

**State of California
Office of Administrative Law**

In re:
California Health Benefit Exchange

Regulatory Action:

Title 10, California Code of Regulations

Adopt sections:

Amend sections: 6408, 6410, 6452, 6454,
6470, 6474, 6496, 6498,
6502, 6504, 6506, 6602

Repeal sections:

**NOTICE OF APPROVAL OF EMERGENCY
REGULATORY ACTION**

**Government Code Sections 11346.1 and
11349.6**

OAL Matter Number: 2019-0927-04

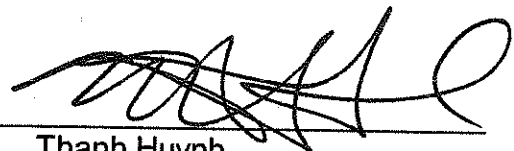
OAL Matter Type: Emergency (E)

In these emergency regulations, the California Health Benefit Exchange amends its regulations pursuant to Government Code section 100504(a)(6). In compliance with state and federal laws, these regulations provide definitions, abbreviations, standards for notice, standards for eligibility determination and redetermination for qualified health plans, requirements for coverage eligibility, procedures for termination of coverage, and an appeals process.

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 10/7/2019 and will expire on 10/7/2024. The Certificate of Compliance for this action is due no later than 10/6/2024.

Date: October 7, 2019



Thanh Huynh
Senior Attorney

For: Kenneth J. Pogue
Director

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

NOTICE PUBLICATION / REGULATIONS / COMMISSION

EMERGENCY

(See instructions on reverse)

For use by Secretary of State only

STD. 400 (REV. 01-2013)

OAL FILE NUMBERS	NOTICE FILE NUMBER Z-	REGULATORY ACTION NUMBER	EMERGENCY NUMBER 2019-0927-04E
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For use by Office of Administrative Law (OAL) only

ENDORSED - FILED
In the office of the Secretary of State
of the State of California

2019 SEP 27 P 12:58
OFFICE OF
ADMINISTRATIVE LAW

OCT 07 2019
4:11 PM

NOTICE	REGULATIONS
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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 <input type="checkbox"/> Notice re Proposed Regulatory Action <input type="checkbox"/> Other	4. AGENCY CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)
OAL USE ONLY <input type="checkbox"/> Approved as Submitted <input type="checkbox"/> Approved as Modified <input type="checkbox"/> Disapproved/Withdrawn	ACTION ON PROPOSED NOTICE		NOTICE REGISTER NUMBER
			PUBLICATION DATE

B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1a. SUBJECT OF REGULATION(S) Eligibility, Enrollment and Appeal Process for the Individual Exchange	1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S) 2018-0810-04 C
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
	AMEND
	REPEAL
TITLE(S) 10	6408, 6410, 6452, 6454, 6470, 6474, 6496, 6498, 6500, 6502, 6504, 6506, 6602, 6610, and 6622

per agency request 10/7/19 TH

3. TYPE OF FILING

<input type="checkbox"/> Regular Rulemaking (Gov. Code §11346)	<input type="checkbox"/> Certificate of Compliance: The agency officer named below certifies that this agency complied with the provisions of Gov. Code §511346.2-11347.3 either before the emergency regulation was adopted or within the time period required by statute.	<input type="checkbox"/> Emergency Readopt (Gov. Code, §11346.1(h))	<input type="checkbox"/> Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100)
<input type="checkbox"/> Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §511349.3, 11349.4)	<input type="checkbox"/> Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1)	<input type="checkbox"/> File & Print	<input type="checkbox"/> Print Only
<input checked="" type="checkbox"/> Emergency (Gov. Code, §11346.1(b))		<input checked="" type="checkbox"/> Other (Specify) Gov. Code, §100504(a)(6)	

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)

<input type="checkbox"/> Effective January 1, April 1, July 1, or October 1 (Gov. Code §11343.4(a))	<input checked="" type="checkbox"/> Effective on filing with Secretary of State	<input type="checkbox"/> §100 Changes Without Regulatory Effect	<input type="checkbox"/> Effective other (Specify)
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6. CHECK IF THESE REGULATIONS REQUIRE NOTICE TO, OR REVIEW, CONSULTATION, APPROVAL OR CONCURRENCE BY, ANOTHER AGENCY OR ENTITY

<input type="checkbox"/> Department of Finance (Form STD. 399) (SAM §6660)	<input type="checkbox"/> Fair Political Practices Commission	<input type="checkbox"/> State Fire Marshal
<input type="checkbox"/> Other (Specify)		

7. CONTACT PERSON

Faviola Adams	TELEPHONE NUMBER 916-228-8668	FAX NUMBER (Optional)	E-MAIL ADDRESS (Optional) faviola.ramirez-adams@covered.ca.gov
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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 	DATE 7/26/19
TYPED NAME AND TITLE OF SIGNATORY Peter V. Lee, Executive Director	

For use by Office of Administrative Law (OAL) only

ENDORSED APPROVED

OCT 07 2019

Office of Administrative Law

California Code of Regulations

Title 10. Investment

Chapter 12. California Health Benefit Exchange (§ 6400 et seq.)

Article 2. Abbreviations and Definitions

§ 6408. Abbreviations.

The following abbreviations shall apply to this chapter:

ACO	Accountable Care Organization
APTC	Advance Payments of Premium Tax Credit
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalHEERS	California Healthcare Eligibility, Enrollment, and Retention System
CCR	California Code of Regulations
CEC	Certified Enrollment Counselor
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CSR	Cost-Sharing Reduction
DHCS	Department of Health Care Services
DHS	U.S. Department of Homeland Security
EPO	Exclusive Provider Organization
FPL	Federal Poverty Level
FQHC	Federally-Qualified Health Center
HDHP	High Deductible Health Plan
HEDIS	Health Effectiveness Data and Information Set
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191)
HMO	Health Maintenance Organization
HSA	Health Savings Account

IAP	Insurance Affordability Program
IPA	Independent Practice Association
IRC	Internal Revenue Code of 1986
IRS	Internal Revenue Services
LEP	Limited English Proficient
MAGI	Modified Adjusted Gross Income
MEC	Minimum Essential Coverage
MMCP	Medi-Cal Managed Care Plan
PBE	Certified Plan-Based Enroller
PBEE	Certified Plan-Based Enrollment Entity
POS	Point of Service
QDP	Qualified Dental Plan
QHP	Qualified Health Plan
SHOP	Small Business Health Options Program
SSA	Social Security Administration
SSN	Social Security Number
TIN	Taxpayer Identification Number
USC	United States Code

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100501, 100502, and 100503, Government Code; 45 CFR Sections 155.20 and 155.300.

§ 6410. Definitions.

As used in this chapter, the following terms shall mean:

“Advance Payments of Premium Tax Credit” (APTC) means payment of the tax credits authorized by Section 36B of IRC (26 USC § 36B) and implementing regulations, which are provided on an advance basis to an eligible individual enrolled in a QHP through an Exchange in accordance with Section 1412 of the Affordable Care Act.

“Affordable Care Act” (ACA) means the federal Patient Protection and Affordable Care Act of 2010 (Pub.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Pub.L. 111-152), and any amendments to, or regulations or guidance issued under, those acts, as defined in Government Code 100501(e).

“Annual Open Enrollment Period” means the period each year during which a qualified individual may enroll or change coverage in a QHP through the Exchange, as specified in Section 6502 of Article 5 of this chapter, Section 1399.849(c) of the Health and Safety Code, and Section 10965.3(c) of the Insurance Code.

“Applicable Children's Health Insurance Program (CHIP) MAGI-based Income Standard” means the applicable income standard as defined at 42 CFR Section 457.310(b)(1) (November 30, 2016), hereby incorporated by reference, as applied under the State plan adopted in accordance with title XXI of the Social Security Act, or waiver of such plan and as certified by the State CHIP Agency in accordance with 42 CFR Section 457.348(d) (November 30, 2016), hereby incorporated by reference, for determining eligibility for child health assistance and enrollment in a separate child health program.

“Applicable Medi-Cal Modified Adjusted Gross Income (MAGI)-based Income Standard” means the same standard as “applicable modified adjusted gross income standard,” as defined in 42 CFR Section 435.911(b) (November 30, 2016), hereby incorporated by reference, and as specified in Sections 14005.60 and 14005.64 of the Welfare and Institutions Code.

“Applicant” means:

(a) An individual who is seeking eligibility for coverage for himself or herself through an application submitted to the Exchange (excluding those individuals seeking eligibility for an

exemption from the shared responsibility payment) or transmitted to the Exchange by an agency administering an insurance affordability program for at least one of the following:

(1) Enrollment in a QHP through the Exchange; or

(2) Medi-Cal and CHIP.

(b) For SHOP (CCSB):

(1) An employer who is seeking eligibility to purchase coverage through the SHOP Exchange but is not seeking to enroll in that coverage for himself or herself.

(2) An employer, employee, or former employee seeking eligibility for enrollment in a QHP through the SHOP for himself or herself, and, if the qualified employer offers dependent coverage through the SHOP, seeking eligibility to enroll his or her dependents in a QHP through the SHOP.

“Application Filer” means an applicant; an adult who is in the applicant's household, as defined in 42 CFR Section 435.603(f) (November 30, 2016), hereby incorporated by reference, or family, as defined in 26 USC Section 36B(d) and 26 CFR Section 1.36B-1(d) (December 19, 2016), hereby incorporated by reference; an authorized representative; or if the applicant is a minor or incapacitated, someone acting responsibly for an applicant; excluding those individuals seeking eligibility for an exemption from the shared responsibility payment.

“Authorized Representative” means any person or entity that has been designated, in writing, by the applicant to act on his/her behalf or individuals who have appropriate power of attorney or legal conservatorship.

“Benefit Year” means a calendar year for which a health plan provides coverage for health benefits.

“Board” means the executive board that governs the California Health Benefit Exchange, established by Government Code Section 100500.

“California Health Benefit Exchange” or the “Exchange” means the entity established pursuant to Government Code Section 100500. The Exchange also does business as and may be referred to as “Covered California.”

“California Healthcare Eligibility, Enrollment, and Retention System” (CalHEERS) means the California Healthcare Eligibility, Enrollment, and Retention System, created pursuant to Government Code Sections 100502 and 100503, as well as 42 USC Section 18031, to enable enrollees and prospective enrollees of QHPs to obtain standardized comparative information on the QHPs as well as apply for eligibility, enrollment, and reenrollment in the Exchange.

“Cancellation of Enrollment” means specific type of termination action that ends a qualified individual's enrollment on or before the coverage effective date resulting in enrollment through the Exchange never having been effective with the QHP.

“Captive Agent” means an insurance agent who is currently licensed in good standing by the California Department of Insurance to sell, solicit, and negotiate health insurance coverage and has a current and exclusive appointment with a single Issuer and may receive compensation on a salary or commission basis as an agent only from that Issuer.

“Carrier” means either a private health insurer holding a valid outstanding certificate of authority from the Insurance Commissioner or a health care service plan, as defined under subdivision (f) of Section 1345 of the Health and Safety Code, licensed by the Department of Managed Health Care.

“Catastrophic Plan” means a health plan described in Section 1302(e) of the Affordable Care Act, Section 1367.008(c)(1) of the Health and Safety Code, and Section 10112.295(c)(1) of the Insurance Code.

“Certified Enrollment Counselor” (CEC) means an individual as defined in Section 6650 of Article 8 of this chapter.

“Certified Insurance Agent” means an agent as defined in Section 6800 of Article 10 of this chapter.

“Certified Plan-Based Enroller” (PBE) means an individual who provides Enrollment Assistance to Consumers, as defined in Section 6700 of Article 9 of this chapter, in the Individual Exchange through a Certified Plan-Based Enroller Program. Such an individual may be:

- (a) A Captive Agent of a QHP issuer; or
- (b) An Issuer Application Assister as defined in 45 CFR Section 155.20 December 22, 2016), hereby incorporated by reference, provided that the issuer application assister is not employed or contracted by a PBEE to sell, solicit, or negotiate health insurance coverage licensed by the California Department of Insurance.

“Certified Plan-Based Enroller Program” (PBE Program) means the Program whereby a PBEE may provide Enrollment Assistance to Consumers in the Individual Exchange in a manner considered to be through the Exchange.

“Certified Plan-Based Enrollment Entity” (PBEE) means a QHP Issuer registered through the Exchange to provide Enrollment Assistance, as defined in Section 6700 of Article 9 of this chapter, to Consumers, as defined in Section 6700 of Article 9 of this chapter, in the Individual Exchange through a Certified Plan-Based Enroller Program sponsored by the Entity. A PBEE

shall be registered by the Exchange only if it meets all of the training and certification requirements specified in Section 6706 of Article 9 of this chapter.

“Child” means a person as defined in Sections 1357.500(a) and 1399.845(a) of the Health and Safety Code and in Section 10753(d) of the Insurance Code.

“Cost-share” or “Cost-sharing” means any expenditure required by or on behalf of an enrollee with respect to receipt of Essential Health Benefits; such term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance-billing amounts for non-network providers, if applicable, and spending for non-covered services.

“Cost-Sharing Reduction” (CSR) means reductions in cost-sharing for an eligible individual enrolled in a silver level plan in the Exchange or for an individual who is an Indian enrolled in a QHP in the Exchange.

“Day” means a calendar day unless a business day is specified.

“Dental Exclusive Provider Organization” (DEPO) means a managed care plan where services are covered if provided through doctors, specialists, and hospitals in the plan's network (except in an emergency).

“Dental Health Maintenance Organization” (DHMO) means a type of dental plan product that delivers dental services by requiring assignment to a primary dental care provider who is paid a capitated fee for providing all required dental services to the enrollee unless specialty care is needed. DHMOs require referral to specialty dental providers. These products do not include coverage of services provided by dental care providers outside the dental plan network.

“Dental Preferred Provider Organization” (DPPO) means a type of dental plan product that delivers dental services to members through a network of contracted dental care providers and includes limited coverage of out-of-network services.

“Dependent” means:

(a) In the Individual Exchange:

(1) For purposes of eligibility determination for APTC and CSR, a dependent as defined in Section 152 of IRC (26 USC § 152) and the regulations thereunder. For purposes of eligibility determinations for enrollment in a QHP without requesting APTC or CSR, “dependent” also includes domestic partners.

(2) For purposes of enrollment in a QHP, including enrollment during a special enrollment period specified in Section 6504 of Article 5 of this chapter, a dependent as defined in Section 1399.845(b) of the Health and Safety Code and in Section 10753(e) of the Insurance Code, referring to the spouse or registered domestic partner, or child until attainment of age 26 (as defined in subdivisions (n) and (o) of Section 599.500 of Title 2 of the CCR) unless the child is disabled (as defined in subdivision (p) of Section 599.500 of Title 2 of the CCR and as specified in Section 1373(d) of the Health and Safety Code), of a qualified individual or enrollee.

(b) In the SHOP Exchange, a dependent as defined in Section 1357.500(b) of the Health and Safety Code and in Section 10753(e) of the Insurance Code and also includes a non-registered domestic partner who meets the requirements established by the qualified employer for non-registered domestic partners and who is approved by the QHP issuer for coverage in the SHOP Exchange.

“Domestic Partner” means:

(a) For purposes of the Individual Exchange, a person as defined in Sections 297 and 299.2 of the Family Code.

(b) For purposes of the SHOP, a person who has established a domestic partnership as described in Sections 297 and 299.2 of the Family Code and also includes a person that has not

established a domestic partnership pursuant to Sections 297 and 299.2 of the Family Code, but who meets the requirements established by his or her employer for non-registered domestic partners and who is approved by the QHP issuer for coverage in the SHOP Exchange.

“Eligible Employee” means an employee as defined in Section 1357.500(c) of the Health and Safety Code and in Section 10753(f) of the Insurance Code.

“Eligible Employer-Sponsored Plan” means a plan as defined in Section 5000A(f)(2) of IRC (26 USC § 5000A(f)(2)).

“Employee” means an individual as defined in Section 2791 of the Public Health Service Act (42 USC § 300gg-91).

“Employer” means a person as defined in Section 2791 of the Public Health Service Act (42 USC § 300gg-91), except that such term includes employers with one or more employees. All persons treated as a single employer under subsection (b), (c), or (m) of Section 414 of IRC (26 USC § 414) are treated as one employer.

“Employer Contributions” means any financial contributions towards an employer sponsored health plan, or other eligible employer-sponsored benefit made by the employer including those made by salary reduction agreement that is excluded from gross income.

“Enrollee” means a person who is enrolled in a QHP. It also means the dependent of a qualified employee enrolled in a QHP through the SHOP, and any other person who is enrolled in a QHP through the SHOP, consistent with applicable law and the terms of the group health plan. If at least one employee enrolls in a QHP through the SHOP, “enrollee” also means a business owner enrolled in a QHP through the SHOP, or the dependent of a business owner enrolled in a QHP through the SHOP.

“Essential Community Providers” means providers that serve predominantly low-income, medically underserved individuals, as defined in 45 CFR Section 156.235 (December 22, 2016), hereby incorporated by reference.

“Essential Health Benefits” means the benefits listed in 42 USC Section 18022, Health and Safety Code Section 1367.005, and Insurance Code Section 10112.27.

“Exchange Service Area” means the entire geographic area of the State of California.

“Exclusive Provider Organization” (EPO) means a health insurance issuer's or carrier's insurance policy that limits coverage to health care services provided by a network of providers who are contracted with the issuer or carrier.

“Executive Director” means the Executive Director of the Exchange.

“Federal Poverty Level” (FPL) means the most recently published federal poverty level, updated periodically in the Federal Register by the Secretary of Health and Human Services pursuant to 42 USC Section 9902(2), as of the first day of the annual open enrollment period for coverage in a QHP through the Exchange, as specified in Section 6502 of Article 5 of this chapter.

“Full-time employee” means a permanent employee with a normal workweek of an average of 30 hours per week over the course of a month.

“Geographic Service Area” or “Service Area” means an area as defined in Section 1345(k) of the Health and Safety Code.

“Group Contribution Rule” means the requirement that a qualified employer pays a specified percentage or fixed dollar amount of the premiums for coverage of eligible employees.

“Group Dental Plan” means a plan certified by the Exchange for offer in the small group marketplace that provides the pediatric dental benefits required in Health and Safety Code

Section 1367.005(a)(5) and Insurance Code Section 10122.27(a)(5), and also includes coverage for certain benefits for adult enrollees and is available to qualified employers meeting the requirements of Section 6522(a)(5)(B) of Article 6 of this chapter.

“Group Participation Rate” means the minimum percentage of all eligible individuals or employees of an employer that must be enrolled.

“Health Insurance Coverage” means coverage as defined in 45 CFR Section 144.103 (December 22, 2016), hereby incorporated by reference.

“Health Insurance Issuer” has the same meaning as the term is defined in 42 USC Section 300gg-91 and 45 CFR Section 144.103. Also referred to as “Carrier,” “Health Issuer,” or “Issuer.”

“Health Maintenance Organization” (HMO) means an organization as defined in Section 1373.10(b) of the Health and Safety Code.

“Health plan” means a plan as defined in Section 1301(b)(1) of the Affordable Care Act (42 USC § 18021(b)(1)).

“High deductible health plan” (HDHP) has the same meaning as the term is defined in Section 223(c)(2) of IRC (26 USC § 223(c)(2)).

“Incarcerated” means confined, after the disposition of charges, in a jail, prison, or similar penal institution or correctional facility.

“Indian” has the same meaning as the term is defined in Section 4(d) of the Indian Self-Determination and Education Assistance Act (Pub.L. 93-638; 25 USC § 450b(d)), referring to a person who is a member of an Indian tribe.

“Indian Tribe” has the same meaning as the term is defined in Section 4(e) of the Indian Self-Determination and Education Assistance Act (Pub.L. 93-638; 25 USC § 450b(e)), referring

to any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 USC § 1601 et seq.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

“Individual and Small Business Health Options Program (SHOP) Exchange” means the program administered by the Exchange pursuant to the Government Code Section 100500 et seq. (2010 Cal. Stat. 655 (AB 1602) and 2010 Cal. Stat. 659 (SB 900)), 42 USC Section 18031(b) of the federal Patient Protection Affordable Care Act and other applicable laws to furnish and to pay for health insurance plans for Qualified Individuals and Qualified Employers.

