a realistic period of time, such as within a year.

(*2*) An individual must be given the opportunity to comply with the recommendations of the individual's personal physician as a second reasonable alternative standard to meeting the reasonable alternative standard defined by the plan or issuer, but only if the physician joins in the request. The individual can make a request to involve a personal physician's recommendations at any time and the personal physician can adjust the physician's recommendations at any time, consistent with medical appropriateness.

(E) It is not reasonable to seek verification, such as a statement from an individual's personal physician, under an outcome-based wellness program that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy, the otherwise applicable standard as a condition of providing a reasonable alternative to the initial standard. However, if a plan or issuer provides an alternative standard to the otherwise applicable measurement, test, or screening that involves an activity that is related to a health factor, then the rules of paragraph (f)(3) of this section for activity-only wellness programs apply to that component of the wellness program and the plan or issuer may, if reasonable under the circumstances, seek verification that it is unreasonably difficult due to a medical condition for an individual to perform or complete the activity (or it is medically inadvisable to attempt to perform or complete the activity). (For example, if an outcome-based wellness program requires participants to maintain a certain healthy weight and provides a diet and exercise program for individuals who do not meet the targeted weight, a plan or issuer may seek verification, as described in paragraph (f)(3)(iv)(D) of this section, if reasonable under the circumstances, that a second reasonable alternative standard is needed for certain individuals because, for those individuals, it would be unreasonably difficult due to a medical condition to comply, or medically inadvisable to attempt to comply, with the diet and exercise program, due to a medical condition.)

(v) *Notice of availability of reasonable alternative standard.* The plan or issuer must disclose in all plan materials describing the terms of an outcome-based wellness program, and in any disclosure that an individual did not satisfy an initial outcome-based standard, the availability of a reasonable alternative standard to qualify for the reward (and, if applicable, the possibility of waiver of the otherwise applicable standard), including contact information for obtaining a reasonable alternative standard and a statement that recommendations of an individual's personal physician will be accommodated. If plan materials merely mention that such a program is available, without describing its terms, this disclosure is not required. Sample language is provided in paragraph (f)(6) of this section, as well as in certain examples of this section.

(vi) *Examples.* The rules of this paragraph (f)(4) are illustrated by the following examples:

Example 1—Cholesterol screening with reasonable alternative standard to work with personal physician. (i) *Facts.* A group health plan offers a reward to participants who achieve a count under 200 on a total cholesterol test. If a participant does not achieve the targeted cholesterol count, the plan allows the participant to develop an alternative cholesterol action plan in conjunction with the participant's personal physician that may include recommendations for medication and additional screening. The plan allows the physician to modify the standards, as medically necessary, over the year. (For example, if a participant develops asthma or depression, requires surgery and convalescence, or some other medical condition or consideration makes completion of the original action plan inadvisable or unreasonably difficult, the physician may modify the original action plan.) All plan materials describing the terms of the program include the following statement: "Your health plan wants to help you take charge of your health. Rewards are available to all employees who participate in our Cholesterol Awareness Wellness Program. If your total cholesterol count is under 200, you will receive the reward. If not, you will still have an opportunity to qualify for the reward. We will work with you and your doctor to find a Health Smart program that is right for you." In addition, when any individual participant receives notification that his or her cholesterol count is 200 or higher, the notification includes the following statement: "Your plan offers a Health Smart program under which we will work with you and your doctor to try to lower your cholesterol. If you complete this program, you will qualify for a reward. Please contact us at [contact information] to get started."

(ii) *Conclusion.* In this *Example 1,* the program is an outcome-based wellness program because the initial standard requires an individual to attain or maintain a specific health outcome (a certain cholesterol level) to obtain a reward. The program satisfies the requirements of paragraph (f)(4)(iii) of this section because the cholesterol program is reasonably designed to promote health and prevent disease. The program satisfies the requirements of paragraph (f)(4)(iv) of this section because it makes available to all participants who do not meet the cholesterol standard a reasonable alternative standard to qualify for the reward. Lastly, the plan also discloses in all materials describing the terms of the program and in any disclosure that an individual did not satisfy the initial outcome-based standard the availability of a reasonable alternative standard (including contact information and the individual's ability to involve his or her personal physician), as required by paragraph (f)(4)(v) of this section. Thus, the program satisfies the requirements of paragraphs (f)(4)(iii), (iv), and (v) of this section.