“Individual Market” means a market as defined in Section 1304(a)(2) of the Affordable Care Act (42 USC § 18024 (a)(2)).

“Initial Open Enrollment Period” means the initial period in which Qualified Individuals may enroll in QHPs, from October 1, 2013 to March 31, 2014, subject to 45 CFR Section 155.410(b), (April 18, 2017), hereby incorporated by reference, Section 1399.849(c)(1) of the Health and Safety Code, and Section 10965.3(c)(1) of the Insurance Code.

“Insurance Affordability Program” (IAP) means a program that is one of the following:

(a) The Medi-Cal program under title XIX of the federal Social Security Act (42 USC § 1396 et seq.).

(b) The State children's health insurance program (CHIP) under title XXI of the federal Social Security Act (42 USC § 1397aa et seq.).

(c) A program that makes available to qualified individuals coverage in a QHP through the Exchange with APTC established under Section 36B of the Internal Revenue Code (26 USC § 36B).

(d) A program that makes available coverage in a QHP through the Exchange with CSR established under section 1402 of the Affordable Care Act.

“Lawfully Present” means a non-citizen individual as defined in 45 CFR Section 152.2 (August 30, 2012), hereby incorporated by reference.

“Level of Coverage” or “Metal Tier” means one of four standardized actuarial values and the catastrophic level of coverage as defined in 42 USC Section 18022(d) and (e), Sections 1367.008(a) and (c)(1) and 1367.009 of the Health and Safety Code, and Sections 10112.295(a) and (c)(1) and 10112.297 of the Insurance Code.

~~“Medi-Cal Managed Care Plan” (MMCP) means a person or an entity contracting with DHCS to provide health care services to enrolled Medi-Cal beneficiaries, as specified in Section 14093.07(b) of the Welfare and Institutions Code.~~

“Minimum Essential Coverage” (MEC) means coverage as defined in Section 5000A(f) of IRC (26 USC § 5000A(f)) and in 26 CFR Section 1.36B-2(c) (July 26, 2017), hereby incorporated by reference.

“Minimum Value” when used to describe coverage in an eligible employer-sponsored plan, means that the plan meets the requirements with respect to coverage of the total allowed costs of benefits set forth in Section 36B(c)(2)(C)(ii) of IRC (26 USC § 36B(c)(2)(C)(ii)) and in 26 CFR Section 1.36B-2(c)(3)(vi).

“Modified Adjusted Gross Income” (MAGI) means income as defined in Section 36B(d)(2)(B) of IRC (26 USC § 36B(d)(2)(B)) and in 26 CFR Section 1.36B-1(e)(2).

“Modified Adjusted Gross Income (MAGI)-based income” means income as defined in 42 CFR Section 435.603(e) for purposes of determining eligibility for Medi-Cal.

“Non-citizen” means an individual who is not a citizen or national of the United States, in accordance with Section 101(a)(3) of the Immigration and Nationality Act (8 USC § 1101(a)(3)).

“Part-time Eligible Employee” means a permanent employee who works at least 20 hours per week but not more than 29 hours per week and who otherwise meets the definition of an eligible employee except for the number of hours worked.

“Plan Year” means:

(a) For purposes of the Individual Exchange, a calendar year.

(b) For purposes of the SHOP, a period of time as defined in 45 CFR Section 144.103.

“Plain Language” means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, uses simple vocabulary, avoids excessive acronyms and technical language, and follows other best practices of plain language writing.

“Preferred Provider Organization” (PPO) means a health insurance issuer's or carrier's insurance policy that offers covered health care services provided by a network of providers who are contracted with the issuer or carrier (“in-network”) and providers who are not part of the provider network (“out-of-network”).

“Premium Payment Due Date” means a date no earlier than the fourth remaining business day of the month prior to the month in which coverage becomes effective.

“QHP Issuer” means a licensed health care service plan or insurer who has been selected and certified by the Exchange to be offered to Qualified Individuals and Qualified Employers purchasing health insurance coverage through the Exchange.

“Qualified Dental Plan” (QDP) means a plan providing limited scope dental benefits as defined in 26 USC Section 9832(c)(2)(A), including the pediatric dental benefits meeting the requirements of 42 USC Section 18022(b)(1)(J).

“Qualified Employee” means any employee or former employee of a qualified employer who has been offered health insurance coverage by such qualified employer through the SHOP for himself or herself and, if the qualified employer offers dependent coverage through the SHOP, for his or her dependents.

“Qualified Employer” has the same meaning as the term is defined in 42 USC Section 8032(f)(2) and 45 CFR Section 155.710 (February 27, 2015), hereby incorporated by reference.

“Qualified Health Plan” (QHP) has the same meaning as the term is defined in Patient Protection and Affordable Care Act Section 1301 (42 USC § 18021) and Government Code Section 100501(g) and includes QDP.

“Qualified Individual” means an individual who meets the requirements of 42 USC Section 18032(f)(1) and 45 CFR Section 155.305(a) (April 17, 2018), hereby incorporated by reference.

“Qualifying Coverage in an Eligible Employer-Sponsored Plan” means coverage in an eligible employer-sponsored plan that meets the affordability and minimum value standards specified in Section 36B(c)(2)(C) of IRC (26 USC § 36B(c)(2)(C)) and in 26 CFR Section 1.36B-2(c)(3).

“Rating Region” means the geographic regions for purposes of rating defined in Sections 1357.512(a)(2)(A) and 1399.855(a)(2)(A) of the Health and Safety Code and Sections 10753.14(a)(2)(A) and 10965.9(a)(2)(A) of the Insurance Code.

“Reasonably Compatible” has the same meaning as the term is defined in 45 CFR Section 155.300(d) (July 15, 2013), hereby incorporated by reference, providing that information the Exchange 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, including the amount of APTC or the category of CSR.

“Reconciliation” means coordination of premium tax credit with advance payments of premium tax credit (APTC), as described in Section 36B(f) of IRC (26 USC § 36B(f)) and 26 CFR Section 1.36B-4(a) (July 26, 2017), hereby incorporated by reference.

“Reference Plan” means a QHP that is selected by an employer, which is used by the SHOP to determine the contribution amount the employer will be making towards its employees' premiums.

“Reinstatement of Enrollment” means a correction of an erroneous termination of coverage or cancellation of enrollment action and results in restoration of an enrollment with no break in coverage.

“Self-only Coverage” means a health care service plan contract or an insurance policy that covers one individual.

“SHOP” means a Small Business Health Options Program operated by the Exchange through which a qualified employer can provide its employees and their dependents with access to one or more QHPs. The SHOP also does business as and may be referred to as “Covered California for Small Business” or “CCSB.”

“SHOP Application Filer” means an applicant, an authorized representative, an agent or broker of the employer, or an employer filing for its employees where not prohibited by law.

“SHOP Plan Year” means a 12-month period beginning with the Qualified Employer's effective date of coverage.

“Small Employer” means an employer as defined in Section 1357.500(k)(3) of the Health and Safety Code and in Section 10753(q)(3) of the Insurance Code.

“Small Group Market” means a group market as defined in Section 1304(a)(3) of the Affordable Care Act.

“Special Enrollment Period” means a period during which a qualified individual or enrollee who experiences certain qualifying events, as specified in Section 6504(a) of Article 5 of this chapter, Section 1399.849(d) of the Health and Safety Code, and Section 10965.3(d) of the Insurance Code, may enroll in, or change enrollment in, a QHP through the Exchange outside of the initial and annual open enrollment periods.

“State Health Insurance Regulator” or “State Health Insurance Regulators” means the Department of Managed Health Care and the Department of Insurance.

“Tax Filer” means an individual, or a married couple, who attests that he, she, or the couple expects:

- (a) To file an income tax return for the benefit year, in accordance with Sections 6011 and 6012 of IRC (26 USC §§ 6011, 6012), and implementing regulations;
- (b) If married (within the meaning of 26 CFR Section 1.7703-1 (January 16, 1997), hereby incorporated by reference), to file a joint tax return for the benefit year, unless the tax filer satisfies one of the exceptions specified in 26 CFR Section 1.36B-2(b)(2)(ii)-(v);
- (c) That no other taxpayer will be able to claim him, her, or the couple as a tax dependent for the benefit year; and

(d) That he, she, or the couple expects to claim a personal exemption deduction under Section 151 of IRC (26 USC § 151) on his or her tax return for one or more applicants, who may or may not include himself or herself and his or her spouse.

“Termination of Coverage” or “Termination of Enrollment” means an action taken after a coverage effective date that ends an enrollee's coverage through the Exchange for a date after the original coverage effective date, resulting in a period during which the individual was enrolled in coverage through the Exchange.

“TIN” means an identification number used by the IRS in the administration of tax laws. It is issued either by the SSA or by the IRS. TINs include SSN, Employer Identification Number (EIN), Individual Taxpayer Identification Number (ITIN), Taxpayer Identification Number for Pending U.S. Adoptions (ATIN), and Preparer Taxpayer Identification Number (PTIN). A SSN is issued by the SSA whereas all other TINs are issued by the IRS.

Note: Authority cited: Sections 100502, 100503, 100504, and 100505, Government Code.
Reference: Sections 100501, 100502, 100503, and 100505, Government Code; Section 10753, Insurance Code; 42 CFR Sections 435.603, 435.911, 457.310 and 457.348; 45 CFR Sections 144.103, 152.2, 155.20, 155.300, 155.305, 155.410, 155.415, 155.430, 155.700, 155.705, 155.710, 155.725, 156.235 and 156.1230; 26 CFR Sections 1.36B-1, 1.36B-2, 1.36B-4, 1.5000A-1(d) and 1.7703-1.

Article 4. General Provisions

§ 6452. Accessibility and Readability Standards.

(a) All applications, including the single, streamlined application described in Section 6470 of Article 5 of this chapter, forms, notices, and correspondence provided to the applicants and enrollees by the Exchange and QHP issuers shall conform to the standards outlined in subdivisions (b), (c), and (d) of this section. This section shall not be interpreted as limiting the application of existing State laws and regulations regarding accessibility and readability standards, if any, that apply to the QHP issuers.

(b) Information shall be provided to applicants and enrollees in plain language, as defined in Section 6410 of Article 2 of this chapter, and to the extent administratively feasible, all written correspondence shall also:

(1) Be formatted and written in such a way that it can be understood at the ninth-grade level and, if possible, at the sixth-grade level;

(2) Be in print no smaller than 12 point-equivalent font; and

(3) Contain no language that minimizes or contradicts the information being provided.

(c) Information shall be provided to applicants and enrollees in a manner that is accessible and timely to:

(1) Individuals living with disabilities through the provision of auxiliary aids and services at no cost to the individual, including accessible Web sites, in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

(2) Individuals who are limited English proficient through the provision of language services at no cost to the individual, including:

- (A) Oral interpretation, including telephonic interpreter services in at least 150 languages;
- (B) Written translations; and
- (C) Taglines in non-English languages indicating the availability of language services in at least the top 15 languages spoken by the limited English proficient population in California.

(3) Inform individuals of the availability of the services described in subdivisions (c)(1) and (2) of this section and how to access such services.

(d) Information shall be provided to applicants and enrollees in a manner that is compliant with the nondiscrimination requirements under Section 11135 of the Government Code and Section 1557 of the ACA (42 USC § 18116) and its implementing regulations under Part 92 of Title 45 of Code of Federal Regulations (45 CFR Part 92) (May 18, 2016), hereby incorporated by reference, ~~which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities.~~

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 42 USC Section 18116; 45 CFR Part 92; 5 CFR Section 155.205.

§ 6454. General Standards for Exchange Notices.

(a) Any notice of action required to be sent by the Exchange to individuals or employers shall be written and include:

- (1) An explanation of the action reflected in the notice, including the effective date of the action;
- (2) Any factual bases upon which the decision was made;
- (3) Citations to, or identification of, the relevant regulations supporting the action;
- (4) Contact information for available customer service resources, including local legal aid and welfare rights offices; and

(5) An explanation of appeal rights, as specified in Section 6604(b) of Article 7 of this chapter.

(b) All Exchange notices shall conform to the accessibility and readability standards specified in Section 6452.

(c) The Exchange shall, at least annually, reevaluate the appropriateness and usability of all notices.

(d) The individual market Exchange shall provide required notices either through standard mail, or if an individual elects, electronically, provided that the requirements for electronic notices in 42 CFR Section 435.918 (July 15, 2017), hereby incorporated by reference, are met, except that the individual market Exchange shall not be required to implement the process specified in 42 CFR Section 435.918(b)(1) for eligibility determinations for enrollment in a QHP through the Exchange and IAPs that are effective before January 1, 2015.

(e) Unless otherwise required by federal or State law, the SHOP shall provide required notices electronically, or if an employer or employee elects, through standard mail. If notices are provided electronically, the SHOP shall comply with the requirements for electronic notices in 42 CFR Section 435.918(b)(2) through (5) for the employer or employee.

(f) In the event that the individual market Exchange, or SHOP is unable to send select required notices electronically due to technical limitations, it may instead send these notices through standard mail, even if an election has been made to receive such notices electronically.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 42 CFR 435.918 and 45 CFR Section 155.230.

Article 5. Application, Eligibility, and Enrollment Process for the Individual Exchange

§ 6470. Application.

(a) A single, streamlined application shall be used to determine eligibility and to collect information necessary for:

- (1) Enrollment in a QHP,
- (2) Medi-Cal,
- (3) CHIP,
- (4) APTC, and
- (5) CSR.

(b) To apply for any of the programs listed in subdivision (a) of this section, an applicant or an application filer, or their Certified Enrollment Counselor (CEC), Certified Application Counselor (CAC), as defined in Section 6850(a)(2) of Article 11 of this chapter, Medi-Cal Managed Care Plan Enroller, as defined in Section 6900(a)(3) of Article 12 of this chapter, Plan-Based Enroller (PBE), or Certified Insurance Agent shall submit all information, documentation, and declarations required on the single, streamlined application, as specified in subdivisions (c), (d), and (e) of this section, and shall sign and date the application. CECs, CACs, Medi-Cal Managed Care Plan Enrollers, PBEs, and Certified Insurance Agents must obtain the applicant's consent before signing and submitting the application. Before a CEC, PBE, or Certified Insurance Agent can submit the application, they shall comply with the requirements specified in subdivision (h) of this section.

(c) An applicant or an application filer shall provide the following information on the single, streamlined application:

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

- (2) The applicant's date of birth.
- (3) The home and mailing address, if different from home address, for the applicant and for all persons for whom application is being made, 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.
- (4) The applicant's SSN, if one has been issued to the applicant, and if the applicant does not have a SSN, the reason for not having one. The applicant's TIN, if one has been issued to the applicant in lieu of a SSN.
- (5) The applicant's gender.
- (6) The applicant's marital status.
- (7) The applicant's status as a U.S. Citizen or U.S. National, or the applicant's immigration status, if the applicant is not a U.S. Citizen or U.S. National and attests to having satisfactory immigration status or lawful presence status.
- (8) The applicant's employment status.
- (9) Sources, amount, and payment frequency of the applicant's taxable gross income as well as the following three types of tax-exempt income: foreign earned income, income from interest that the applicant receives or accrues during the taxable year, and income from Social Security benefits, ~~but excluding income from child support payments, veteran's payments, and Supplemental Security Income/State Supplementary Payment (SSI/SSP).~~ If self-employed, the type of work, and the amount of net income. Exclude income from child support payments, veteran's payments, and Supplemental Security Income/State Supplementary Payment (SSI/SSP).

(10) The applicant's expected annual household income from all sources, as specified in subdivision (c)(9) of this section.

(11) The number of members in the applicant's household.

(12) Whether the applicant is an American Indian or Alaska Native, and if so:

(A) Name and state of the tribe;

(B) Whether the applicant has ever received a service from the Indian Health Service, a tribal health program, or an urban Indian health program or through a referral from one of these programs, and if not, whether he or she is eligible to receive such services; and

(C) The sources, amount, and frequency of payment for any income the applicant receives due to his or her status as American Indian or Alaska Native, if applicable.

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

(14) Whether the applicant currently has MEC through an employer-sponsored plan, as defined in Section 5000A(f)(2) of IRC (26 USC § 5000A(f)(2)), and if so, the amount of monthly premium the applicant pays for self-only coverage through his or her employer and whether it meets the minimum value standards, as defined in Section 6410 of Article 2 of this chapter.

(15) Whether the applicant currently has MEC through any government sponsored programs, as defined in Section 5000A(f)(1)(A) of IRC (26 USC § 5000A(f)(1)(A)).

(16) Whether the applicant has any physical, mental, emotional, or developmental disability.

(17) Whether the applicant needs help with long-term care or home and community-based services.

- (18) Pregnancy status, if applicable, and if pregnant, the number of babies expected and the expected delivery date.
- (19) The applicant's preferred written and spoken language.
- (20) The applicant's preferred method of communication, including telephone, mail, and email, and if email has been selected, the applicant's email address.
- (21) Whether the applicant is 18 to 20 years old and a full-time student.
- (22) Whether the applicant is 18 to 26 years old and lived in foster care on his or her 18th birthday or whether the applicant was in foster care and enrolled in Medicaid in any state.
- (23) Whether the applicant is temporarily living out of state.
- (24) Whether the applicant intends to file a federal income tax return for the year for which he or she is requesting coverage, and if so, the applicant's expected tax-filing status.
- (25) 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(c)(1) through (13) of this section, except for the information in subdivision (c)(7) regarding citizenship, status as a national, or immigration status.
- (26) For each person for whom the applicant is applying for coverage:
- (A) The relationship of each person to the applicant; and
 - (B) The information in subdivision(c)(1) through (25) of this section.
- (27) Whether the applicant designates an authorized representative, and if so, 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 application, eligibility and enrollment, and appeals process, if applicable.

(d) An applicant or an application filer shall declare under penalty of perjury that he or she:

(1) Understood all questions on the application, and gave true and correct answers to the best of his or her personal knowledge, and where he or she did not know the answer personally, he or she made every effort to confirm the answer with someone who did know the answer;

(2) Knows that if he or she does not tell the truth on the application, there may be a civil or criminal penalty for perjury that may include up to four years in jail, pursuant to California Penal Code Section 126;

(3) Knows that the information provided on the application shall be only used for purposes of eligibility determination and enrollment for all the individuals listed on the application who are requesting coverage, and that the Exchange shall keep such information private in accordance with the applicable federal and State privacy and security laws;

(4) Agrees to notify the Exchange if any information in the application for any person applying for health insurance changes, which may affect the person's eligibility; and

(5) Understands that if he or she received premium tax credits for health coverage through the Exchange during the previous benefit year, he or she must have filed or will file a federal tax return for that benefit year; ~~and~~

(e) An applicant or an application filer shall indicate that he or she understands his or her rights and responsibilities by providing, on the single, streamlined application, a declaration that:

(1) The information the applicant provides on the application is true and accurate to the best of his or her knowledge, and that the applicant may be subject to a penalty if he or she does not tell the truth.

(2) The applicant understands that the information he or she provides on the application shall be only used for purposes of eligibility determination and enrollment for all the individuals listed on the application.

(3) The applicant understands that information he or she provides on the application shall be kept private in accordance with the applicable federal and State privacy and security laws and that the Exchange shares such information with other federal and State agencies in order to verify the information and to make an eligibility determination for the applicant and for any other person(s) for whom he or she has requested coverage on the application, if applicable.

(4) The applicant understands that to be eligible for Medi-Cal, the applicant is required to apply for other income or benefits to which he or she, or any member(s) of his or her household, is entitled, including: pensions, government benefits, retirement income, veterans' benefits, annuities, disability benefits, Social Security benefits (also called OASDI or Old Age, Survivors, and Disability Insurance), and unemployment benefits. However, such income or benefits do not include public assistance benefits, such as CalWORKs or CalFresh.

(5) The applicant understands that he or she is required to report any changes to the information provided on the application to the Exchange.

(6) The applicant 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, marital status, veteran's status, or disability.

(7) The applicant understands that, except for purposes of applying for Medi-Cal, the applicant and any other person(s) the applicant has included in the application shall not be confined, after the disposition of charges (judgment), in a jail, prison, or similar penal institution or correctional facility.

(8) If the applicant or any other persons the applicant has included in the application qualifies for Medi-Cal, the applicant understands that if Medi-Cal pays for a medical expense, any money the applicant, or any other person(s) included in the application, receives from other health insurance, legal settlements, or judgments covering that medical expense shall be used to repay Medi-Cal until the medical expense is paid in full.

(9) The applicant understands that he or she shall have the right to appeal any action or inaction taken by the Exchange and shall receive assistance from the Exchange regarding how to file an appeal.

(10) The applicant understands that any changes in his or her information or information of any member(s) in the applicant's household may affect the eligibility of other members of the household.

(f) If an applicant or an application filer selects a health insurance plan or a QDP, as applicable, in the application:

(1) He or she shall provide:

(A) The name of the applicant and each family member who is enrolling in a plan; and

(B) The plan information, including plan name, metal tier, metal number, coverage level and plan type, as applicable; and

(2) All individuals, responsible parties, or authorized representatives, age 18 or older who are selecting and enrolling into a health insurance plan shall agree to, sign, and date the agreement for binding arbitration, as set forth below:

(A) For an Exchange Plan: "I understand that every participating health plan has its own rules for resolving disputes or claims, including, but not limited to, any claim asserted by me, my enrolled dependents, heirs, or authorized representatives against a health plan, any contracted

health care providers, administrators, or other associated parties, about the membership in the health plan, the coverage for, or the delivery of, services or items, medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), or premises liability. I understand that, if I select a health plan that requires binding arbitration to resolve disputes, I accept, and agree to, the use of binding arbitration to resolve disputes or claims (except for Small Claims Court cases and claims that cannot be subject to binding arbitration under governing law) and give up my right to a jury trial and cannot have the dispute decided in court, except as applicable law provides for judicial review of arbitration proceedings. I understand that the full arbitration provision for each participating health plan, if they have one, is in the health plan's coverage document, which is available online at CoveredCA.com for my review, or, I can call Covered California at 1-800-300-1506 (TTY: 1-888-889-4500) for more information."

(B) For a Kaiser Medi-Cal health plan: "I have read the plan description. I understand that Kaiser requires the use of binding neutral arbitration to resolve certain disputes. This includes disputes about whether the right medical treatment was provided (called medical malpractice) and other disputes relating to benefits or the delivery of services, including whether any medical services provided were unnecessary or unauthorized, or were improperly, negligently, or incompetently rendered. If I pick Kaiser as my Medi-Cal health plan, I give up my constitutional right to a jury or court trial for those certain disputes. I also agree to use binding neutral arbitration to resolve those certain disputes. I do not give up my right to a state hearing of any issue, which is subject to the state hearing process."

(g) The Exchange may request on the application that the applicant authorizes the Exchange to obtain updated tax return information, as described in Section 6498(b), for up to

five years to conduct an annual redetermination, provided that the Exchange inform the applicant that he or she shall have the option to:

- (1) Decline to authorize the Exchange to obtain updated tax return information; or
- (2) Discontinue, change, or renew his or her authorization at any time.

(h) If a CEC, PBE, or a Certified Insurance Agent assists an applicant or an application filer in completing the application, he or she shall:

- (1) Provide his or her name;
- (2) Provide his or her certification or license number, if applicable;
- (3) Provide the name of the entity with which he or she is affiliated;
- (4) Certify that he or she assisted the applicant complete the application free of charge;
- (5) Certify that he or she provided true and correct answers to all questions on the application to the best of his or her knowledge and explained to the applicant in plain language, and the applicant understood, the risk of providing inaccurate or false information; and
- (6) Date and sign the application.

(i) To apply for an eligibility determination and enrollment in a QHP through the Exchange without requesting any IAPs, an applicant or an application filer shall, for the applicant and each person for whom the applicant is applying for coverage, submit all information, documentation, and declarations required in:

- (1) Subdivision (c)(1), (2), (3), (4), (5), (6), (7), (12)(A), (19), (20), (26)(A), and (27) of this section;
- (2) Subdivision (d) of this section;
- (3) Subdivision (e)(1), (2), (3), (5), (6), (7), (9), and (10) of this section;
- (4) Subdivision (f)(1) and (2)(A) of this section; and

(5) Subdivision (h) of this section.

(j) An applicant or an application filer may file an application through one of the following channels:

(1) The Exchange's Internet Web site;

(2) Telephone;

(3) Facsimile;

(4) Mail; or

(5) In person.

(k) The Exchange shall accept an application from an applicant or application filer and make an eligibility determination for an applicant seeking an eligibility determination at any point in time during the year.

(l) If an applicant or application filer submits an incomplete application that does not include sufficient information for the Exchange to conduct an eligibility determination for enrollment in a QHP through the Exchange or for an IAP, if applicable, the Exchange shall proceed as follows:

(1) The Exchange shall 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) The Exchange shall provide the applicant with a period of 90 calendar days from the date of the notice described in subdivision (l)(1) of this section, or until the end of an enrollment period, whichever date is earlier, to provide the information needed to complete the application to the Exchange. In no event, shall this period be less than 30 calendar days from the date of the notice described in subdivision (l)(1) of this section.

(3) During the period specified in subdivision (1)(2) of this section, the Exchange shall not proceed with the applicant's eligibility determination or provide APTC or CSR, unless the applicant or application filer has provided sufficient information to determine the applicant's eligibility for enrollment in a QHP through the Exchange, in which case the Exchange shall make such a determination for enrollment in a QHP.

(4) If the applicant fails to provide the requested information within the period specified in subdivision (1)(2) of this section, the Exchange shall provide notice of denial to the applicant, including notice of appeals rights in accordance with Section 6604 of Article 7 of this chapter.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR Sections 155.310, 155.405.

§ 6474. Eligibility Requirements for APTC and CSR.

(a) Those individuals who apply to receive APTC and CSR shall meet the eligibility requirements of this section in addition to the requirements of Section 6472, except for the requirements specified in Section 6472(f) relating to enrollment in a catastrophic QHP.

(b) For purposes of this section, household income has the meaning given the term in Section 36B(d)(2) of IRC (26 USC § 36B(d)(2)) and in 26 CFR Section 1.36B-1(e).

(c) Eligibility for APTC.

(1) A tax filer shall be eligible for APTC if:

(A) Tax filer is expected to have a household income of greater than or equal to 100 percent but not more than 400 percent of the FPL for the benefit year for which coverage is requested; and

(B) One or more applicants for whom the tax filer expects to claim a personal exemption deduction on his or her tax return for the benefit year, including the tax filer and his or her spouse:

1. Meets the requirements for eligibility for enrollment in a QHP that is not a catastrophic plan through the Exchange, as specified in subdivisions (a) through (e) of Section 6472;

2. Is not eligible for MEC, with the exception of coverage in the individual market, in accordance with section 36B(c)(2)(B) and (C) of IRC (26 USC § 36B(c)(2)(B), (C)) and 26 CFR Section 1.36B-2(a)(2) and (c); and

3. Is enrolled in a QHP that is neither a catastrophic plan nor a QDP through the Exchange.

(2) A non-citizen tax filer who is lawfully present and ineligible for Medi-Cal by reason of immigration status, and is not otherwise eligible for APTC under subdivision (c)(1) of this section, shall be eligible for APTC if:

(A) Tax filer meets the requirements specified in subdivision (c)(1) of this section, except for subdivision (c)(1)(A);

(B) Tax filer is expected to have a household income of less than 100 percent of the FPL for the benefit year for which coverage is requested; and

(C) One or more applicants for whom the tax filer expects to claim a personal exemption deduction on his or her tax return for the benefit year, including the tax filer and his or her spouse, is a non-citizen who is lawfully present and ineligible for Medi-Cal by reason of immigration status, in accordance with section 36B(c)(1)(B) of IRC (26 USC § 36B(c)(1)(B)) and in 26 CFR Section 1.36B-2(b)(5).

(3) Tax filer shall not be eligible for APTC if:

(A) HHS notifies the Exchange, as part of the verification process described in Sections 6482 through 6486, that APTC was made on behalf of the tax filer (or either spouse if the tax filer is a married couple) for a year for which tax data would be used to verify household income and family size in accordance with Section 6482(d) and (e);

(B) Tax filer (or his or her spouse) did not comply with the requirement to file an income tax return for that year, as required by Sections 6011 and 6012 of IRC (26 USC §§ 6011, 6012) and implementing regulations; and

(C) The APTC was not reconciled for that period.

(4) The APTC amount shall be calculated in accordance with section 36B of IRC (26 USC § 36B) and 26 CFR Section 1.36B-3 (July 26, 2017), hereby incorporated by reference.

(5) An application filer shall provide the SSN of a tax filer who is not an applicant only if an applicant attests that the tax filer has a SSN and filed a tax return for the year for which tax data would be used to verify household income and family size.

(6) Notwithstanding the requirements in subdivision (c)(3) of this section, the Exchange shall not deny eligibility for APTC under that subdivision unless the Exchange first sends direct notification to the tax filer, consistent with the standards set forth in Section 6454, that his or her eligibility will be discontinued as a result of the tax filer's failure to comply with the tax filing requirement specified under subdivision (c)(3) of this section.

(d) Eligibility for CSR.

(1) An applicant shall be eligible for CSR if he or she:

(A) Meets the eligibility requirements for enrollment in a QHP through the Exchange, as specified in Section 6472;

(B) Meets the requirements for APTC, as specified in subdivision (c) of this section; and

(C) Is expected to have a household income that does not exceed 250 percent of the FPL for the benefit year for which coverage is requested.

(2) The Exchange may only provide CSR to an enrollee who is not an Indian if he or she is enrolled through the Exchange in a silver-level QHP, as defined by section 1302(d)(1)(B) of the Affordable Care Act.

(3) The Exchange shall use the following eligibility categories for CSR when making eligibility determinations under this section:

(A) An individual who is expected to have a household income:

1. Greater than or equal to 100 percent of the FPL and less than or equal to 150 percent of the FPL for the benefit year for which coverage is requested, or

2. Less than 100 percent of the FPL for the benefit year for which coverage is requested, if he or she is eligible for APTC under subdivision (c)(2) of this section;

(B) An individual is expected to have a household income greater than 150 percent of the FPL and less than or equal to 200 percent of the FPL for the benefit year for which coverage is requested; or

(C) An individual who is expected to have a household income greater than 200 percent of the FPL and less than or equal to 250 percent of the FPL for the benefit year for which coverage is requested.

(4) If an enrollment in a QHP under a single family policy covers two or more individuals, the Exchange shall deem the individuals under such family policy to be collectively eligible only for the last category of eligibility listed below for which all the individuals covered by the family policy would be eligible:

(A) Not eligible for CSR;

(B) Section 6494(a)(3) and (4) - Special CSR eligibility standards and process for Indians regardless of income;

(C) Subdivision (d)(3)(C) of this section;

(D) Subdivision (d)(3)(B) of this section;

(E) Subdivision (d)(3)(A) of this section; or

(F) Section 6494(a)(1) and (2) - Special CSR eligibility standards and process for Indians with household incomes under 300 percent of FPL.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 26 CFR Sections 1.36B-1, 1.36B-2, 1.36B-3; 45 CFR Section 155.305.

§ 6496. Eligibility Redetermination During a Benefit Year.

(a) The Exchange shall redetermine the eligibility of an enrollee in a QHP through the Exchange during the benefit year if it receives and verifies new information reported by an enrollee or identifies updated information through the data matching described in subdivision (g) of this section.

(b) Except as specified in subdivisions (c) and (d) of this section, an enrollee, or an application filer on behalf of the enrollee, shall report any change of circumstances with respect to the eligibility standards specified in Sections 6472 and 6474 within 30 days of such change. Changes shall be reported through any of the channels available for the submission of an application, as described in Section 6470(j).

(c) An enrollee who has not requested an eligibility determination for IAPs shall not be required to report changes that affect eligibility for IAPs.

(d) An enrollee who experiences a change in income that does not impact the amount of the enrollee's APTC or the level of CSR for which he or she is eligible shall not be required to report such a change.

(e) The Exchange shall verify any reported changes in accordance with the process specified in Sections 6478 through 6492 before using such information in an eligibility determination.

(f) The Exchange shall provide electronic notifications to an enrollee who has elected to receive electronic notifications, unless he or she has declined to receive notifications under this subdivision, regarding the requirements for reporting changes, as specified in subdivision (b) of this section, and the enrollee's opportunity not to report any changes described in subdivision (d) of this section.

(g) The Exchange shall examine available data sources ~~on a semiannual basis~~ at least once during the benefit year to identify the following changes of circumstances:

(1) Death; and

(2) For an enrollee on whose behalf APTC or CSR are being provided, eligibility determination for or enrollment in Medicare, Medi-Cal, or CHIP;

~~(A) Eligibility determination for or enrollment in Medicare, Medi-Cal, or CHIP; and~~

~~(B) Failure of the tax filer for the enrollee's household or the tax filer's spouse to comply with the requirement to file an income tax return for the last benefit year during which he or she received APTC, as required by Sections 6011 and 6012 of IRC (26 USC §§ 6011, 6012) and implementing regulations, and to reconcile the APTC received for that period.~~

(h) If the Exchange verifies updated information reported by an enrollee, the Exchange shall:

(1) Redetermine the enrollee's eligibility in accordance with the standards specified in Sections 6472 and 6474;

(2) Notify the enrollee regarding the determination, in accordance with the requirements specified in Section 6476(h); and

(3) Notify the enrollee's employer, as applicable, in accordance with the requirements specified in Section 6476(i).

(i) If the Exchange identifies updated information through the semiannual data matching specified in subdivision (g) of this section regarding death or, eligibility for or enrollment in Medicare, Medi-Cal, or CHIP, or failure to meet the requirements of Section 6474(e)(3), in accordance with subdivision (g) of this section, the Exchange shall:

(1) Notify the enrollee regarding the updated information, as well as the enrollee's projected eligibility determination after considering such information;

(2) Allow an enrollee 30 days from the date of the notice described in subdivision (i)(1) to notify the Exchange that such information is inaccurate;

(3) If the enrollee responds contesting the updated information, proceed in accordance with Section 6492; and

(4) If the enrollee does not respond within the 30-day period specified in subdivision (i)(2), proceed in accordance with subdivisions (h)(1) and (2) of this section.

(j) The Exchange shall implement changes resulting from an appeal decision, on the date specified in the appeal decision or consistent with the effective dates specified in Section 6618(c)(1) of Article 7 of this chapter.

(k) Except as specified in subdivision (l) of this section, the Exchange shall:

(1) Implement changes on the first day of the month following the month of the notice of eligibility redetermination described in subdivision (h)(2) of this section when the date of such notice is on or between the first and fifteenth day of the month; and

(2) Implement changes on the first day of the second month following the month of the notice of eligibility redetermination described in subdivision (h)(2) of this section when the date of such notice is on or between the 16th and last day of the month.

(l) The Exchange shall implement a change associated with the events described in Section 6504(h)(1), (2), (3), (4), (5), and (6) on the coverage effective dates described in Section 6504(h)(1), (2), (3), (4), (5), and (6) respectively.

(m) When an eligibility redetermination in accordance with this section results in a change in the amount of APTC for the benefit year, the Exchange shall recalculate the amount of APTC in such a manner as to:

(1) Account for any APTC already made on behalf of the tax filer for the benefit year for which information is available to the Exchange, such that the recalculated APTC amount is projected to result in total APTC for the benefit year that correspond to the tax filer's total projected premium tax credit for the benefit year, calculated in accordance with Section 36B of IRC (26 USC § 36B) and 26 CFR Section 1.36B-3; and

(2) If the recalculated APTC amount is less than zero, set the APTC provided on the tax filer's behalf to zero.

(n) In the case of a redetermination that results in a change in CSR, the Exchange shall determine an individual eligible for the category of CSR that corresponds to his or her expected annual household income for the benefit year, subject to the special rule for family policies set forth in Section 6474(d)(4).

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 26 CFR 1.36B-3; 45 CFR Section 155.330.

§ 6498. Annual Eligibility Redetermination.

(a) Except as specified in subdivisions (d) and (m) of this section, the Exchange shall redetermine the eligibility of an enrollee or a qualified individual on an annual basis.

(b) To conduct an annual redetermination for an enrollee or a qualified individual who requested an eligibility determination for IAPs in accordance with Section 6476(b), the Exchange shall have on file an active authorization from the qualified individual to obtain updated tax return information described in subdivision (c) of this section. This authorization shall be for a period of no more than five years based on a single authorization, provided that an individual may:

(1) Decline to authorize the Exchange to obtain updated tax return information; or

(2) Authorize the Exchange to obtain updated tax return information for fewer than five years; and

(3) Discontinue, change, or renew his or her authorization at any time.

(c) If an enrollee or a qualified individual requested an eligibility determination for IAPs on the original application, in accordance with Section 6476(b), and the Exchange has an active authorization to obtain tax data as a part of the annual redetermination process, the Exchange shall request:

(1) Updated tax return information ~~through HHS~~, as described in Section 6482(b);

(2) Data regarding Social Security benefits ~~through HHS~~, as described in Section 6482(b); and

(3) Income data from available State data sources, such as Franchise Tax Board and Employment Development Department.

(d) If an enrollee or a qualified individual requested an eligibility determination for IAPs on the original application, in accordance with Section 6476(b), and the Exchange does not have an active authorization to obtain tax data as a part of the annual redetermination process, the Exchange:

(1) Shall notify the individual at least 30 days prior to the date of the notice of annual redetermination described in subdivision (f) of this section. This notice shall include an explanation that unless the individual authorizes the Exchange to obtain his or her updated tax return information to redetermine the individual's eligibility for coverage effective January first of the following benefit year:

(A) His or her APTC and CSR will end on the last day of the current benefit year; and

(B) His or her coverage in a QHP will be renewed for the following benefit year, in accordance with the process specified in subdivision (l) of this section, without APTC and CSR;

(2) Shall redetermine the enrollee's or the qualified individual's eligibility only for enrollment in a QHP; and

(3) Shall not proceed with a redetermination for IAPs until such authorization has been obtained or the qualified individual continues his or her request for an eligibility determination for IAPs in accordance with Section 6476(b).

(e) The Exchange shall provide an annual redetermination notice in accordance with the following process:

(1) For all qualified individuals who are not currently enrolled in a QHP through the Exchange, the notice shall include at least:

(A) A description of the annual redetermination and renewal process;

(B) The requirement to report changes to information affecting eligibility, as specified in Section 6496(b);

(C) The instructions on how to report a change to the Exchange; and

(D) The open enrollment date and the last day on which a plan selection may be made for coverage effective on January first of the following benefit year to avoid any coverage gap.

(2) For all current enrollees who have requested an eligibility determination for IAPs for the current benefit year, the notice shall include at least:

(A) All the information specified in subdivision (e)(1) of this section;

(B) An explanation that the premiums for the QHPs and the amount of APTC and the level of CSR, for which he or she may be eligible, may change each benefit year;

(C) A description of the reconciliation process for APTC;

(D) Data used in the enrollee's most recent eligibility determination and the amount of monthly APTC and the level of CSR the enrollee has been receiving during the current benefit year;

(E) An explanation that if he or she does not complete the Exchange's renewal process to obtain an updated eligibility determination by December 15 of the current benefit year for coverage effective January first of the following benefit year, the Exchange will redetermine the enrollee's eligibility and renew the enrollee's coverage for the following benefit year, in accordance with the process specified in subdivision (l) of this section, using information obtained from the electronic data sources specified in subdivision (c) of this section and the most recent information the enrollee provided to the Exchange; and

(F) An explanation that in order to obtain the most accurate eligibility determination from the Exchange, including APTC that may increase or decrease, or to change his or her QHP, the enrollee shall contact the Exchange and update his or her information, as required under subdivision (g) of this section, or make a plan selection by the end of the open enrollment period.