Example 2—Cholesterol screening with plan alternative and no opportunity for personal physician involvement. (i) *Facts.* Same facts as *Example 1,* except that the wellness program's physician or nurse practitioner (rather than the individual's personal physician) determines the alternative

cholesterol action plan. The plan does not provide an opportunity for a participant's personal physician to modify the action plan if it is not medically appropriate for that individual.

(ii) *Conclusion.* In this *Example 2,* the wellness program does not satisfy the requirements of paragraph (f)(4)(iii) of this section because the program does not accommodate the recommendations of the participant's personal physician with regard to medical appropriateness, as required under paragraph (f)(4)(iv)(C)(*3*) of this section. Thus, the program is not reasonably designed under paragraph (f)(4)(iii) of this section and is not available to all similarly situated individuals under paragraph (f)(4)(iv) of this section. The notice also does not provide all the content required under paragraph (f)(4)(v) of this section.

Example 3—Cholesterol screening with plan alternative that can be modified by personal physician. (i) *Facts.* Same facts as *Example 2,* except that if a participant's personal physician disagrees with any part of the action plan, the personal physician may modify the action plan at any time, and the plan discloses this to participants.

(ii) *Conclusion.* In this *Example 3,* the wellness program satisfies the requirements of paragraph (f)(4)(iii) of this section because the participant's personal physician may modify the action plan determined by the wellness program's physician or nurse practitioner at any time if the physician states that the recommendations are not medically appropriate, as required under paragraph (f)(4)(iv)(C)(*3*) of this section. Thus, the program is reasonably designed under paragraph (f)(4)(iii) of this section and is available to all similarly situated individuals under paragraph (f)(4)(iv) of this section. The notice, which includes a statement that recommendations of an individual's personal physician will be accommodated, also complies with paragraph (f)(4)(v) of this section.

Example 4—BMI screening with walking program alternative. (i) *Facts.* A group health plan will provide a reward to participants who have a body mass index (BMI) that is 26 or lower, determined shortly before the beginning of the year. Any participant who does not meet the target BMI is given the same discount if the participant complies with an exercise program that consists of walking 150 minutes a week. Any participant for whom it is unreasonably difficult due to a medical condition to comply with this walking program (and any participant for whom it is medically inadvisable to attempt to comply with the walking program) during the year is given the same discount if the participant satisfies an alternative standard that is reasonable taking into consideration the participant's medical situation, is not unreasonably burdensome or impractical to comply with, and is otherwise reasonably designed based on all the relevant facts and circumstances. All plan materials describing the terms of the wellness program include the following statement: "Fitness is Easy! Start Walking! Your health plan cares about your health. If you are considered overweight because you have a BMI of over 26, our Start Walking program will help you lose weight and feel better. We will help you enroll. (* *If your doctor says that walking isn't right for you, that's okay too. We will work with you (and, if you wish, your own doctor) to develop a wellness program that is.)" Participant *E* is unable to achieve a BMI that is 26 or lower within the plan's timeframe and receives notification that complies with paragraph (f)(4)(v) of this section. Nevertheless, it is unreasonably difficult due to a medical condition for *E* to comply with the walking program. *E* proposes a program based on the recommendations of *E*'s physician. The plan agrees to make the same discount available to *E* that is available to other participants in the BMI program or the alternative walking program, but only if *E* actually follows the physician's recommendations.

(ii) *Conclusion.* In this *Example 4,* the program is an outcome-based wellness program because the initial standard requires an individual to attain or maintain a specific health outcome (a certain BMI level) to obtain a reward. The program satisfies the requirements of paragraph (f)(4)(iii) of this section because it is reasonably designed to promote health and prevent disease. The program also satisfies the requirements of paragraph (f)(4)(iv) of this section because it makes available to all individuals who do not satisfy the BMI standard a reasonable alternative standard to qualify for the reward (in this case, a walking program that is not unreasonably burdensome or impractical for individuals to comply with and that is otherwise reasonably designed based on all the relevant facts and circumstances). In addition, the walking program is, itself, an activity-only standard and the plan complies with the requirements of paragraph (f)(3) of this section (including the requirement of paragraph (f)(3)(iv) that, if there are individuals for whom it is unreasonably difficult due to a medical condition to comply, or for whom it is medically inadvisable to attempt to comply, with the walking program, the plan provide a reasonable alternative to those individuals). Moreover, the plan satisfies the requirements of paragraph (f)(4)(v) of this section because it discloses, in all materials describing the terms of the program and in any disclosure that an individual did not satisfy the initial outcome-based standard, the availability of a reasonable alternative standard (including contact information and the individual's option to involve his or her personal physician) to qualify for the reward or the possibility of waiver of the otherwise applicable standard. Thus, the program satisfies the requirements of paragraphs (f)(4)(iii), (iv), and (v) of this section.

Example 5—BMI screening with alternatives available to either lower BMI or meet personal physician's recommendations. (i) *Facts.* Same facts as *Example 4* except that, with respect to any participant who does not meet the target BMI, instead of a walking program, the participant is expected to reduce BMI by one point. At any point during the year upon request, any individual can obtain a second reasonable alternative standard, which is compliance with the recommendations of the participant's personal physician regarding weight, diet, and exercise as set forth in a treatment plan that the physician recommends or to which the physician agrees. The participant's personal physician is permitted to change or adjust the treatment plan at any time and the option of following the participant's personal physician's recommendations is clearly disclosed.

(ii) *Conclusion.* In this *Example 5,* the reasonable alternative standard to qualify for the reward (the alternative BMI standard requiring a one-point reduction) does not make the program unreasonable under paragraph (f)(4)(iii) or (iv) of this section because the program complies with paragraph (f)(4)(iv)(C)(*4*) of this section by allowing a second reasonable alternative standard to qualify for the reward (compliance with the recommendations of the participant's personal physician, which can be changed or adjusted at any time). Accordingly, the program continues to satisfy the applicable requirements of paragraph (f) of this section.

Example 6—Tobacco use surcharge with smoking cessation program alternative. (i) *Facts.* In conjunction with an annual open enrollment period, a group health plan provides a premium differential based on tobacco use, determined using a health risk assessment. The following statement is included in all plan materials describing the tobacco premium differential: "Stop smoking today! We can help! If you are a smoker, we offer a smoking cessation program. If you complete the program, you can avoid this surcharge." The plan accommodates participants who smoke by facilitating their enrollment in a smoking cessation program that requires participation at a time and place that are not unreasonably burdensome or impractical for participants, and that is otherwise reasonably designed based on all the relevant facts and circumstances, and discloses contact information and the individual's option to involve his or her personal physician. The plan pays for the cost of participation in the smoking cessation program. Any participant can avoid the surcharge for the plan year by participating in the program, regardless of whether the participant stops smoking, but the plan can require a participant who wants to avoid the surcharge in a subsequent year to complete the smoking cessation program again.

(ii) *Conclusion.* In this *Example 6,* the premium differential satisfies the requirements of paragraphs (f)(4)(iii), (iv), and (v). The program is an outcome-based wellness program because the initial standard for obtaining a reward is dependent on the results of a health risk assessment (a measurement, test, or screening). The program is reasonably designed under paragraph (f)(4)(iii) because the plan provides a reasonable alternative standard (as required under paragraph (f)(4)(iv) of this section) to qualify for the reward to all tobacco users (a smoking cessation program). The plan discloses, in all materials describing the terms of the program, the availability of the reasonable alternative standard (including contact information and the individual's option to involve his or her personal physician). Thus, the program satisfies the requirements of paragraphs (f)(4)(iii), (iv), and (v) of this section.

Example 7—Tobacco use surcharge with alternative program requiring actual cessation. (i) *Facts.* Same facts as *Example 6,* except the plan does not provide participant *F* with the reward in subsequent years unless *F* actually stops smoking after participating in the tobacco cessation program.

(ii) *Conclusion.* In this *Example 7,* the program is not reasonably designed under paragraph (f)(4)(iii) of this section and does not provide a reasonable alternative standard as required under paragraph (f)(4)(iv) of this section. The plan cannot cease to provide a reasonable alternative standard merely because the participant did not stop smoking after participating in a smoking cessation program. The plan must continue to offer a reasonable alternative standard whether it is the same or different (such as a new recommendation from *F*'s personal physician or a new nicotine replacement therapy).

Example 8—Tobacco use surcharge with smoking cessation program alternative that is not reasonable. (i) *Facts.* Same facts as *Example 6,* except the plan does not facilitate participant *F*'s enrollment in a smoking cessation program. Instead the plan advises *F* to find a program, pay for it, and provide a certificate of completion to the plan.

(ii) *Conclusion.* In this *Example 8,* the requirement for *F* to find and pay for *F*'s own smoking cessation program means that the alternative program is not reasonable. Accordingly, the plan has not offered a reasonable alternative standard that complies with paragraphs (f)(4)(iii) and (iv) of this section and the program fails to satisfy the requirements of paragraph (f) of this section.