(3) For all current enrollees who have not requested an eligibility determination for IAPs for the current benefit year, the notice shall include at least:

(A) All the information specified in subdivision (e)(1) of this section;

(B) An explanation that the premiums for the QHPs may change each benefit year;

(C) An explanation that unless the enrollee completes the Exchange's renewal process to obtain an updated eligibility determination by December 15 of the current benefit year for coverage effective January first of the following benefit year, the Exchange will redetermine the enrollee's eligibility and renew the enrollee's coverage for the following benefit year, in accordance with the process specified in subdivision (l) of this section, using the most recent information the enrollee provided to the Exchange; and

(D) An explanation that in order to obtain the most accurate eligibility determination from the Exchange or to change his or her QHP, the enrollee shall contact the Exchange and update his or her information, as required under subdivision (g) of this section or make a plan selection by the end of the open enrollment period.

(f) For eligibility redeterminations under this section, the Exchange shall provide the annual redetermination notice, as specified in subdivision (e) of this section, and the notice of annual open enrollment period, as specified in Section 6502(e), through a single, coordinated notice.

(g) Except as specified in Section 6496(c), an enrollee, a qualified individual, or an application filer on behalf of the qualified individual, shall report to the Exchange any changes with respect to the eligibility standards specified in Sections 6472 and 6474 within 30 days of such change, using any of the channels available for the submission of an application, as described in Section 6470(j).

(h) The Exchange shall verify any information reported by an enrollee or a qualified individual under subdivision (g) of this section using the processes specified in Sections 6478 through 6492, prior to using such information to determine eligibility.

(i) A current enrollee or a qualified individual who has selected a QHP through the Exchange during the current benefit year but his or her coverage has not been effectuated, shall complete the Exchange's renewal process, as specified in subdivision (i)(1) of this section, within 30 days from the date of the notice described in subdivision (e) of this section.

(1) To complete the Exchange's renewal process, the enrollee or the qualified individual shall:

(A) Check his or her application information for accuracy, and make any changes to the application information, as required under subdivision (g) of this section;

(B) If any changes made, provide a reason for the change and the date of the change;

(C) Declare under penalty of perjury that he or she:

1. Understands that he or she must report any changes to the information on the application that may affect his or her eligibility for enrollment in a QHP or for APTC and CSR, if applicable, to the Exchange within 30 days of such change;

2. Understands that if he or she, or someone in his or her household, has health insurance through Medi-Cal, he or she must report any changes to information on the application to his or her county social services office within 10 days of such change;
3. Provided true answers and correct information to the best of his or her knowledge during the renewal process;
4. Knows that if he or she does not tell the truth, there may be a civil or criminal penalty for perjury that may include up to four years in jail, pursuant to California Penal Code Section 126;
5. Understands that if he or she received premium tax credits for health coverage through the Exchange during the previous benefit year, he or she must have filed or will file a federal tax return for that benefit year;
6. Understands that, unless he or she has already provided authorization for the Exchange to use electronic data sources to obtain his or her updated tax return information to conduct the annual redetermination for all IAPs, except for Medi-Cal or CHIP, he or she is giving the Exchange authorization to obtain updated tax return information to provide him or her with an updated eligibility determination for the following benefit year; and
7. Understands that he or she must provide his or her electronic signature and PIN to complete the Exchange's renewal process for enrollment in a QHP or for APTC and CSR, if applicable;
 - (D) Provide his or her electronic signature and PIN;
 - (E) Submit any reported changes and the signed declarations, through any of the channels specified in subdivision (i)(2) of this section, to obtain an updated eligibility determination for the following benefit year; and

(F) If eligible to enroll in a QHP, make a plan selection for the following benefit year.

(2) The enrollee or the qualified individual may complete the renewal process described in subdivision (i)(1) of this section through the channels available for the submission of an application, as described in Section 6470(j), except mail and facsimile.

(3) The enrollee or the qualified individual may seek assistance from a CEC, PBE, or a Certified Insurance Agent to complete the renewal process described in subdivision (i)(1) of this section.

(4) If the enrollee or the qualified individual does not complete the Exchange's renewal process specified in subdivision (i)(1) of this section within 30 days from the date of the notice described in subdivision (e) of this section, the Exchange shall proceed in accordance with the process specified in subdivision (j) of this section.

(j) After the 30-day period specified in subdivision (i) of this section has elapsed, the Exchange shall:

(1) Redetermine the enrollee's or the qualified individual's eligibility in accordance with the standards specified in Sections 6472 and 6474 using information obtained from the electronic data sources specified in subdivision (c) of this section and the most recent information the individual provided to the Exchange and renew the enrollee's coverage for the following benefit year, in accordance with the process specified in subdivision (l) of this section;

(2) Notify the enrollee or the qualified individual in accordance with the requirements specified in Section 6476(h); and

(3) If applicable, notify the enrollee's or the qualified individual's employer, in accordance with the requirements specified in Section 6476(i).

(k) A redetermination under this section shall be effective on the first day of the coverage year following the year in which the Exchange provided the notice in subdivision (e) of this section, or in accordance with the rules specified in Section 6496(j) through (l), whichever is later.

(l) If an enrollee remains eligible for enrollment in a QHP through the Exchange upon annual redetermination, and he or she does not terminate coverage, including termination of coverage in connection with voluntarily selecting a different QHP in accordance with Section 6506, the Exchange shall proceed in accordance with the following process:

(1) The enrollee shall be enrolled in the same QHP as the enrollee's current QHP, unless the enrollee's current QHP is not available.

(2) If the enrollee is not eligible for the same level of CSR as the enrollee's current level of CSR, he or she shall be enrolled in a silver-tier QHP offered by the same QHP issuer at the CSR level for which the enrollee is eligible. If the enrollee is not eligible for any level of CSR, he or she shall be enrolled in a standard silver-tier QHP offered by the same QHP issuer without CSR.

(3) If the enrollee's current QHP is not available and the current QHP is a HDHP as defined in Section 6410, the enrollee shall be enrolled in the lowest cost HDHP offered by the same QHP issuer at the same metal tier, as determined by the Exchange on a case-by-case basis. If there is no HDHP available, the enrollee shall be enrolled in the lowest cost QHP that is not a HDHP offered by the same QHP issuer at the same metal tier, as determined by the Exchange on a case-by-case basis.

(4) If the enrollee's current QHP is not available and the current QHP is not a HDHP, the enrollee shall be enrolled in the lowest cost QHP that is not a HDHP offered by the same QHP issuer at the same metal tier, as determined by the Exchange on a case-by-case basis.

(5) If the enrollee who is currently enrolled in a catastrophic QHP attains the age of 30 before the beginning of the following benefit year, the enrollee shall be enrolled in the lowest cost bronze-tier QHP that is not a HDHP offered by the same QHP issuer.

(6) If the issuer of the QHP in which the enrollee is currently enrolled is no longer available, the enrollee shall be enrolled in the lowest cost QHP that is most similar to the enrollee's current QHP offered by a different QHP issuer that is available to the enrollee through the Exchange at the same metal tier and in accordance with the same hierarchy specified in subdivision (1)(3) through (5) of this section, as determined by the Exchange on a case-by-case basis.

(7) If the enrollee who is currently enrolled in a QHP as a dependent attains the age of 26 before the beginning of the following benefit year, the enrollee shall be enrolled in his or her own individual QHP through the Exchange in accordance with the process specified in subdivision (1)(1) through (6) of this section.

(8) Notwithstanding the process specified in subdivision (1)(1) through (7) of this section, a federally-recognized American Indian or Alaska Native enrollee who is currently enrolled in a zero cost sharing QHP shall be enrolled in the lowest cost zero cost sharing QHP that offers the same benefits and provider networks offered by the same QHP issuer. If the issuer of the QHP in which the enrollee is currently enrolled is no longer available, the enrollee shall be enrolled in the lowest cost zero cost sharing QHP offered by a different QHP issuer that is available to the enrollee through the Exchange, as determined by the Exchange on a case-by-case basis.

(m) The Exchange shall not redetermine a qualified individual's eligibility in accordance with this section if the qualified individual's eligibility was redetermined under this section during the prior year, and the qualified individual was not enrolled in a QHP through the Exchange at the time of such redetermination, and has not enrolled in a QHP through the Exchange since such redetermination.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR Section 155.335.

§ 6502. Initial and Annual Open Enrollment Periods.

(a) A qualified individual may enroll in a QHP, or an enrollee may change QHPs, only during the initial open enrollment period, as specified in subdivision (b) of this section, the annual open enrollment period, as specified in subdivision (d) of this section, or a special enrollment period, as described in Section 6504, for which the qualified individual has been determined eligible.

(b) The initial open enrollment period begins October 1, 2013 and extends through March 31, 2014.

(c) Regular coverage effective dates for initial open enrollment period for a QHP selection received by the Exchange from a qualified individual:

(1) On or before December 23, 2013, shall be January 1, 2014;

(2) On or Between December 24, 2013 and December 31, 2013, shall be February 1, 2014;

(3) On or Between the first and fifteenth day of the month for any month between January 2014 and March 31, 2014, shall be the first day of the following month; and

(4) ~~On or B~~etween the sixteenth and last day of the month for any month between January 2014 and March 31, 2014, shall be the first day of the second following month.

(d) Annual open enrollment period for benefit years beginning:

(1) On January 1, 2015 begins on November 15, 2014 and extends through February 15, 2015.

(2) On or after January 1, 2016 through December 31, 2018 begins on November 1, of the calendar year preceding the benefit year, and extends through January 31 of the benefit year.

(3) On or after January 1, 2019 begins on November 1 and extends through December 15 of the calendar year preceding the benefit year.

(e) Beginning 2014, the Exchange shall provide a written annual open enrollment notification to each enrollee no earlier than the first day of the month before the open enrollment period begins and no later than the first day of the open enrollment period.

(f) Coverage effective dates are as follows:

(1) For the benefit year beginning on January 1, 2015, for a QHP selection received by the Exchange from a qualified individual:

(A) From November 15, 2014 through December 15, 2014, shall be January 1, 2015;

(B) From December 16, 2014 through January 15, 2015, shall be February 1, 2015; and

(C) From January 16, 2015 through February 15, 2015, shall be March 1, 2015.

(2) For the benefit year beginning on or after January 1, 2016, for a QHP selection received by the Exchange from a qualified individual:

(A) On or before December 15 of the calendar year preceding the benefit year, shall be January 1;

(B) From December 16 of the calendar year preceding the benefit year through January 15 of the benefit year, shall be February 1; and

(C) From January 16 through January 31 of the benefit year, shall be March 1.

(g) A qualified individual's coverage shall be effectuated in accordance with the coverage effective dates specified in subdivisions (c) and (f) of this section if:

(1) The individual makes his or her initial premium payment, reduced by the APTC amount he or she is determined eligible for by the Exchange, by the premium payment due date, as defined in Section 6410 of Article 2 of this chapter; and

(2) The applicable QHP issuer receives such payment on or before such due date.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR Section 155.410.

§ 6504. Special Enrollment Periods.

(a) A qualified individual may enroll in a QHP, or an enrollee may change from one QHP to another, during special enrollment periods only if one of the following triggering events occurs:

(1) A qualified individual or his or her dependent either:

(A) Loses MEC, as specified in subdivision (b) of this section. The date of the loss of MEC shall be:

1. Except as provided in subdivision (a)(1)(A)2 of this section, the last day the qualified individual or his or her dependent would have coverage under his or her previous plan or coverage;

2. If loss of MEC occurs due to a QHP decertification, the date of the notice of decertification as described in 45 CFR Section 155.1080(e)(2) (May 29, 2012), hereby incorporated by reference;

(B) Is enrolled in any non-calendar year group health plan or individual health insurance coverage, including both grandfathered and non-grandfathered health plans that expired or will expire, even if the qualified individual or his or her dependent has the option to renew such coverage. The date of the loss of coverage shall be the last day of the plan or policy year;

(C) Loses Medi-Cal coverage for pregnancy-related services, as described under Section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (42 USC 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX)) and Section 14005.18 of the Welfare and Institutions Code or loses access to healthcare services through coverage provided to a pregnant woman's unborn child, based on the definition of a child in 42 CFR Section 457.10, (November 30, 2016), hereby incorporated by reference. The date of the loss of coverage shall be the last day the consumer would have pregnancy-related coverage or access to healthcare services through unborn child coverage; or

(D) Loses Medi-Cal coverage for medically needy, as described under Section 1902(a)(10)(C) of the Social Security Act and Section 14005.21 of the Welfare and Institutions Code, only once per calendar year. The date of the loss of coverage shall be the last day the consumer would have medically needy coverage.

(2) A qualified individual gains a dependent or becomes a dependent through marriage or entry into domestic partnership, birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order.

(3) An enrollee loses a dependent or is no longer considered a dependent through divorce, legal separation, or dissolution of domestic partnership as defined by State law in the State in which the divorce, legal separation, or dissolution of domestic partnership occurs, or if the enrollee, or his or her dependent, dies.

(4) A qualified individual, or his or her dependent, becomes newly eligible for enrollment in a QHP through the Exchange because he or she newly meets the requirements specified in Section 6472(c) or (d).

(5) A qualified individual's, or his or her dependent's, enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of the Exchange or HHS, its instrumentalities, a QHP issuer, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities. For purposes of this provision, misconduct, as determined by the Exchange, includes the failure to comply with applicable standards under this title, or other applicable Federal or State laws.

(6) An enrollee, or his or her dependent, adequately demonstrates to the Exchange, as determined by the Exchange on a case-by-case basis, that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.

(7) An enrollee, or his or her dependent enrolled in the same QHP, is determined newly eligible or ineligible for APTC or has a change in eligibility for CSR.

(8) A qualified individual, or his or her dependent, who is enrolled in an eligible employer-sponsored plan is determined newly eligible for APTC because such individual is ineligible for qualifying coverage in an eligible employer-sponsored plan in accordance with 26 CFR Section 1.36B-2(c)(3), including as a result of his or her employer discontinuing or

changing available coverage within the next 60 days, provided that such individual is allowed to terminate existing coverage.

(9) A qualified individual or enrollee, or his or her dependent, gains access to new QHPs as a result of a permanent move.

(10) A qualified individual who:

(A) Gains or maintains status as an Indian, as defined in Section 6410 of Article 2 of this chapter, may enroll in a QHP or change from one QHP to another one time per month; or

(B) Is or becomes a dependent of an Indian, as defined in Section 6410 of Article 2 of this chapter, and is enrolled or is enrolling in a QHP through the Exchange on the same application as the Indian, may change from one QHP to another one time per month, at the same time as the Indian.

(11) A qualified individual or enrollee, or his or her dependent, demonstrates to the Exchange, in accordance with guidelines issued by HHS and as determined by the Exchange on a case-by-case basis, that the individual meets other exceptional circumstances. Such circumstances include, but are not limited to, the following:

(A) If an individual receives a certificate of exemption for hardship based on the eligibility standards described in 45 CFR Section 155.605(gd)(1) (April 17, 2018), hereby incorporated by reference, or the eligibility standards described in Section 6914 of Article 13 of this chapter for a month or months during the coverage year, and based on the circumstances of the hardship attested to, he or she is no longer eligible for a hardship exemption within a coverage year but outside of an open enrollment period described in Section 6502, the individual and his or her dependents shall be eligible for a special enrollment period if otherwise eligible for enrollment in a QHP.

(B) If an individual with a certificate of exemption reports a change regarding the eligibility standards for an exemption, as required under 45 CFR Section 155.620(b); (July 1, 2013), hereby incorporated by reference, or under Section 6920 of Article 13 of this chapter and the change resulting from a redetermination is implemented, the certificate provided for the month in which the redetermination occurs, and for prior months, remains effective. If the individual is no longer eligible for an exemption, the individual and his or her dependents shall be eligible for a special enrollment period if otherwise eligible for enrollment in a QHP.

(C) If an enrollee provides satisfactory documentary evidence to verify his or her eligibility for an IAP or enrollment in a QHP through the Exchange within 30 days following his or her termination of Exchange enrollment due to a failure to verify such status within the 95-day period specified in Section 6492(a)(2)(B), the enrollee shall be eligible for a special enrollment period if otherwise eligible for enrollment in a QHP.

(D) If a qualified individual or enrollee experiences a fire, flood, or other natural or human-caused disaster that results in the declaration of state of emergency in California, the individual shall be eligible for a special enrollment period if otherwise eligible for enrollment in a QHP.

(12) A qualified individual or enrollee is a victim of domestic abuse or spousal abandonment, as specified in 26 CFR Section 1.36B-2 (b)(2)(ii) through (v), or a dependent or unmarried victim within a household, is enrolled in MEC, and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment. A dependent of a victim of domestic abuse or spousal abandonment who is on the same application as the victim may enroll in coverage at the same time as the victim.

(13) A qualified individual, or his or her dependent:

(A) Applies for coverage on the Exchange during the annual open enrollment period or due to a qualifying event, is assessed by the Exchange as potentially eligible for Medi-Cal or CHIP, and is determined ineligible for Medi-Cal or CHIP by the State Medi-Cal or CHIP agency either after open enrollment period has ended or more than 60 days after the qualifying event; or

(B) Applies for coverage at the State Medi-Cal or CHIP agency during the annual open enrollment period, and is determined ineligible for Medi-Cal or CHIP after open enrollment period has ended.

(14) The qualified individual or enrollee, or his or her dependent, adequately demonstrates to the Exchange, as determined by the Exchange on a case-by-case basis, that a material error related to plan benefits, service area, or premium influenced the qualified individual's or enrollee's decision to purchase a QHP through the Exchange.

(15) The qualified individual, enrollee, or dependent newly gains access to an individual coverage HRA, as defined in 45 CFR Section 146.123(b) (August 19, 2019), hereby incorporated by reference, or is newly provided a qualified small employer health reimbursement arrangement (QSEHRA), as defined in Section 9831(d)(2) of the Internal Revenue Code. The date of this triggering event shall be the first day on which coverage for the qualified individual, enrollee, or dependent under the individual coverage HRA can take effect, or the first day on which coverage under the QSEHRA takes effect. An individual, enrollee, or dependent shall qualify for this special enrollment period regardless of whether they were previously offered or enrolled in an individual coverage HRA or previously provided a QSEHRA, so long as the individual, enrollee, or dependent is not enrolled in the individual coverage HRA or covered by the QSEHRA on the day immediately prior to the triggering event.

(16) Any other triggering events listed in the Health and Safety Code Section 1399.849(d)(1) and the Insurance Code Section 10965.3(d)(1).

(b) Loss of MEC, as specified in subdivision (a)(1)(A) of this section, includes:

(1) Loss of eligibility for coverage, including but not limited to:

(A) Loss of eligibility for coverage as a result of:

1. Legal separation,
2. Divorce or dissolution of domestic partnership,
3. Cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan),
4. Death of an employee,
5. Termination of employment,
6. Reduction in the number of hours of employment, or
7. Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;

(B) Loss of eligibility for coverage through Medicare, Medi-Cal, or other government-sponsored health care programs, other than programs specified as not MEC under 26 CFR Section 1.5000A-2(b)(1)(ii) (November 26, 2014), hereby incorporated by reference;

(C) In the case of coverage offered through an HMO or similar program in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);

(D) In the case of coverage offered through an HMO or similar program in the group market that does not provide benefits to individuals who no longer reside, live, or work in a

service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual; and

(E) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

(2) Termination of employer contributions toward the employee's or dependent's coverage that is not COBRA continuation coverage, including contributions by any current or former employer that was contributing to coverage for the employee or dependent; and

(3) Exhaustion of COBRA continuation coverage, meaning that such coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan. An individual is considered to have exhausted COBRA continuation coverage if such coverage ceases:

(A) Due to the failure of the employer or other responsible entity to remit premiums on a timely basis;

(B) When the individual no longer resides, lives, or works in the service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other COBRA continuation coverage available to the individual; or

(C) When the individual incurs a claim that would meet or exceed a lifetime limit on all benefits and there is no other COBRA continuation coverage available to the individual.