(5) *Applicable percentage*—(i) For purposes of this paragraph (f), the applicable percentage is 30 percent, except that the applicable percentage is increased by an additional 20 percentage points (to 50 percent) to the extent that the additional percentage is in connection with a program designed to prevent or reduce tobacco use.

(ii) The provisions of this paragraph (f)(5) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan. The annual premium for employee-only coverage is $6,000 (of which the employer pays $4,500 per year and the employee pays $1,500 per year). The plan offers employees a health-contingent wellness program with several components, focused on exercise, blood sugar, weight, cholesterol, and blood pressure. The reward for compliance is an annual premium rebate of $600.

(ii) *Conclusion.* In this *Example 1,* the reward for the wellness program, $600, does not exceed the applicable percentage of 30 percent of the total annual cost of employee-only coverage, $1,800. ($6,000 × 30% = $1,800.)

Example 2. (i) *Facts.* Same facts as *Example 1,* except the wellness program is exclusively a tobacco prevention program. Employees who have used tobacco in the last 12 months and who are not enrolled in the plan's tobacco cessation program are charged a $1,000 premium surcharge (in addition to their employee contribution towards the coverage). (Those who participate in the plan's tobacco cessation program are not assessed the $1,000 surcharge.)

(ii) *Conclusion.* In this *Example 2,* the reward for the wellness program (absence of a $1,000 surcharge), does not exceed the applicable percentage of 50 percent of the total annual cost of employee-only coverage, $3,000. ($6,000 × 50% = $3,000.)

Example 3. (i) *Facts.* Same facts as *Example 1,* except that, in addition to the $600 reward for compliance with the health-contingent wellness program, the plan also imposes an additional $2,000 tobacco premium surcharge on employees who have used tobacco in the last 12 months and who are not enrolled in the plan's tobacco cessation program. (Those who participate in the plan's tobacco cessation program are not assessed the $2,000 surcharge.)

(ii) *Conclusion.* In this *Example 3,* the total of all rewards (including absence of a surcharge for participating in the tobacco program) is $2,600 ($600 + $2,000 = $2,600), which does not exceed the applicable percentage of 50 percent of the total annual cost of employee-only coverage ($3,000); and, tested separately, the $600 reward for the wellness program unrelated to tobacco use does not exceed the applicable percentage of 30 percent of the total annual cost of employee-only coverage ($1,800).

Example 4. (i) *Facts.* An employer sponsors a group health plan. The total annual premium for employee-only coverage (including both employer and employee contributions towards the coverage) is $5,000. The plan provides a $250 reward to employees who complete a health risk assessment, without regard to the health issues identified as part of the assessment. The plan also offers a Healthy Heart program, which is a health-contingent wellness program, with an opportunity to earn a $1,500 reward.

(ii) *Conclusion.* In this *Example 4,* even though the total reward for all wellness programs under the plan is $1,750 ($250 + $1,500 = $1,750, which exceeds the applicable percentage of 30 percent of the cost of the annual premium for employee-only coverage ($5,000 × 30% = $1,500)), only the reward offered for compliance with the health-contingent wellness program ($1,500) is taken into account in determining whether the rules of this paragraph (f)(5) are met. (The $250 reward is offered in connection with a participatory wellness program and therefore is not taken into account.) Accordingly, the health-contingent wellness program offers a reward that does not exceed the applicable percentage of 30 percent of the total annual cost of employee-only coverage.

(6) *Sample language.* The following language, or substantially similar language, can be used to satisfy the notice requirement of paragraphs (f)(3)(v) or (f)(4)(v) of this section: "Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at [insert contact information] and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status."

(g) *More favorable treatment of individuals with adverse health factors permitted*—(1) *In rules for eligibility.* (i) Nothing in this section prevents a group health plan from establishing more favorable rules for eligibility (described in paragraph (b)(1) of this section) for individuals with an adverse health factor, such as disability, than for individuals without the adverse health factor. Moreover, nothing in this section prevents a plan from charging a higher premium or contribution with respect to individuals with an adverse health factor if they would not be eligible for the coverage were it not for the adverse health factor. (However, other laws, including State insurance laws, may set or limit premium rates; these laws are not affected by this section.)

(ii) The rules of this paragraph (g)(1) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan that generally is available to employees, spouses of employees, and dependent children until age 26. However, dependent children who are disabled are eligible for coverage beyond age 26.