(c) Loss of coverage, as specified in subdivision (a)(1) of this section, does not include voluntary termination of coverage or loss due to:

(1) Failure to pay premiums on a timely basis, including COBRA premiums prior to exhaustion of COBRA coverage; or

(2) Termination of coverage for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with a plan.

(d) A qualified individual or an enrollee shall attest under penalty of perjury that he or she meets at least one of the triggering events specified in subdivision (a) of this section. The Exchange shall inform the qualified individual or the enrollee that pursuant to 45 CFR Section 155.285, (July 1, 2013), hereby incorporated by reference, HHS may impose civil money penalties of:

(1) Up to \$25,000 on the qualified individual or the enrollee who fails to provide the correct information requested by the Exchange, subject to the exception specified in subdivision (e)(4) of this section, due to his or her negligence or disregard of the federal or State rules or regulations related to the Exchange with negligence and disregard defined as they are in section 6662 of IRC (26 USC § 6662), as follows:

(A) "Negligence" includes any failure to make a reasonable attempt to provide accurate, complete, and comprehensive information; and

(B) "Disregard" includes any careless, reckless, or intentional disregard for any federal or State rules or regulations related to the Exchange; and

(2) Up to \$250,000 on the qualified individual or the enrollee who:

(A) Knowingly and willfully provides false or fraudulent information requested by the Exchange, where knowingly and willfully means intentionally providing information that the person knows to be false or fraudulent; or

(B) Knowingly and willfully uses or discloses information in violation of Section 1411(g) of the Affordable Care Act (42 USC § 18081(g)), where knowingly and willfully means intentionally using or disclosing information in violation of Section 1411(g).

(e) The Exchange shall accept the qualified individual's or the enrollee's attestation provided in accordance with subdivision (d) of this section, subject to the following statistically valid random sampling verification process:

(1) The Exchange may select a statistically valid random sample of the qualified individuals or the enrollees who, in accordance with subdivision (d) of this section, have attested that they met at least one of the triggering events specified in subdivision (a) of this section and request, in writing, that they provide documentation as proof of the triggering event to which they attested or for which they qualify.

(2) The qualified individual or the enrollee shall provide the requested document(s) within 30 days from the date of the Exchange's written request, as specified in subdivision (e)(1) of this section, to the Exchange for verification. The Exchange may extend this period if the Exchange determines on a case-by-case basis that the qualified individual or the enrollee has demonstrated that he or she has made a good-faith effort but was unable to obtain the requested documentation during the 30-day time period.

(3) Except as specified in subdivision (e)(4) of this section, if the qualified individual or the enrollee fails to submit the requested document(s) by the end of the time period specified in subdivision (e)(2) of this section or the Exchange is unable to verify the provided document(s), the Exchange shall:

(A) Determine the qualified individual or the enrollee ineligible for any special enrollment period;

(B) Notify the qualified individual or the enrollee regarding the determination and his or her appeals rights, in accordance with the requirements specified in Section 6476(h); and

(C) Implement such eligibility determination in accordance with the dates specified in Section 6496(j) and (k), as applicable.

(4) The Exchange shall provide an exception, on a case-by-case basis, to accept a qualified individual's or an enrollee's attestation as to his or her triggering event which cannot otherwise be verified and his or her explanation of circumstances as to why he or she does not have documentation if:

(A) The qualified individual or the enrollee does not have the requested documentation with which to prove a triggering event through the process described in subdivision (e)(1) through (3) of this section because such documentation does not exist or is not reasonably available;

(B) The Exchange is unable to otherwise verify the triggering event for the qualified individual or the enrollee; and

(C) The qualified individual or the enrollee provides the Exchange with a signed written statement of his or her attestation under penalty of perjury as to the triggering event and the explanation of circumstances as to why he or she does not have the documentation.

(5) The sampling described in this subdivision shall not be based on the qualified individual's or the enrollee's claims costs, diagnosis code, or demographic information. For purposes of this subdivision (e)(5), demographic information does not include geographic factors.

(f) Except as provided in subdivision (f)(1), ~~and (2) and (3)~~ of this section, a qualified individual or an enrollee shall have 60 days from the date of a triggering event to select a QHP.

(1) A qualified individual or his or her dependent who loses coverage, as described in subdivision (a)(1) of this section shall have 60 days before and after the date of the loss of coverage to select a QHP.

(2) A qualified individual who is enrolled in an eligible employer-sponsored plan and will lose eligibility for qualifying coverage in an eligible employer-sponsored plan within the next 60 days, as described in subdivision (a)(8) of this section, shall have 60 days before and after the loss of eligibility for qualifying coverage in an eligible employer-sponsored plan to select a QHP.

(3) A qualified individual, enrollee, or his or her dependent who is described in subdivision (a)(15) of this section shall have 60 days before the triggering event to select a QHP, unless the HRA or QSEHRA was not required to provide the notice setting forth its terms to such individual or enrollee at least 90 days before the beginning of the plan year, as specified in 45 CFR Section 146.123(c)(6), 26 CFR Section 54.9802-4(c)(6) (August 19, 2019), hereby incorporated by reference, and 29 CFR Section 2590.702-2(c)(6) (August 19, 2019), hereby incorporated by reference, or Section 9831(d)(4) of the Internal Revenue Code, as applicable, in which case the qualified individual, enrollee, or his or her dependent shall have 60 days before or after the triggering event to select a QHP.

(g) Except as specified in subdivision (h) of this section, regular coverage effective dates for a special enrollment period for a QHP selection received by the Exchange from a qualified individual:

(1) On or Between the first and fifteenth day of any month, shall be the first day of the following month; and

(2) On or Between the sixteenth and last day of any month, shall be the first day of the second following month.

(h) Special coverage effective dates shall apply to the following situations.

(1) In the case of birth, adoption, placement for adoption, or placement in foster care, the coverage shall be effective either:

(A) On the date of birth, adoption, placement for adoption, or placement in foster care;

(B) On the first day of the month following birth, adoption, placement for adoption, or placement in foster care;

(C) On the first day of the month following plan selection; or

(~~D~~) In accordance with the regular coverage effective dates specified in subdivision (g) of this section, at the option of the qualified individual or the enrollee.

(2) In the case of marriage or entry into domestic partnership, the coverage and APTC and CSR, if applicable, shall be effective on the first day of the month following plan selection.

(3) In the case where a qualified individual, or his or her dependent, loses coverage, as described in subdivisions (a)(1) and (a)(8) of this section, the coverage and APTC and CSR, if applicable, shall be effective:

(A) On the first day of the month following the loss of coverage if the plan selection is made on or before the date of the loss of coverage; or

(B) On the first day of the month following plan selection if the plan selection is made after the date of the loss of coverage.

(4) In the case of a qualified individual or enrollee eligible for a special enrollment period described in subdivisions (a)(5), (a)(6), (a)(11), (a)(13), or (a)(14) of this section, the coverage

shall be effective on an appropriate date, including a retroactive date, determined by the Exchange on a case-by-case basis based on the circumstances of the special enrollment period.

(5) In the case of a court order described in subdivision (a)(2) of this section, the coverage shall be effective either:

(A) On the date the court order is effective;

(B) On the first day of the month following plan selection; or

(C) In accordance with the regular coverage effective dates specified in subdivision (g) of this section, at the option of the qualified individual or the enrollee.

(6) If an enrollee or his or her dependent dies, as described in subdivision (a)(3) of this section, the coverage shall be effective on the first day of the month following the plan selection.

(7) If a qualified individual, enrollee, or dependent newly gains access to an individual coverage HRA or is newly provided a QSEHRA, each as described in subdivision (a)(15) of this section, and if the plan selection is made before the day of the triggering event, the coverage shall be effective on the first day of the month following the date of the triggering event or, if the triggering event is on the first day of a month, on the date of the triggering event. If the plan selection is made on or after the day of the triggering event, the coverage shall be effective on the first day of the month following plan selection.

(i) A qualified individual's coverage shall be effectuated in accordance with the coverage effective dates specified in subdivisions (g) and (h) of this section if:

(1) The individual makes his or her initial premium payment, reduced by the APTC amount he or she is determined eligible for by the Exchange, by the premium payment due date, as defined in Section 6410 of Article 2 of this chapter. In cases of retroactive enrollment dates, the initial premium shall consist of the premium due for all months of retroactive coverage

through the first month of coverage following the plan selection date. If only partial premium for less than all months of retroactive coverage is paid, only prospective coverage shall be effectuated, in accordance with the regular coverage effective dates specified in subdivision (g) of this section; and

(2) The applicable QHP issuer receives such payment on or before such due date.

(j) Notwithstanding the standards of this section, APTC and CSR shall adhere to the effective dates specified in subdivisions (j) through (l) of Section 6496.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 26 USC Section 9831(d)(4); 26 CFR Sections 1.36B-2, and 1.5000A-2, and 54.9802-4; 29 CFR Section 2590.702-2; 42 CFR Section 457.10; 45 CFR Sections; 146.123, 155.420, 155.605, 155.620 and 155.1080.

§ 6506. Termination of Coverage in a QHP.

(a) Enrollee-initiated terminations shall be conducted in accordance with the following process:

(1) An enrollee may terminate his or her coverage in a QHP through the Exchange, including as a result of the enrollee obtaining other MEC, by notifying the Exchange or the QHP issuer.

(2) An enrollee may choose to remain enrolled in a QHP at the time of plan selection if he or she becomes eligible for other MEC and the enrollee does not request termination in accordance with subdivision (a)(1) of this section. If the enrollee does not choose to remain enrolled in a QHP in such a situation, the Exchange shall initiate termination of his or her enrollment in the QHP upon completion of the redetermination process specified in Section 6496.

(3) An individual, including an enrollee's authorized representative, shall be permitted to report the death of an enrollee to the Exchange for purposes of initiating termination of the enrollee's coverage in accordance with the following requirements:

(A) The individual shall be at least 18 years old.

(B) If the individual reporting the death is the application filer, the enrollee's authorized representative, or anyone in the household of the deceased who was included in the initial application, he or she shall be permitted to initiate termination of the deceased's coverage.

(C) If the individual reporting the death is not the application filer, the enrollee's authorized representative, or anyone in the household of the deceased who was included in the initial application, he or she shall submit satisfactory documentation of death to the Exchange before he or she can initiate termination of the deceased's coverage. Satisfactory documentation may include a copy of a death certificate, obituary, medical record, power of attorney, proof of executor, or proof of estate. The documentation or an attached cover note shall provide the following information:

1. Full name of the deceased;
2. Date of birth of the deceased;
3. The Exchange application ID or case number (if known) of the deceased;
4. Social Security Number (if known) of the deceased; and
5. Contact information for the person submitting the documentation, including full name, address, and phone number.

(4) The Exchange shall permit an enrollee to retroactively terminate or cancel his or her coverage or enrollment in a QHP if the enrollee demonstrates to the Exchange that:

(A) He or she attempted to terminate his or her coverage or enrollment in a QHP and experienced a technical error that did not allow the enrollee to terminate his or her coverage or enrollment through the Exchange, and requests retroactive termination within 60 days after he or she discovered the technical error;

(B) His or her enrollment in a QHP through the Exchange was unintentional, inadvertent, or erroneous and was the result of the error or misconduct of an officer, employee, or agent of the Exchange or HHS, its instrumentalities, a QHP issuer, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities. Such enrollee must request cancellation within 60 days of discovering the unintentional, inadvertent, or erroneous enrollment. For purposes of this provision, misconduct, as determined by the Exchange, includes the failure to comply with applicable standards under this title, or other applicable Federal or State laws; or

(C) He or she was enrolled in a QHP without his or her knowledge or consent by any third party, including third parties who have no connection with the Exchange, and requests cancellation within 60 days of discovering of the enrollment.

(b) The Exchange may initiate termination of an enrollee's coverage in a QHP, and shall permit a QHP issuer to terminate such coverage, provided that the issuer makes reasonable accommodations for all individuals with disabilities (as defined by the Americans with Disabilities Act) before terminating coverage for such individuals, under the following circumstances:

- (1) The enrollee is no longer eligible for coverage in a QHP through the Exchange;
- (2) The enrollee fails to pay premiums for coverage, as specified in subdivision (c) of this section, and:

(A) The three-month grace period required for individuals receiving APTC specified in subdivision (c)(2) of this section has been exhausted, as described in subdivision (c)(4) of this section; or

(B) Any other grace period required under the State law not described in subdivision (b)(2)(A) of this section has been exhausted;

(3) The enrollee's coverage is rescinded by the QHP issuer because the enrollee has made a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan, in accordance with Section 1389.21 of the Health and Safety Code and Section 10384.17 of the Insurance Code 45 CFR Section 147.128 (November 18, 2015), hereby incorporated by reference, after the QHP issuer demonstrates to the Exchange that the rescission is appropriate, due to the enrollee's fraudulent claim or intentional misrepresentation of a material fact;

(4) The QHP terminates or is decertified as described in 45 CFR Section 155.1080; or

(5) The enrollee changes from one QHP to another during an annual open enrollment period or special enrollment period in accordance with Sections 6502 and 6504.

(6) The enrollee was enrolled in a QHP without his or her knowledge or consent by a third party, including by a third party with no connection with the Exchange.

(7) Any other reason for termination of coverage described in 45 CFR Section 147.106 (December 22, 2016), hereby incorporated by reference.

(c) In the case of termination of enrollee's coverage due to non-payment of premium, as specified in subdivision (b)(2) of this section, a QHP issuer shall:

(1) Provide the enrollee, who is delinquent on premium payment, with notice of such payment delinquency;

- (2) Provide a grace period of three consecutive months for an enrollee who, when first failing to timely pay premiums, is receiving APTC;
- (3) During the grace period specified in subdivision (c)(2) of this section:
- (A) Pay all appropriate claims for services rendered to the enrollee during the first month of the grace period;
 - (B) Notify the Exchange and HHS of such non-payment;
 - (C) Continue to collect APTC on behalf of the enrollee from the IRS; and
 - (D) Comply with any other applicable State laws and regulations relating to the grace period specified in subdivision (c)(2) of this section; and
- (4) If an enrollee receiving APTC exhausts the three-month grace period specified in subdivision (c)(2) of this section without paying all outstanding premiums:
- (A) Terminate the enrollee's coverage on the effective date described in subdivision (d)(6) of this section, provided that the QHP issuer meets the notice requirements specified in subdivision (e)(1) and (2) of this section; and
 - (B) Return APTC paid on behalf of such enrollee for the second and third months of the grace period.
- (d) If an enrollee's coverage in a QHP is terminated for any reason, the following effective dates for termination of coverage shall apply.
- (1) For purposes of this subdivision, reasonable notice is defined as 14 days before the requested effective date of termination.
 - (2) Changes in eligibility for APTC and CSR, including terminations, shall adhere to the effective dates specified in subdivisions (j) through (l) of Section 6496.

(3) In the case of a termination in accordance with subdivision (a)(1) through (3) of this section, the last day of coverage shall be:

(A) The termination date specified by the enrollee, if the enrollee provides reasonable notice;

(B) Fourteen days after the termination is requested by the enrollee, if the enrollee does not provide reasonable notice;

(C) On a date on or after the date on which the termination is requested by the enrollee if the enrollee's QHP issuer agrees to effectuate termination in fewer than 14 days, and the enrollee requests an earlier termination effective date;

(D) If the enrollee is newly eligible for full-scope Medi-Cal or CHIP, the last day of the month during which the enrollee is determined eligible for full-scope Medi-Cal or CHIP; or

(E) The retroactive termination date requested by the enrollee, if specified by applicable State laws.

(4) In the case of a retroactive termination in accordance with subdivision (a)(4) of this section, the following termination dates apply:

(A) For a termination in accordance with subdivision (a)(4)(A) of this section, the termination date shall be no sooner than 14 days after the date that the enrollee can demonstrate he or she contacted the Exchange to terminate his or her coverage or enrollment through the Exchange, unless the QHP issuer agrees to an earlier effective date as set forth in paragraph (d)(3)(C) of this section.

(B) For a termination or cancellation in accordance with subdivision (a)(4)(B) or (C) of this section, the cancellation or termination date shall be the original coverage effective date or a

later date, as determined appropriate by the Exchange on a case by case basis, based on the circumstances of the cancellation or termination.

(5) In the case of a termination in accordance with subdivision (b)(1) of this section, the last day of QHP coverage shall be the last day of eligibility, as described in Section 6496(k) unless the individual requests an earlier termination effective date per subdivision (a) of this section.

(6) In the case of a termination in accordance with subdivision (b)(2)(A) of this section, the last day of coverage shall be the last day of the first month of the three-month grace period.

(7) In the case of a termination in accordance with subdivision (b)(2)(B) of this section, the last day of coverage shall be consistent with existing California laws regarding grace periods.

(8) In the case of a termination in accordance with subdivision (b)(5) of this section, the last day of coverage in an enrollee's prior QHP shall be the day before the effective date of coverage in his or her new QHP, including any retroactive enrollments effectuated under Section 6504(h)(4) when an enrollee is granted a special enrollment period to change QHPs with a retroactive coverage effective date.

(9) In the case of a cancellation of enrollment in accordance with subdivision (b)(6) of this section, the Exchange may cancel the enrollee's enrollment upon its determination that the enrollment was performed without the enrollee's knowledge or consent. The cancellation date shall be the original coverage effective date.

(10) In the case of a termination due to the enrollee's death, the last day of coverage is the date of death.

(11) In cases of retroactive termination dates, the Exchange shall ensure that:

(A) The enrollee receives the APTC and CSR for which he or she is determined eligible;

(B) The enrollee is refunded any ~~excess-premiums owed to the enrollee by the QHP issuer paid or out-of-pocket payments made by or for the enrollee for covered benefits and services, including prescription drugs, incurred after the retroactive termination date;~~

(C) If the enrollee enrolls in a new QHP:

1. The enrollee's premium and cost sharing are adjusted to reflect the enrollee's obligations under the new QHP, ~~if applicable;~~ and

~~(D)~~ 2. Consistent with 45 CFR Section 156.425(b) (February 27, 2015), hereby incorporated by reference, in the case of a change in the level of CSR (or a QHP without CSR) under the same QHP issuer during a benefit year, any cost sharing paid by the enrollee under the previous level of CSR (or a QHP without CSR) for that benefit year is taken into account in the new level of CSR for purposes of calculating cost sharing based on aggregate spending by the individual, such as for deductibles or for the annual limitations on cost sharing.

(e) If an enrollee's coverage in a QHP is terminated in accordance with subdivision (a)(1) or (b)(2) and (3), of this section, the QHP issuer shall:

(1) Provide the enrollee, within five business days from the date of the termination, with a written notice of termination of coverage that includes:

(A) The termination effective date;

(B) The reason for termination; and

(C) The notice of appeals right, in accordance with the requirements specified in Section 6604 of Article 7 of this chapter.

(2) Notify the Exchange of the termination effective date and reason for termination;

(3) Abide by the termination of coverage effective dates described in subdivision (d) of this section; and

(4) Maintain electronic records of termination of coverage, including audit trails and reason codes for termination, for a minimum of ten years.

(f) If an enrollee's coverage in a QHP is terminated for any reason other than terminations pursuant to subdivision (b)(2) and (3) of this section, the Exchange shall:

(1) Send termination information to the QHP issuer within three business days from the date of the termination;

(2) Send termination information to HHS promptly and without undue delay, in the manner and timeframe specified by HHS; and

(3) Retain records of termination of coverage for a minimum of ten years in order to facilitate audit functions.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR Sections 147.106, 147.128, 155.430, 155.1080, 156.270 and 156.425.

Article 7. Appeals Process for the Individual Exchange

§ 6602. General Eligibility Appeals Requirements.

(a) In accordance with Section 6510 of Article 5, an applicant or enrollee shall have the right to appeal:

(1) An eligibility determination made in accordance with Article 5 of this chapter, including:

(A) An initial determination of eligibility, including the amount of APTC and level of CSR, made in accordance with the standards specified in Sections 6472 and 6474 of Article 5 of this chapter;

(B) A redetermination of eligibility, including the amount of APTC and level of CSR, made in accordance with Sections 6496 and 6498 of Article 5 of this chapter; and

(C) A determination of eligibility for an enrollment period, made in accordance with Section 6476(c) of Article 5 of this chapter;

(2) An eligibility determination or redetermination for the State financial assistance, including the amount of the State advance premium assistance subsidy, made in accordance with Title 25 (commencing with Section 100800) of the Government Code and Article 5 of this chapter.

(3) An eligibility determination or redetermination for an hardship or religious conscious exemption made in accordance with Article 13 of this chapter-45 CFR Section 155.605 to the HHS;

(34) The Exchange's failure to provide a timely eligibility determination in accordance with Section 6476(f) of Article 5 of this chapter or failure to provide timely notice of an

eligibility determination or redetermination in accordance with Sections 6476(h), 6496(h)(2), or 6498(j)(2) of Article 5 of this chapter; and

(45) A denial of a request to vacate a dismissal made by the Exchange appeals entity in accordance with Section 6610(d)(2) to the HHS.

(b) The Exchange appeals entity shall conduct all eligibility appeals, ~~except for including~~ appeals of an eligibility determination for an hardship or religious conscious exemption made in accordance with Article 13 of this chapter ~~45 CFR Section 155.605~~.

(c) For purposes of this Article, an administrative law judge designated by the appeals entity shall determine, on a case-by-case basis:

(1) The validity of all appeal requests received by the Exchange, the appeals entity, or the counties; and

(2) Whether good cause exists, including, but not limited to, good cause for an untimely appeal request and continuance.

(d) An applicant or enrollee may request an appeal of any of the actions specified in subdivision (a) of this section to HHS upon exhaustion of the Exchange appeals process.

(e) During the appeal, an appellant may represent himself or herself, or be represented by an authorized representative, as provided in Section 6508 of Article 5 of this chapter, or by legal counsel, a relative, a friend, or another spokesperson.

(f) Appeals processes established under this Article shall comply with the accessibility and readability requirements specified in Section 6452 of Article 4 of this chapter.

(g) An appellant may seek judicial review to the extent it is available by law.

(h) When an appellant seeks review of an adverse MAGI Medi-Cal or CHIP determination made by the Exchange, the appeals entity shall transmit the eligibility

determination and all information provided as part of the appeal via secure electronic interface, within three business days from the date the appeal request is received to DHCS, as applicable, unless the appeal request is for an expedited appeal, in which case, the appeals entity shall follow the procedure provided in Section 6616.

(i) The appeals entity shall:

(1) Ensure all data exchanges in the appeals process comply with the federal and State privacy and security standards specified in 45 CFR Section 155.260, and the Information Practices Act of 1977 (Cal. Civ. Code, § 1798 et seq.) and are in an electronic format consistent with 45 CFR Section 155.270; and

(2) Comply with all data sharing requests made by HHS.

(j) The Exchange shall provide the appellant with the opportunity to review his or her entire eligibility file, including all papers, requests, documents, and relevant information in the Exchange's possession at any time from the date on which an appeal request is filed to the date on which the appeal decision is issued pursuant to Section 6618.

Note: Authority cited: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR Sections 155.260, 155.270, 155.505, 155.510, 155.605.

ELECTRONIC CODE OF FEDERAL REGULATIONS

e-CFR data is current as of September 17, 2019

Title 26 → Chapter I → Subchapter D → Part 54 → §54.9802-4

Title 26: Internal Revenue
PART 54—PENSION EXCISE TAXES**§54.9802-4 Special Rule Allowing Integration of Health Reimbursement Arrangements (HRAs) and Other Account-Based Group Health Plans with Individual Health Insurance Coverage and Medicare and Prohibiting Discrimination In HRAs and Other Account-Based Group Health Plans.**

(a) *Scope.* This section applies to health reimbursement arrangements (HRAs) and other account-based group health plans, as defined in §54.9815-2711(d)(6)(i) of this chapter. For ease of reference, the term "HRA" is used in this section to include other account-based group health plans. For related regulations, see 26 CFR 1.36B-2(c)(3)(i) and (c)(5), 29 CFR 2510.3-1(l), and 45 CFR 155.420.

(b) *Purpose.* This section provides the conditions that an HRA must satisfy in order to be integrated with individual health insurance coverage for purposes of Public Health Service Act (PHS Act) sections 2711 and 2713 and §54.9815-2711(d)(4) of this chapter (referred to as an individual coverage HRA). This section also allows an individual coverage HRA to be integrated with Medicare for purposes of PHS Act sections 2711 and 2713 and §54.9815-2711(d)(4), subject to the conditions provided in this section (see paragraph (e) of this section). Some of the conditions set forth in this section specifically relate to compliance with PHS Act sections 2711 and 2713 and some relate to the effect of having or being offered an individual coverage HRA on eligibility for the premium tax credit under section 36B. In addition, this section provides conditions that an individual coverage HRA must satisfy in order to comply with the nondiscrimination provisions in section 9802 and PHS Act section 2705 (which is incorporated in section 9815) and that are consistent with the provisions of 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)), each as amended, that are designed to create a competitive individual market. These conditions are intended to prevent an HRA plan sponsor from intentionally or unintentionally, directly or indirectly, steering any participants or dependents with adverse health factors away from its traditional group health plan, if any, and toward individual health insurance coverage.

(c) *General rule.* An HRA will be considered to be integrated with individual health insurance coverage for purposes of PHS Act sections 2711 and 2713 and §54.9815-2711(d)(4) of this chapter and will not be considered to discriminate in violation of section 9802 and PHS Act section 2705 solely because it is integrated with individual health insurance coverage, provided that the conditions of this paragraph (c) are satisfied. See paragraph (e) of this section for how these conditions apply to an individual coverage HRA integrated with Medicare. For purposes of this section, medical care expenses means medical care expenses as defined in §54.9815-2711(d)(6)(ii) of this chapter and Exchange means Exchange as defined in 45 CFR 155.20.

(1) *Enrollment in individual health insurance coverage—(i) In general.* The HRA must require that the participant and any dependent(s) are enrolled in individual health insurance coverage that is subject to and complies with the requirements in PHS Act section 2711 (and §54.9815-2711(a)(2) of this chapter) and PHS Act section 2713 (and §54.9815-2713(a)(1) of this chapter), for each month that the individual(s) are covered by the HRA. For purposes of this paragraph (c), all individual health insurance coverage, except for individual health insurance coverage that consists solely of excepted benefits, is treated as being subject to and complying with PHS Act sections 2711 and 2713. References to individual health insurance coverage in this paragraph (c) do not include individual health insurance coverage that consists solely of excepted benefits.

(ii) *Forfeiture.* The HRA must provide that if any individual covered by the HRA ceases to be covered by individual health insurance coverage, the HRA will not reimburse medical care expenses that are incurred by that individual after the individual health insurance coverage ceases. In addition, if the participant and all dependents covered by the participant's HRA cease to be covered by individual health insurance coverage, the participant must forfeit the HRA. In either case, the HRA must reimburse medical care expenses incurred by the individual prior to the cessation of individual health insurance coverage to the extent the medical care expenses are otherwise covered by the HRA, but the HRA may limit the period to submit medical care expenses for reimbursement to a reasonable specified time period. If a participant or dependent loses coverage under the HRA for a reason other than cessation of individual health insurance coverage, COBRA and other continuation coverage requirements may apply.

(iii) *Grace periods and retroactive termination of individual health insurance coverage.* In the event an individual is initially enrolled in individual health insurance coverage and subsequently timely fails to pay premiums for the coverage, with the result that the individual is in a grace period, the individual is considered to be enrolled in individual health insurance coverage for purposes of this paragraph (c)(1) and the individual coverage HRA must reimburse medical care expenses incurred by the individual during that time period to the extent the medical care expenses are otherwise covered by the HRA. If the individual fails to pay the applicable premium(s) by the end of the grace period and the coverage is cancelled or terminated, including retroactively, or if the individual health insurance coverage is cancelled or terminated retroactively for some other reason (for

example, a rescission), an individual coverage HRA must require that a participant notify the HRA that coverage has been cancelled or terminated and the date on which the cancellation or termination is effective. After the individual coverage HRA has received the notice of cancellation or termination, the HRA may not reimburse medical care expenses incurred on and after the date the individual health insurance coverage was cancelled or terminated, which is considered to be the date of termination of coverage under the HRA.

(2) *No traditional group health plan may be offered to same participants.* To the extent a plan sponsor offers any class of employees (as defined in paragraph (d) of this section) an individual coverage HRA, the plan sponsor may not also offer a traditional group health plan to the same class of employees, except as provided in paragraph (d)(5) of this section. For purposes of this section, a traditional group health plan is any group health plan other than either an account-based group health plan or a group health plan that consists solely of excepted benefits. Therefore, a plan sponsor may not offer a choice between an individual coverage HRA or a traditional group health plan to any participant or dependent.

(3) *Same terms requirement—(i) In general.* If a plan sponsor offers an individual coverage HRA to a class of employees described in paragraph (d) of this section, the HRA must be offered on the same terms to all participants within the class, except as provided in paragraphs (c)(3)(ii) through (vi) and (d)(5) of this section.

(ii) *Carryover amounts, salary reduction arrangements, and transfer amounts.* Amounts that are not used to reimburse medical care expenses for any plan year that are made available to participants in later plan years are disregarded for purposes of determining whether an HRA is offered on the same terms, provided that the method for determining whether participants have access to unused amounts in future years, and the methodology and formula for determining the amounts of unused funds which they may access in future years, is the same for all participants in a class of employees. In addition, the ability to pay the portion of the premium for individual health insurance coverage that is not covered by the HRA, if any, by using a salary reduction arrangement under section 125 is considered to be a term of the HRA for purposes of this paragraph (c)(3). Therefore, an HRA is not provided on the same terms unless the salary reduction arrangement, if made available to any participant in a class of employees, is made available on the same terms to all participants (other than former employees, as defined in paragraph (c)(3)(iv) of this section) in the class of employees. Further, to the extent that a participant in an individual coverage HRA was previously covered by another HRA and the current individual coverage HRA makes available amounts that were not used to reimburse medical care expenses under the prior HRA (transferred amounts), the transferred amounts are disregarded for purposes of determining whether the HRA is offered on the same terms, provided that if the HRA makes available transferred amounts, it does so on the same terms for all participants in the class of employees.

(iii) *Permitted variation.* An HRA does not fail to be provided on the same terms solely because the maximum dollar amount made available to participants in a class of employees to reimburse medical care expenses for any plan year increases in accordance with paragraph (c)(3)(iii)(A) or (B) of this section.

(A) *Variation due to number of dependents.* An HRA does not fail to be provided on the same terms to participants in a class of employees solely because the maximum dollar amount made available to those participants to reimburse medical care expenses for any plan year increases as the number of the participant's dependents who are covered under the HRA increases, so long as the same maximum dollar amount attributable to the increase in family size is made available to all participants in that class of employees with the same number of dependents covered by the HRA.

(B) *Variation due to age.* An HRA does not fail to be provided on the same terms to participants in a class of employees solely because the maximum dollar amount made available under the terms of the HRA to those participants to reimburse medical care expenses for any plan year increases as the age of the participant increases, so long as the requirements in paragraphs (c)(3)(iii)(B)(1) and (2) of this section are satisfied. For the purpose of this paragraph (c)(3)(iii)(B), the plan sponsor may determine the age of the participant using any reasonable method for a plan year, so long as the plan sponsor determines each participant's age for the purpose of this paragraph (c)(3)(iii)(B) using the same method for all participants in the class of employees for the plan year and the method is determined prior to the plan year.

(1) The same maximum dollar amount attributable to the increase in age is made available to all participants who are the same age.

(2) The maximum dollar amount made available to the oldest participant(s) is not more than three times the maximum dollar amount made available to the youngest participant(s).

(iv) *Former employees.* An HRA does not fail to be treated as provided on the same terms if the plan sponsor offers the HRA to some, but not all, former employees within a class of employees. However, if a plan sponsor offers the HRA to one or more former employees within a class of employees, the HRA must be offered to the former employee(s) on the same terms as to all other employees within the class, except as provided in paragraph (c)(3)(ii) of this section. For purposes of this section, a former employee is an employee who is no longer performing services for the employer.

(v) *New employees or new dependents.* For a participant whose coverage under the HRA becomes effective later than the first day of the plan year, the HRA does not fail to be treated as being provided on the same terms to the participant if the maximum dollar amount made available to the participant either is the same as the maximum dollar amount made available to participants in the participant's class of employees whose coverage became effective as of the first day of the plan year, or is pro-rated consistent with the portion of the plan year in which the participant is covered by the HRA. Similarly, if the HRA provides for variation in the maximum amount made available to participants in a class of employees based on the number of a participant's dependents covered by the HRA, and the number of a participant's dependents covered by the HRA changes

during a plan year (either increasing or decreasing), the HRA does not fail to be treated as being provided on the same terms to the participant if the maximum dollar amount made available to the participant either is the same as the maximum dollar amount made available to participants in the participant's class of employees who had the same number of dependents covered by the HRA on the first day of the plan year or is pro-rated for the remainder of the plan year after the change in the number of the participant's dependents covered by the HRA consistent with the portion of the plan year in which that number of dependents are covered by the HRA. The method the HRA uses to determine amounts made available for participants whose coverage under the HRA is effective later than the first day of the plan year or who have changes in the number of dependents covered by the HRA during a plan year must be the same for all participants in the class of employees and the method must be determined prior to the beginning of the plan year.

(vi) *HSA-compatible HRAs.* An HRA does not fail to be treated as provided on the same terms if the plan sponsor offers participants in a class of employees a choice between an HSA-compatible individual coverage HRA and an individual coverage HRA that is not HSA compatible, provided both types of HRAs are offered to all participants in the class of employees on the same terms. For the purpose of this paragraph (c)(3)(vi), an HSA-compatible individual coverage HRA is an individual coverage HRA that is limited in accordance with applicable guidance under section 223 such that an individual covered by such an HRA is not disqualified from being an eligible individual under section 223.

(vii) *Examples.* The following examples illustrate the provisions of this paragraph (c)(3), without taking into account the provisions of paragraph (d) of this section. In each example, the HRA is an individual coverage HRA that has a calendar year plan year and may reimburse any medical care expenses, including premiums for individual health insurance coverage (except as provided in paragraph (c)(3)(vii)(E) of this section (*Example 5*)). Further, in each example, assume the HRA is offered on the same terms, except as otherwise specified in the example and that no participants or dependents are Medicare beneficiaries.

(A) *Example 1: Carryover amounts permitted—(1) Facts.* For 2020 and again for 2021, Plan Sponsor A offers all employees \$7,000 each in an HRA, and the HRA provides that amounts that are unused at the end of a plan year may be carried over to the next plan year, with no restrictions on the use of the carryover amounts compared to the use of newly available amounts. At the end of 2020, some employees have used all of the funds in their HRAs, while other employees have balances remaining that range from \$500 to \$1,750 that are carried over to 2021 for those employees.

(2) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(A) (*Example 1*) for 2020 because Plan Sponsor A offers all employees the same amount, \$7,000, in an HRA for that year. The same terms requirement is also satisfied for 2021 because Plan Sponsor A again offers all employees the same amount for that year, and the carryover amounts that some employees have are disregarded in applying the same terms requirement because the amount of the carryover for each employee (that employee's balance) and each employee's access to the carryover amounts is based on the same terms.

(B) *Example 2: Employees hired after the first day of the plan year—(1) Facts.* For 2020, Plan Sponsor B offers all employees employed on January 1, 2020, \$7,000 each in an HRA for the plan year. Employees hired after January 1, 2020, are eligible to enroll in the HRA with an effective date of the first day of the month following their date of hire, as long as they have enrolled in individual health insurance coverage effective on or before that date, and the amount offered to these employees is pro-rated based on the number of months remaining in the plan year, including the month which includes their coverage effective date.

(2) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(B) (*Example 2*) for 2020 because Plan Sponsor B offers all employees employed on the first day of the plan year the same amount, \$7,000, in an HRA for that plan year and all employees hired after January 1, 2020, a pro-rata amount based on the portion of the plan year during which they are enrolled in the HRA.

(C) *Example 3: HRA amounts offered vary based on number of dependents—(1) Facts.* For 2020, Plan Sponsor C offers its employees the following amounts in an HRA: \$1,500, if the employee is the only individual covered by the HRA; \$3,500, if the employee and one dependent are covered by the HRA; and \$5,000, if the employee and more than one dependent are covered by the HRA.

(2) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(C) (*Example 3*) because paragraph (c)(3)(iii)(A) of this section allows the maximum dollar amount made available in an HRA to increase as the number of the participant's dependents covered by the HRA increases and Plan Sponsor C makes the same amount available to each employee with the same number of dependents covered by the HRA.

(D) *Example 4: HRA amounts offered vary based on increases in employees' ages—(1) Facts.* For 2020, Plan Sponsor D offers its employees the following amounts in an HRA: \$1,000 each for employees age 25 to 35; \$2,000 each for employees age 36 to 45; \$2,500 each for employees age 46 to 55; and \$4,000 each for employees over age 55.

(2) *Conclusion.* The same terms requirement of this paragraph (c)(3) is not satisfied in this paragraph (c)(3)(vii)(D) (*Example 4*) because the terms of the HRA provide the oldest participants (those over age 55) with more than three times the amount made available to the youngest participants (those ages 25 to 35), in violation of paragraph (c)(3)(iii)(B)(2) of this section.

(E) *Example 5: Application of same terms requirement to premium only HRA—(1) Facts.* For 2020, Plan Sponsor E offers its employees an HRA that reimburses only premiums for individual health insurance coverage, up to \$10,000 for the year.

Employee A enrolls in individual health insurance coverage with a \$5,000 premium for the year and is reimbursed \$5,000 from the HRA. Employee B enrolls in individual health insurance coverage with an \$8,000 premium for the year and is reimbursed \$8,000 from the HRA.

(2) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(E) (*Example 5*) because Plan Sponsor E offers the HRA on the same terms to all employees, notwithstanding that some employees receive a greater amount of reimbursement than others based on the cost of the individual health insurance coverage selected by the employee.

(4) *Opt out.* Under the terms of the HRA, a participant who is otherwise eligible for coverage must be permitted to opt out of and waive future reimbursements on behalf of the participant and all dependents eligible for the HRA from the HRA once, and only once, with respect to each plan year. The HRA may establish timeframes for enrollment in (and opting out of) the HRA but, in general, the opportunity to opt out must be provided in advance of the first day of the plan year. For participants who become eligible to participate in the HRA on a date other than the first day of the plan year (or who become eligible fewer than 90 days prior to the plan year or for whom the notice under paragraph (c)(6) of this section is required to be provided as set forth in paragraph (c)(6)(i)(C) of this section), or for a dependent who newly becomes eligible during the plan year, this opportunity must be provided during the applicable HRA enrollment period(s) established by the HRA for these individuals. Further, under the terms of the HRA, upon termination of employment, for a participant who is covered by the HRA, either the remaining amounts in the HRA must be forfeited or the participant must be permitted to permanently opt out of and waive future reimbursements from the HRA on behalf of the participant and all dependents covered by the HRA.

(5) *Reasonable procedures for coverage substantiation*—(i) *Substantiation of individual health insurance coverage for the plan year.* The HRA must implement, and comply with, reasonable procedures to substantiate that participants and each dependent covered by the HRA are, or will be, enrolled in individual health insurance coverage for the plan year (or for the portion of the plan year the individual is covered by the HRA, if applicable). The HRA may establish the date by which this substantiation must be provided, but, in general, the date may be no later than the first day of the plan year. However, for a participant who is not eligible to participate in the HRA on the first day of the plan year (or who becomes eligible fewer than 90 days prior to the plan year or for whom the notice under paragraph (c)(6) of this section is required to be provided as set forth in paragraph (c)(6)(i)(C) of this section), the HRA may establish the date by which this substantiation must be provided, but that date may be no later than the date the HRA coverage begins. Similarly, for a participant who adds a new dependent during the plan year, the HRA may establish the date by which this substantiation must be provided, but the date may be no later than the date the HRA coverage for the new dependent begins; however, to the extent the dependent's coverage under the HRA is effective retroactively, the HRA may establish a reasonable time by which this substantiation is required, but must require it be provided before the HRA will reimburse any medical care expense for the newly added dependent. The reasonable procedures an HRA may use to implement the substantiation requirement set forth in this paragraph (c)(5)(i) may include a requirement that a participant substantiate enrollment by providing either:

(A) A document from a third party (for example, the issuer or an Exchange) showing that the participant and any dependents covered by the HRA are, or will be, enrolled in individual health insurance coverage (for example, an insurance card or an explanation of benefits document pertaining to the relevant time period or documentation from the Exchange showing that the individual has completed the application and plan selection); or

(B) An attestation by the participant stating that the participant and dependent(s) covered by the HRA are, or will be, enrolled in individual health insurance coverage, the date coverage began or will begin, and the name of the provider of the coverage.