(ii) *Conclusion.* In this Example 1, the plan provision allowing coverage for disabled dependent children beyond age 26 satisfies this paragraph (g)(1) (and thus does not violate this section).

Example 2. (i) *Facts.* An employer sponsors a group health plan, which is generally available to employees (and members of the employee's family) until the last day of the month in which the employee ceases to perform services for the employer. The plan generally charges employees $50 per month for employee-only coverage and $125 per month for family coverage. However, an employee who ceases to perform services for the employer by reason of disability may remain covered under the plan until the last day of the month that is 12 months after the month in which the employee ceased to perform services for the employer. During this extended period of coverage, the plan charges the employee $100 per month for employee-only coverage and $250 per month for family coverage. (This extended period of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation coverage.)

(ii) *Conclusion.* In this *Example 2*, the plan provision allowing extended coverage for disabled employees and their families satisfies this paragraph (g)(1) (and thus does not violate this section). In addition, the plan is permitted, under this paragraph (g)(1), to charge the disabled employees a higher premium during the extended period of coverage.

Example 3. (i) *Facts.* To comply with the requirements of a COBRA continuation provision, a group health plan generally makes COBRA continuation coverage available for a maximum period of 18 months in connection with a termination of employment but makes the coverage available for a maximum period of 29 months to certain disabled individuals and certain members of the disabled individual's family. Although the plan generally requires payment of 102 percent of the applicable premium for the first 18 months of COBRA continuation coverage, the plan requires payment of 150 percent of the applicable premium for the disabled individual's COBRA continuation coverage during the disability extension if the disabled individual would not be entitled to COBRA continuation coverage but for the disability.

(ii) *Conclusion.* In this *Example 3*, the plan provision allowing extended COBRA continuation coverage for disabled individuals satisfies this paragraph (g)(1) (and thus does not violate this section). In addition, the plan is permitted, under this paragraph (g)(1), to charge the disabled individuals a higher premium for the extended coverage if the individuals would not be eligible for COBRA continuation coverage were it not for the disability. (Similarly, if the plan provided an extended period of coverage for disabled individuals pursuant to State law or plan provision rather than pursuant to a COBRA continuation coverage provision, the plan could likewise charge the disabled individuals a higher premium for the extended coverage.)

(2) *In premiums or contributions*—(i) Nothing in this section prevents a group health plan from charging individuals a premium or contribution that is less than the premium (or contribution) for similarly situated individuals if the lower charge is based on an adverse health factor, such as disability.

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

Example. (i) *Facts.* Under a group health plan, employees are generally required to pay $50 per month for employee-only coverage and $125 per month for family coverage under the plan. However, employees who are disabled receive coverage (whether employee-only or family coverage) under the plan free of charge.

(ii) *Conclusion.* In this *Example*, the plan provision waiving premium payment for disabled employees is permitted under this paragraph (g)(2) (and thus does not violate this section).

(h) *No effect on other laws.* Compliance with this section is not determinative of compliance with any provision of ERISA (including the COBRA continuation provisions) or any other State or Federal law, such as the Americans with Disabilities Act. Therefore, although the rules of this section would not prohibit a plan from treating one group of similarly situated individuals differently from another (such as providing different benefit packages to current and former employees), other Federal or State laws may require that two separate groups of similarly situated individuals be treated the same for certain purposes (such as making the same benefit package available to COBRA qualified beneficiaries as is made available to active employees). In addition, although this section generally does not impose new disclosure obligations on plans, this section does not affect any other laws, including those that require accurate disclosures and prohibit intentional misrepresentation.

(i) *Applicability dates.* This section applies for plan years beginning on or after July 1, 2007.

[T.D. 9298, 71 FR 75030, Dec. 13, 2006; 72 FR 7929, Feb. 22, 2007, as amended by T.D. 9464, 74 FR 51678, Oct. 7, 2009; T.D. 9620, 78 FR 33176, June 3, 2013; T.D. 9656, 79 FR 10305, Feb. 24, 2014]

§447.51 Definitions.

As used in this part—

Alternative non-emergency services provider means a Medicaid provider, such as a physician's office, health care clinic, community health center, hospital outpatient department, or similar provider that can provide clinically appropriate services in a timely manner.