(ii) *Coverage substantiation with each request for reimbursement of medical care expenses.* Following the initial substantiation of coverage, with each new request for reimbursement of an incurred medical care expense for the same plan year, the HRA may not reimburse a participant for any medical care expenses unless, prior to each reimbursement, the participant substantiates that the individual on whose behalf medical care expenses are requested to be reimbursed continues to be enrolled in individual health insurance coverage for the month during which the medical care expenses were incurred. The HRA must implement, and comply with, reasonable procedures to satisfy this requirement. This substantiation may be in the form of a written attestation by the participant, which may be part of the form used to request reimbursement, or a document from a third party (for example, a health insurance issuer) showing that the participant or the dependent, if applicable, are or were enrolled in individual health insurance coverage for the applicable month.

(iii) *Reliance on substantiation.* For purposes of this paragraph (c)(5), an HRA may rely on the participant's documentation or attestation unless the HRA, its plan sponsor, or any other entity acting in an official capacity on behalf of the HRA has actual knowledge that any individual covered by the HRA is not, or will not be, enrolled in individual health insurance coverage for the plan year (or applicable portion of the plan year) or the month, as applicable.

(6) *Notice requirement*—(i) *Timing.* The HRA must provide a written notice to each participant:

(A) At least 90 calendar days before the beginning of each plan year for any participant who is not described in either paragraph (c)(6)(i)(B) or (C) of this section;

(B) No later than the date on which the HRA may first take effect for the participant, for any participant who is not eligible to participate at the beginning of the plan year (or is not eligible to participate at the time the notice is provided at least 90 calendar days before the beginning of the plan year pursuant to paragraph (c)(6)(i)(A) of this section); or

(C) No later than the date on which the HRA may first take effect for the participant, for any participant who is employed by an employer that is first established less than 120 days before the beginning of the first plan year of the HRA; this paragraph (c)(6)(i)(C) applies only with respect to the first plan year of the HRA.

(ii) *Content.* The notice must include all the information described in this paragraph (c)(6)(ii) (and may include any additional information that does not conflict with that information). To the extent that the Departments of the Treasury, Labor and Health and Human Services provide model notice language for certain elements of this required notice, HRAs are permitted, but not required, to use the model language.

(A) A description of the terms of the HRA, including the maximum dollar amount available for each participant (including the self-only HRA amount available for the plan year (or the maximum dollar amount available for the plan year if the HRA provides for reimbursements up to a single dollar amount regardless of whether a participant has self-only or other than self-only coverage)), any rules regarding the proration of the maximum dollar amount applicable to any participant (or dependent, if applicable) who is not eligible to participate in the HRA for the entire plan year, whether (and which of) the participant's dependents are eligible for the HRA, a statement that there are different kinds of HRAs (including a qualified small employer health reimbursement arrangement) and the HRA being offered is an individual coverage HRA, a statement that the HRA requires the participant and any covered dependents to be enrolled in individual health insurance coverage (or Medicare Part A and B or Medicare Part C, if applicable), a statement that the coverage in which the participant and any covered dependents must be enrolled cannot be short-term, limited-duration insurance or consist solely of excepted benefits, if the HRA is subject to the Employee Retirement Income Security Act (ERISA), a statement that individual health insurance coverage in which the participant and any covered dependents are enrolled is not subject to ERISA, if the conditions under 29 CFR 2510.3-1(l) are satisfied, the date as of which coverage under the HRA may first become effective (both for participants whose coverage will become effective on the first day of the plan year and for participants whose HRA coverage may become effective at a later date), the dates on which the HRA plan year begins and ends, and the dates on which the amounts newly made available under the HRA will be made available.

(B) A statement of the right of the participant to opt out of and waive future reimbursements from the HRA, as set forth under paragraph (c)(4) of this section.

(C) A description of the potential availability of the premium tax credit if the participant opts out of and waives future reimbursements from the HRA and the HRA is not affordable for one or more months under §1.36B-2(c)(5) of this chapter, a statement that even if the participant opts out of and waives future reimbursements from an HRA, the offer will prohibit the participant (and, potentially, the participant's dependents) from receiving a premium tax credit for the participant's coverage (or the dependent's coverage, if applicable) on an Exchange for any month that the HRA is affordable under §1.36B-2(c)(5) of this chapter, a statement describing how the participant may find assistance with determining affordability, a statement that, if the participant is a former employee, the offer of the HRA does not render the participant (or the participant's dependents, if applicable) ineligible for the premium tax credit regardless of whether it is affordable under §1.36B-2(c)(5) of this chapter, and a statement that if the participant or dependent is enrolled in Medicare, he or she is ineligible for the premium tax credit without regard to the offer or acceptance of the HRA;

(D) A statement that if the participant accepts the HRA, the participant may not claim a premium tax credit for the participant's Exchange coverage for any month the HRA may be used to reimburse medical care expenses of the participant, and a premium tax credit may not be claimed for the Exchange coverage of the participant's dependents for any month the HRA may be used to reimburse medical care expenses of the dependents.

(E) A statement that the participant must inform any Exchange to which the participant applies for advance payments of the premium tax credit of the availability of the HRA; the self-only HRA amount available for the HRA plan year (or the maximum dollar amount available for the plan year if the HRA provides for reimbursements up to a single dollar amount regardless of whether a participant has self-only or other than self-only coverage) as set forth in the written notice in accordance with paragraph (c)(6)(ii)(A) of this section; whether the HRA is also available to the participant's dependents and if so, which ones; the date as of which coverage under the HRA may first become effective; the date on which the plan year begins and the date on which it ends; and whether the participant is a current employee or former employee.

(F) A statement that the participant should retain the written notice because it may be needed to determine whether the participant is allowed a premium tax credit on the participant's individual income tax return.

(G) A statement that the HRA may not reimburse any medical care expense unless the substantiation requirement set forth in paragraph (c)(5)(ii) of this section is satisfied and a statement that the participant must also provide the substantiation required by paragraph (c)(5)(i) of this section.

(H) A statement that if the individual health insurance coverage (or coverage under Medicare Part A and B or Medicare Part C) of a participant or dependent ceases, the HRA will not reimburse any medical care expenses that are incurred by the participant or dependent, as applicable, after the coverage ceases, and a statement that the participant must inform the HRA if the participant's or dependent's individual health insurance coverage (or coverage under Medicare Part A and B or Medicare Part C) is cancelled or terminated retroactively and the date on which the cancellation or termination is effective.

(I) The contact information (including a phone number) for an individual or a group of individuals who participants may contact in order to receive additional information regarding the HRA. The plan sponsor may determine which individual or group of individuals is best suited to be the specified contact.

(J) A statement of availability of a special enrollment period to enroll in or change individual health insurance coverage, through or outside of an Exchange, for the participant and any dependents who newly gain access to the HRA and are not already covered by the HRA.

(d) *Classes of employees*—(1) *In general.* This paragraph (d) sets forth the rules for determining classes of employees. Paragraph (d)(2) of this section sets forth the specific classes of employees; paragraph (d)(3) of this section sets forth a minimum class size requirement that applies in certain circumstances; paragraph (d)(4) of this section sets forth rules regarding the definition of “full-time employees,” “part-time employees,” and “seasonal employees”; paragraph (d)(5) of this section sets forth a special rule for new hires; and paragraph (d)(6) of this section addresses student premium reduction arrangements. For purposes of this section, including determining classes under this paragraph (d), the employer is the common law employer and is determined without regard to the rules under sections 414(b), (c), (m), and (o) that would treat the common law employer as a single employer with certain other entities.

(2) *List of classes.* Participants may be treated as belonging to a class of employees based on whether they are, or are not, included in the classes described in this paragraph (d)(2). If the individual coverage HRA is offered to former employees, former employees are considered to be in the same class in which they were included immediately before separation from service. Before each plan year, a plan sponsor must determine for the plan year which classes of employees it intends to treat separately and the definition of the relevant class(es) it will apply, to the extent these regulations permit a choice. After the classes and the definitions of the classes are established for a plan year, a plan sponsor may not make changes to the classes of employees or the definitions of those relevant classes with respect to that plan year.

(i) Full-time employees, defined at the election of the plan sponsor to mean either full-time employees under section 4980H (and §54.4980H-1(a)(21) of this chapter) or employees who are not part-time employees (as described in §1.105-11(c)(2)(iii)(C) of this chapter);

(ii) Part-time employees, defined at the election of the plan sponsor to mean either employees who are not full-time employees under section 4980H (and under §54.4980H-1(a)(21) of this chapter (which defines full-time employee)) or employees who are part-time employees as described in §1.105-11(c)(2)(iii)(C) of this chapter;

(iii) Employees who are paid on a salary basis;

(iv) Non-salaried employees (such as, for example, hourly employees);

(v) Employees whose primary site of employment is in the same rating area as defined in 45 CFR 147.102(b);

(vi) Seasonal employees, defined at the election of the plan sponsor to mean seasonal employees as described in either §54.4980H-1(a)(38) or §1.105-11(c)(2)(iii)(C) of this chapter;

(vii) Employees included in a unit of employees covered by a particular collective bargaining agreement (or an appropriate related participation agreement) in which the plan sponsor participates (as described in §1.105-11(c)(2)(iii)(D) of this chapter);

(viii) Employees who have not satisfied a waiting period for coverage (if the waiting period complies with §54.9815-2708 of this chapter);

(ix) Non-resident aliens with no U.S.-based income (as described in §1.105-11(c)(2)(iii)(E) of this chapter);

(x) Employees who, under all the facts and circumstances, are employees of an entity that hired the employees for temporary placement at an entity that is not the common law employer of the employees and that is not treated as a single employer with the entity that hired the employees for temporary placement under section 414(b), (c), (m), or (o); or

(xi) A group of participants described as a combination of two or more of the classes of employees set forth in paragraphs (d)(2)(i) through (x) of this section.

(3) *Minimum class size requirement*—(i) *In general.* If a class of employees is subject to the minimum class size requirement as set forth in this paragraph (d)(3), the class must consist of at least a minimum number of employees (as described in paragraphs (d)(3)(iii) and (iv) of this section), otherwise, the plan sponsor may not treat that class as a separate class of employees. Paragraph (d)(3)(ii) of this section sets forth the circumstances in which the minimum class size requirement applies to a class of employees, paragraph (d)(3)(iii) of this section sets forth the rules for determining the applicable class size minimum, and paragraph (d)(3)(iv) of this section sets forth the rules for a plan sponsor to determine if it satisfies the minimum class size requirement with respect to a class of employees.

(ii) *Circumstances in which minimum class size requirement applies*—(A) The minimum class size requirement applies only if a plan sponsor offers a traditional group health plan to one or more classes of employees and offers an individual coverage HRA to one or more other classes of employees.

(B) The minimum class size requirement does not apply to a class of employees offered a traditional group health plan or a class of employees offered no coverage.

(C) The minimum class size requirement applies to a class of employees offered an individual coverage HRA if the class is full-time employees, part-time employees, salaried employees, non-salaried employees, or employees whose primary site of

employment is in the same rating area (described in paragraph (d)(2)(i), (ii), (iii), (iv), or (v) of this section, respectively, and referred to collectively as the applicable classes or individually as an applicable class), except that:

(1) In the case of the class of employees whose primary site of employment is in the same rating area (as described in paragraph (d)(2)(v) of this section), the minimum class size requirement does not apply if the geographic area defining the class is a State or a combination of two or more entire States; and

(2) In the case of the classes of employees that are full-time employees and part-time employees (as described in paragraphs (d)(2)(i) and (ii) of this section, respectively), the minimum class size requirement applies only to those classes (and the classes are only applicable classes) if the employees in one such class are offered a traditional group health plan while the employees in the other such class are offered an individual coverage HRA. In such a case, the minimum class size requirement applies only to the class offered an individual coverage HRA.

(D) A class of employees offered an individual coverage HRA is also subject to the minimum class size requirement if the class is a class of employees created by combining at least one of the applicable classes (as defined in paragraph (d)(3)(ii)(C) of this section) with any other class, except that the minimum class size requirement shall not apply to a class that is the result of a combination of one of the applicable classes and a class of employees who have not satisfied a waiting period (as described in paragraph (d)(2)(viii) of this section).

(iii) *Determination of the applicable class size minimum—(A) In general.* The minimum number of employees that must be in a class of employees that is subject to the minimum class size requirement (the applicable class size minimum) is determined prior to the beginning of the plan year for each plan year of the individual coverage HRA and is:

(1) 10, for an employer with fewer than 100 employees;

(2) A number, rounded down to a whole number, equal to 10 percent of the total number of employees, for an employer with 100 to 200 employees; and

(3) 20, for an employer with more than 200 employees.

(B) *Determining employer size.* For purposes of this paragraph (d)(3), the number of employees of an employer is determined in advance of the plan year of the HRA based on the number of employees that the employer reasonably expects to employ on the first day of the plan year.

(iv) *Determining if a class satisfies the applicable class size minimum.* For purposes of this paragraph (d)(3), whether a class of employees satisfies the applicable class size minimum for a plan year of the individual coverage HRA is based on the number of employees in the class offered the individual coverage HRA as of the first day of the plan year. Therefore, this determination is not based on the number of employees that actually enroll in the individual coverage HRA, and this determination is not affected by changes in the number of employees in the class during the plan year.

(4) *Consistency requirement.* For any plan year, a plan sponsor may define "full-time employee," "part-time employee," and "seasonal employee" in accordance with the relevant provisions of sections 105(h) or 4980H, as set forth in paragraphs (d)(2)(i), (ii), and (vi) of this section, if:

(i) To the extent applicable under the HRA for the plan year, each of the three classes of employees are defined in accordance with section 105(h) or each of the three classes of employees are defined in accordance with section 4980H for the plan year; and

(ii) The HRA plan document sets forth the applicable definitions prior to the beginning of the plan year to which the definitions will apply.

(5) *Special rule for new hires—(i) In general.* Notwithstanding paragraphs (c)(2) and (3) of this section, a plan sponsor that offers a traditional group health plan to a class of employees may prospectively offer the employees in that class of employees who are hired on or after a certain future date (the new hire date) an individual coverage HRA (with this group of employees referred to as the new hire subclass), while continuing to offer employees in that class of employees who are hired before the new hire date a traditional group health plan (with the rule set forth in this sentence referred to as the special rule for new hires). For the new hire subclass, the individual coverage HRA must be offered on the same terms to all participants within the subclass, in accordance with paragraph (c)(3) of this section. In accordance with paragraph (c)(2) of this section, a plan sponsor may not offer a choice between an individual coverage HRA or a traditional group health plan to any employee in the new hire subclass or to any employee in the class who is not a member of the new hire subclass.

(ii) *New hire date.* A plan sponsor may set the new hire date for a class of employees prospectively as any date on or after January 1, 2020. A plan sponsor may set different new hire dates prospectively for separate classes of employees.

(iii) *Discontinuation of use of special rule for new hires and multiple applications of the special rule for new hires.* A plan sponsor may discontinue use of the special rule for new hires at any time for any class of employees. In that case, the new hire subclass is no longer treated as a separate subclass of employees. In the event a plan sponsor applies the special rule for new hires to a class of employees and later discontinues use of the rule to the class of employees, the plan sponsor may later apply the rule if the application of the rule would be permitted under the rules for initial application of the special rule for new hires. If a

plan sponsor, in accordance with the requirements for the special rule for new hires, applies the rule to a class of employees subsequent to any prior application and discontinuance of the rule to that class, the new hire date must be prospective.

(iv) *Application of the minimum class size requirement under the special rule for new hires.* The minimum class size requirement set forth in paragraph (d)(3) of this section does not apply to the new hire subclass. However, if a plan sponsor subdivides the new hire subclass subsequent to creating the new hire subclass, the minimum class size requirement set forth in paragraph (d)(3) of this section applies to any class of employees created by subdividing the new hire subclass, if the minimum class size requirement otherwise applies.

(6) *Student employees offered student premium reduction arrangements.* For purposes of this section, if an institution of higher education (as defined in the Higher Education Act of 1965) offers a student employee a student premium reduction arrangement, the employee is not considered to be part of the class of employees to which the employee would otherwise belong. For the purpose of this paragraph (d)(6) and paragraph (f)(1) of this section, a student premium reduction arrangement is defined as any program offered by an institution of higher education under which the cost of insured or self-insured student health coverage is reduced for certain students through a credit, offset, reimbursement, stipend or similar arrangement. A student employee offered a student premium reduction arrangement is also not counted for purposes of determining the applicable class size minimum under paragraph (d)(3)(iii) of this section. If a student employee is not offered a student premium reduction arrangement (including if the student employee is offered an individual coverage HRA instead), the student employee is considered to be part of the class of employees to which the employee otherwise belongs and is counted for purposes of determining the applicable class size minimum under paragraph (d)(3)(iii) of this section.

(e) *Integration of Individual Coverage HRAs with Medicare—(1) General rule.* An individual coverage HRA will be considered to be integrated with Medicare (and deemed to comply with PHS Act sections 2711 and 2713 and §54.9815-2711(d) (4) of this chapter), provided that the conditions of paragraph (c) of this section are satisfied, subject to paragraph (e)(2) of this section. Nothing in this section requires that a participant and his or her dependents all have the same type of coverage; therefore, an individual coverage HRA may be integrated with Medicare for some individuals and with individual health insurance coverage for others, including, for example, a participant enrolled in Medicare Part A and B or Part C and his or her dependents enrolled in individual health insurance coverage.

(2) *Application of conditions in paragraph (c) of this section—(i) In general.* Except as provided in paragraph (e)(2)(ii) of this section, in applying the conditions of paragraph (c) of this section with respect to integration with Medicare, a reference to "individual health insurance coverage" is deemed to refer to coverage under Medicare Part A and B or Part C. References in this section to integration of an HRA with Medicare refer to integration of an individual coverage HRA with Medicare Part A and B or Part C.

(ii) *Exceptions.* For purposes of the statement regarding ERISA under the notice content element under paragraph (c)(6)(ii) (A) of this section and the statement regarding the availability of a special enrollment period under the notice content element under paragraph (c)(6)(ii)(J) of this section, the term individual health insurance coverage means only individual health insurance coverage and does not also mean coverage under Medicare Part A and B or Part C.

(f) *Examples—(1) Examples regarding classes and the minimum class size requirement.* The following examples illustrate the provisions of paragraph (c)(3) of this section, taking into account the provisions of paragraphs (d)(1) through (4) and (d)(6) of this section. In each example, the HRA is an individual coverage HRA that may reimburse any medical care expenses, including premiums for individual health insurance coverage and it is assumed that no participants or dependents are Medicare beneficiaries.

(i) *Example 1: Collectively bargained employees offered traditional group health plan; non-collectively bargained employees offered HRA—(A) Facts.* For 2020, Plan Sponsor A offers its employees covered by a collective bargaining agreement a traditional group health plan (as required by the collective bargaining agreement) and all other employees (non-collectively bargained employees) each an HRA on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(i) (*Example 1*) because collectively bargained and non-collectively bargained employees may be treated as different classes of employees, one of which may be offered a traditional group health plan and the other of which may be offered an individual coverage HRA, and Plan Sponsor A offers the HRA on the same terms to all participants who are non-collectively bargained employees. The minimum class size requirement does not apply to this paragraph (f)(1)(i) (*Example 1*) even though Plan Sponsor A offers one class a traditional group health plan and one class the HRA because collectively bargained and non-collectively bargained employees are not applicable classes that are subject to the minimum class size requirement.