Contract health service means any health service that is:

(1) Delivered based on a referral by, or at the expense of, an Indian health program; and

(2) Provided by a public or private medical provider or hospital that is not a provider or hospital of the IHS or any other Indian health program

Cost sharing means any copayment, coinsurance, deductible, or other similar charge.

Emergency services has the same meaning as in §438.114 of this chapter.

Federal poverty level (FPL) means the Federal poverty level updated periodically in the FEDERAL REGISTER by the Secretary of Health and Human Services under the authority of 42 U.S.C. 9902(2).

Indian means any individual defined at 25 U.S.C. 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12. This means the individual:

(1) Is a member of a Federally-recognized Indian tribe;

(2) Resides in an urban center and meets one or more of the following four criteria:

(i) Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;

(ii) Is an Eskimo or Aleut or other Alaska Native;

(iii) Is considered by the Secretary of the Interior to be an Indian for any purpose; or

(iv) Is determined to be an Indian under regulations promulgated by the Secretary;

(3) Is considered by the Secretary of the Interior to be an Indian for any purpose; or

(4) Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

Indian health care provider means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization

(otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

Inpatient stay means the services received during a continuous period of inpatient days in either a single medical institution or multiple medical institutions, and also includes a return to an inpatient medical institution after a brief period when the return is for treatment of a condition that was present in the initial period. Inpatient has the same meaning as in §440.2 of this chapter.

Non-emergency services means any care or services that are not considered emergency services as defined in this section. This does not include any services furnished in a hospital emergency department that are required to be provided as an appropriate medical screening examination or stabilizing examination and treatment under section 1867 of the Act.

Outpatient services for purposes of imposing cost sharing means any service or supply not meeting the definition of an inpatient stay.

Preferred drugs means drugs that the state has identified on a publicly available schedule as being determined by a pharmacy and therapeutics committee for clinical efficacy as the most cost effective drugs within each therapeutically equivalent or therapeutically similar class of drugs, or all drugs within such a class if the agency does not differentiate between preferred and non-preferred drugs.

Premium means any enrollment fee, premium, or other similar charge.

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§156.145 Determination of minimum value.

(a) *Acceptable methods for determining MV.* An employer-sponsored plan provides minimum value (MV) only if the percentage of the total allowed costs of benefits provided under the plan is greater than or equal to 60 percent, and the benefits under the plan include substantial coverage of inpatient hospital services and physician services. An employer-sponsored plan may use one of the following methods to determine whether the percentage of the total allowed costs of benefits provided under the plan is not less than 60 percent.

(1) The MV Calculator to be made available by HHS and the Internal Revenue Service. The result derived from the calculator may be modified under the rules in paragraph (b) of this section.

(2) Any safe harbor established by HHS and the Internal Revenue Service.

(3) A group health plan may seek certification by an actuary to determine MV if the plan contains non-standard features that are not suitable for either of the methods described in paragraphs (a)(1) or (2) of this section. The determination of MV must be made by a member of the American Academy of Actuaries, based on an analysis performed in accordance with generally accepted actuarial principles and methodologies.

(4) Any plan in the small group market that meets any of the levels of coverage, as described in §156.140 of this subpart, satisfies minimum value.

(b) *Benefits that may be counted towards the determination of MV.* (1) In the event that a group health plan uses the MV Calculator and offers an EHB outside of the parameters of the MV Calculator, the plan may seek an actuary, who is a member of the American Academy of Actuaries, to determine the value of that benefit and adjust the result derived from the MV Calculator to reflect that value.

(2) For the purposes of applying the options described in paragraph (a) of this section in determining MV, a group health plan will be permitted to take into account all benefits provided by the plan that are included in any one of the EHB-benchmarks.

(c) *Standard population.* The standard population for MV determinations described in paragraph (a) of this section is the standard population developed by HHS for such use and described through summary statistics issued by HHS. The standard population for MV must reflect the population covered by self-insured group health plans.

(d) *Employer contributions to health savings accounts and amounts made available under certain health reimbursement arrangements.* For employer-sponsored self-insured group health plans and insured group health plans that at the time of purchase are offered in conjunction with an HSA or with integrated HRAs that may be used only for cost-sharing, annual employer contributions to HSAs and amounts newly made available under such HRAs for the current year are:

(1) Counted towards the total anticipated medical spending of the standard population that is paid by the health plan; and

(2) Adjusted to reflect the expected spending for health care costs in a benefit year so that:

(i) Any current year HSA contributions are accounted for; and

(ii) The amounts newly made available under such integrated HRAs for the current year are accounted for.

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