(ii) *Example 2: Collectively bargained employees in one unit offered traditional group health plan and in another unit offered HRA—(A) Facts.* For 2020, Plan Sponsor B offers its employees covered by a collective bargaining agreement with Local 100 a traditional group health plan (as required by the collective bargaining agreement), and its employees covered by a collective bargaining agreement with Local 200 each an HRA on the same terms (as required by the collective bargaining agreement).

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(ii) (*Example 2*) because the employees covered by the collective bargaining agreements with the two separate bargaining units (Local 100 and Local 200) may be treated as two different classes of employees and Plan Sponsor B offers an HRA on the same terms to the participants covered by the agreement with Local 200. The minimum class size requirement does not apply to this paragraph (f)(1)(ii) (*Example 2*) even though Plan Sponsor B offers the Local 100 employees a traditional group health

plan and the Local 200 employees an HRA because collectively bargained employees are not applicable classes that are subject to the minimum class size requirement.

(iii) *Example 3: Employees in a waiting period offered no coverage; other employees offered an HRA—(A) Facts.* For 2020, Plan Sponsor C offers its employees who have completed a waiting period that complies with the requirements for waiting periods in §54.9815-2708 of this chapter each an HRA on the same terms and does not offer coverage to its employees who have not completed the waiting period.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(iii) (*Example 3*) because employees who have completed a waiting period and employees who have not completed a waiting period may be treated as different classes and Plan Sponsor C offers the HRA on the same terms to all participants who have completed the waiting period. The minimum class size requirement does not apply to this paragraph (f)(1)(iii) (*Example 3*) because Plan Sponsor C does not offer at least one class of employees a traditional group health plan and because the class of employees who have not completed a waiting period and the class of employees who have completed a waiting period are not applicable classes that are subject to the minimum class size requirement.

(iv) *Example 4: Employees in a waiting period offered an HRA; other employees offered a traditional group health plan—(A) Facts.* For 2020, Plan Sponsor D offers its employees who have completed a waiting period that complies with the requirements for waiting periods in §54.9815-2708 of this chapter a traditional group health plan and offers its employees who have not completed the waiting period each an HRA on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(iv) (*Example 4*) because employees who have completed a waiting period and employees who have not completed a waiting period may be treated as different classes and Plan Sponsor D offers an HRA on the same terms to all participants who have not completed the waiting period. The minimum class size requirement does not apply to this paragraph (f)(1)(iv) (*Example 4*) even though Plan Sponsor D offers employees who have completed a waiting period a traditional group health plan and employees who have not completed a waiting period an HRA because the class of employees who have not completed a waiting period is not an applicable class that is subject to the minimum class size requirement (nor is the class made up of employees who have completed the waiting period).

(v) *Example 5: Staffing firm employees temporarily placed with customers offered an HRA; other employees offered a traditional group health plan—(A) Facts.* Plan Sponsor E is a staffing firm that places certain of its employees on temporary assignments with customers that are not the common law employers of Plan Sponsor E's employees or treated as a single employer with Plan Sponsor E under section 414(b), (c), (m), or (o) (unrelated entities); other employees work in Plan Sponsor E's office managing the staffing business (non-temporary employees). For 2020, Plan Sponsor E offers its employees who are on temporary assignments with customers each an HRA on the same terms. All other employees are offered a traditional group health plan.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(v) (*Example 5*) because the employees who are hired for temporary placement at an unrelated entity and non-temporary employees of Plan Sponsor E may be treated as different classes of employees and Plan Sponsor E offers an HRA on the same terms to all participants temporarily placed with customers. The minimum class size requirement does not apply to this paragraph (f)(1)(v) (*Example 5*) even though Plan Sponsor E offers one class a traditional group health plan and one class the HRA because the class of employees hired for temporary placement is not an applicable class that is subject to the minimum class size requirement (nor is the class made up of non-temporary employees).

(vi) *Example 6: Staffing firm employees temporarily placed with customers in rating area 1 offered an HRA; other employees offered a traditional group health plan—(A) Facts.* The facts are the same as in paragraph (f)(1)(v) of this section (*Example 5*), except that Plan Sponsor E has work sites in rating area 1 and rating area 2, and it offers its 10 employees on temporary assignments with a work site in rating area 1 an HRA on the same terms. Plan Sponsor E has 200 other employees in rating areas 1 and 2, including its non-temporary employees in rating areas 1 and 2 and its employees on temporary assignments with a work site in rating area 2, all of whom are offered a traditional group health plan.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(vi) (*Example 6*) because, even though the employees who are temporarily placed with customers generally may be treated as employees of a different class, because Plan Sponsor E is also using a rating area to identify the class offered the HRA (which is an applicable class for the minimum class size requirement) and is offering one class the HRA and another class the traditional group health plan, the minimum class size requirement applies to the class offered the HRA, and the class offered the HRA fails to satisfy the minimum class size requirement. Because Plan Sponsor E employs 210 employees, the applicable class size minimum is 20, and the HRA is offered to only 10 employees.

(vii) *Example 7: Employees in State 1 offered traditional group health plan; employees in State 2 offered HRA—(A) Facts.* Plan Sponsor F employs 45 employees whose work site is in State 1 and 7 employees whose primary site of employment is in State 2. For 2020, Plan Sponsor F offers its 45 employees in State 1 a traditional group health plan, and each of its 7 employees in State 2 an HRA on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(vii) (*Example 7*) because Plan Sponsor F offers the HRA on the same terms to all employees with a work site in State 2 and that class is a permissible class under paragraph (d) of this section. This is because employees whose work sites are in different

rating areas may be considered different classes and a plan sponsor may create a class of employees by combining classes of employees, including by combining employees whose work site is in one rating area with employees whose work site is in a different rating area, or by combining all employees whose work site is in a state. The minimum class size requirement does not apply to this paragraph (f)(1)(vii) (*Example 7*) because the minimum class size requirement does not apply if the geographic area defining a class of employees is a state or a combination of two or more entire states.

(viii) *Example 8: Full-time seasonal employees offered HRA; all other full-time employees offered traditional group health plan; part-time employees offered no coverage—(A) Facts.* Plan Sponsor G employs 6 full-time seasonal employees, 75 full-time employees who are not seasonal employees, and 5 part-time employees. For 2020, Plan Sponsor G offers each of its 6 full-time seasonal employees an HRA on the same terms, its 75 full-time employees who are not seasonal employees a traditional group health plan, and offers no coverage to its 5 part-time employees.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(viii) (*Example 8*) because full-time seasonal employees and full-time employees who are not seasonal employees may be considered different classes and Plan Sponsor G offers the HRA on the same terms to all full-time seasonal employees. The minimum class size requirement does not apply to the class offered the HRA in this paragraph (f)(1)(viii) (*Example 8*) because part-time employees are not offered coverage and full-time employees are not an applicable class subject to the minimum class size requirement if part-time employees are not offered coverage.

(ix) *Example 9: Full-time employees in rating area 1 offered traditional group health plan; full-time employees in rating area 2 offered HRA; part-time employees offered no coverage—(A) Facts.* Plan Sponsor H employs 17 full-time employees and 10 part-time employees whose work site is in rating area 1 and 552 full-time employees whose work site is in rating area 2. For 2020, Plan Sponsor H offers its 17 full-time employees in rating area 1 a traditional group health plan and each of its 552 full-time employees in rating area 2 an HRA on the same terms. Plan Sponsor H offers no coverage to its 10 part-time employees in rating area 1. Plan Sponsor H reasonably expects to employ 569 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(ix) (*Example 9*) because employees whose work sites are in different rating areas may be considered different classes and Plan Sponsor H offers the HRA on the same terms to all full-time employees in rating area 2. The minimum class size requirement applies to the class offered the HRA in this paragraph (f)(1)(ix) (*Example 9*) because the minimum class size requirement applies to a class based on a geographic area unless the geographic area is a state or a combination of two or more entire states. However, the minimum class size requirement applies only to the class offered the HRA, and Plan Sponsor H offers the HRA to the 552 full-time employees in rating area 2 on the first day of the plan year, satisfying the minimum class size requirement (because the applicable class size minimum for Plan Sponsor H is 20).

(x) *Example 10: Employees in rating area 1 offered HRA; employees in rating area 2 offered traditional group health plan—(A) Facts.* The facts are the same as in paragraph (f)(1)(ix) of this section (*Example 9*) except that Plan Sponsor H offers its 17 full-time employees in rating area 1 the HRA and offers its 552 full-time employees in rating area 2 the traditional group health plan.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(x) (*Example 10*) because, even though employees whose work sites are in different rating areas generally may be considered different classes and Plan Sponsor H offers the HRA on the same terms to all participants in rating area 1, the HRA fails to satisfy the minimum class size requirement. Specifically, the minimum class size requirement applies to this paragraph (f)(1)(x) (*Example 10*) because the minimum class size requirement applies to a class based on a geographic area unless the geographic area is a state or a combination of two or more entire states. Further, the applicable class size minimum for Plan Sponsor H is 20 employees, and the HRA is only offered to the 17 full-time employees in rating area 1 on the first day of the HRA plan year.

(xi) *Example 11: Employees in State 1 and rating area 1 of State 2 offered HRA; employees in all other rating areas of State 2 offered traditional group healthplan—(A) Facts.* For 2020, Plan Sponsor I offers an HRA on the same terms to a total of 200 employees it employs with work sites in State 1 and in rating area 1 of State 2. Plan Sponsor I offers a traditional group health plan to its 150 employees with work sites in other rating areas in State 2. Plan Sponsor I reasonably expects to employ 350 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xi) (*Example 11*). Plan Sponsor I may treat all of the employees with a work site in State 1 and rating area 1 of State 2 as a class of employees because employees whose work sites are in different rating areas may be considered different classes and a plan sponsor may create a class of employees by combining classes of employees, including by combining employees whose work site is in one rating area with a class of employees whose work site is in a different rating area. The minimum class size requirement applies to the class of employees offered the HRA (made up of employees in State 1 and in rating area 1 of State 2) because the minimum class size requirement applies to a class based on a geographic area unless the geographic area is a state or a combination of two or more entire states. In this case, the class is made up of a state plus a rating area which is not the entire state. However, this class satisfies the minimum class size requirement because the applicable class size minimum for Plan Sponsor I is 20, and Plan Sponsor I offered the HRA to 200 employees on the first day of the plan year.

(xii) *Example 12: Salaried employees offered a traditional group health plan; hourly employees offered an HRA—(A) Facts.* Plan Sponsor J has 163 salaried employees and 14 hourly employees. For 2020, Plan Sponsor J offers its 163 salaried

employees a traditional group health plan and each of its 14 hourly employees an HRA on the same terms. Plan Sponsor J reasonably expects to employ 177 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(xii) (*Example 12*) because, even though salaried and hourly employees generally may be considered different classes and Plan Sponsor J offers the HRA on the same terms to all hourly employees, the HRA fails to satisfy the minimum class size requirement. Specifically, the minimum class size requirement applies in this paragraph (f)(1)(xii) (*Example 12*) because employees who are paid on a salaried basis and employees who are not paid on a salaried basis are applicable classes subject to the minimum class size requirement. Because Plan Sponsor J reasonably expects to employ between 100 and 200 employees on the first day of the plan year, the applicable class size minimum is 10 percent, rounded down to a whole number. Ten percent of 177 total employees, rounded down to a whole number is 17, and the HRA is offered to only 14 hourly employees.

(xiii) *Example 13: Part-time employees and full-time employees offered different HRAs; no traditional group health plan offered—(A) Facts.* Plan Sponsor K has 50 full-time employees and 7 part-time employees. For 2020, Plan Sponsor K offers its 50 full-time employees \$2,000 each in an HRA otherwise provided on the same terms and each of its 7 part-time employees \$500 in an HRA otherwise provided on the same terms. Plan Sponsor K reasonably expects to employ 57 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xiii) (*Example 13*) because full-time employees and part-time employees may be treated as different classes and Plan Sponsor K offers an HRA on the same terms to all the participants in each class. The minimum class size requirement does not apply to either the full-time class or the part-time class because (although in certain circumstances the minimum class size requirement applies to a class of full-time employees and a class of part-time employees) Plan Sponsor K does not offer any class of employees a traditional group health plan, and the minimum class size requirement applies only when, among other things, at least one class of employees is offered a traditional group health plan while another class is offered an HRA.

(xiv) *Example 14: No employees offered an HRA—(A) Facts.* The facts are the same facts as in paragraph (f)(1)(xiii) of this section (*Example 13*), except that Plan Sponsor K offers its full-time employees a traditional group health plan and does not offer any group health plan (either a traditional group health plan or an HRA) to its part-time employees.

(B) *Conclusion.* The regulations set forth under this section do not apply to Plan Sponsor K because Plan Sponsor K does not offer an individual coverage HRA to any employee.

(xv) *Example 15: Full-time employees offered traditional group health plan; part-time employees offered HRA—(A) Facts.* The facts are the same as in paragraph (f)(1)(xiii) of this section (*Example 13*), except that Plan Sponsor K offers its full-time employees a traditional group health plan and offers each of its part-time employees \$500 in an HRA and otherwise on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(xv) (*Example 15*) because, even though the full-time employees and the part-time employees generally may be treated as different classes, in this paragraph (f)(1)(xv) (*Example 15*), the minimum class size requirement applies to the part-time employees, and it is not satisfied. Specifically, the minimum class size requirement applies to the part-time employees because that requirement applies to an applicable class offered an HRA when one class is offered a traditional group health plan while another class is offered an HRA, and to the part-time and full-time employee classes when one of those classes is offered a traditional group health plan while the other is offered an HRA. Because Plan Sponsor K reasonably expects to employ fewer than 100 employees on the first day of the HRA plan year, the applicable class size minimum for Plan Sponsor K is 10 employees, but Plan Sponsor K offered the HRA only to its 7 part-time employees.

(xvi) *Example 16: Satisfying minimum class size requirement based on employees offered HRA—(A) Facts.* Plan Sponsor L employs 78 full-time employees and 12 part-time employees. For 2020, Plan Sponsor L offers its 78 full-time employees a traditional group health plan and each of its 12 part-time employees an HRA on the same terms. Only 6 part-time employees enroll in the HRA. Plan Sponsor L reasonably expects to employ fewer than 100 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xvi) (*Example 16*) because full-time employees and part-time employees may be treated as different classes, Plan Sponsor L offers an HRA on the same terms to all the participants in the part-time class, and the minimum class size requirement is satisfied. Specifically, whether a class of employees satisfies the applicable class size minimum is determined as of the first day of the plan year based on the number of employees in a class that is offered an HRA, not on the number of employees who enroll in the HRA. The applicable class size minimum for Plan Sponsor L is 10 employees, and Plan Sponsor L offered the HRA to its 12 part-time employees.

(xvii) *Example 17: Student employees offered student premium reduction arrangements and same terms requirement—(A) Facts.* Plan Sponsor M is an institution of higher education that offers each of its part-time employees an HRA on the same terms, except that it offers its part-time employees who are student employees a student premium reduction arrangement, and the student premium reduction arrangement provides different amounts to different part-time student employees.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xvii) (*Example 17*) because Plan Sponsor M offers the HRA on the same terms to its part-time employees who are not students and because the part-time student employees offered a student premium reduction arrangement (and their varying HRAs) are not taken into account as part-time employees for purposes of determining whether a class of employees is offered an HRA on the same terms.

(xiii) *Example 18: Student employees offered student premium reduction arrangements and minimum class size requirement—(A) Facts.* Plan Sponsor N is an institution of higher education with 25 hourly employees. Plan Sponsor N offers 15 of its hourly employees, who are student employees, a student premium reduction arrangement and it wants to offer its other 10 hourly employees an HRA for 2022. Plan Sponsor N offers its salaried employees a traditional group health plan. Plan Sponsor N reasonably expects to have 250 employees on the first day of the 2022 HRA plan year, 15 of which will have offers of student premium reduction arrangements.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(xviii) (*Example 18*). The minimum class size requirement will apply to the class of hourly employees to which Plan Sponsor N wants to offer the HRA because Plan Sponsor N offers a class of employees a traditional group health plan and another class the HRA, and the minimum class size requirement generally applies to a class of hourly employees offered an HRA. Plan Sponsor N's applicable class size minimum is 20 because Plan Sponsor N reasonably expects to employ 235 employees on the first day of the plan year (250 employees minus 15 employees receiving a student premium reduction arrangement). Plan Sponsor N may not offer the HRA to its hourly employees because the 10 employees offered the HRA as of the first day of the plan year does not satisfy the applicable class size minimum.

(2) *Examples regarding special rule for new hires.* The following examples illustrate the provisions of paragraph (c)(3) of this section, taking into account the provisions of paragraph (d) of this section, in particular the special rule for new hires under paragraph (d)(5) of this section. In each example, the HRA is an individual coverage HRA that has a calendar year plan year and may reimburse any medical care expenses, including premiums for individual health insurance coverage. The examples also assume that no participants or dependents are Medicare beneficiaries.

(i) *Example 1: Application of special rule for new hires to all employees—(A) Facts.* For 2021, Plan Sponsor A offers all employees a traditional group health plan. For 2022, Plan Sponsor A offers all employees hired on or after January 1, 2022, an HRA on the same terms and continues to offer the traditional group health plan to employees hired before that date. On the first day of the 2022 plan year, Plan Sponsor A has 2 new hires who are offered the HRA.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(i) (*Example 1*) because, under the special rule for new hires in paragraph (d)(5) of this section, the employees newly hired on and after January 1, 2022, may be treated as a new hire subclass, Plan Sponsor A offers the HRA on the same terms to all participants in the new hire subclass, and the minimum class size requirement does not apply to the new hire subclass.

(ii) *Example 2: Application of special rule for new hires to full-time employees—(A) Facts.* For 2021, Plan Sponsor B offers a traditional group health plan to its full-time employees and does not offer any coverage to its part-time employees. For 2022, Plan Sponsor B offers full-time employees hired on or after January 1, 2022, an HRA on the same terms, continues to offer its full-time employees hired before that date a traditional group health plan, and continues to offer no coverage to its part-time employees. On the first day of the 2022 plan year, Plan Sponsor B has 2 new hire, full-time employees who are offered the HRA.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(ii) (*Example 2*) because, under the special rule for new hires in paragraph (d)(5) of this section, the full-time employees newly hired on and after January 1, 2022, may be treated as a new hire subclass and Plan Sponsor B offers the HRA on the same terms to all participants in the new hire subclass. The minimum class size requirement does not apply to the new hire subclass.

(iii) *Example 3: Special rule for new hires impermissibly applied retroactively—(A) Facts.* For 2025, Plan Sponsor C offers a traditional group health plan to its full-time employees. For 2026, Plan Sponsor C wants to offer an HRA to its full-time employees hired on and after January 1, 2023, while continuing to offer a traditional group health plan to its full-time employees hired before January 1, 2023.

(B) *Conclusion.* The special rule for new hires under paragraph (d)(5) of this section does not apply in this paragraph (f)(2)(iii) (*Example 3*) because the rule must be applied prospectively. That is, Plan Sponsor C may not, in 2026, choose to apply the special rule for new hires retroactive to 2023. If Plan Sponsor C were to offer an HRA in this way, it would fail to satisfy the conditions under paragraphs (c)(2) and (3) of this section because the new hire subclass would not be treated as a subclass for purposes of applying those rules and, therefore, all full-time employees would be treated as one class to which either a traditional group health plan or an HRA could be offered, but not both.

(iv) *Example 4: Permissible second application of the special rule for new hires to the same class of employees—(A) Facts.* For 2021, Plan Sponsor D offers all of its full-time employees a traditional group health plan. For 2022, Plan Sponsor D applies the special rule for new hires and offers an HRA on the same terms to all employees hired on and after January 1, 2022, and continues to offer a traditional group health plan to full-time employees hired before that date. For 2025, Plan Sponsor D discontinues use of the special rule for new hires, and again offers all full-time employees a traditional group health plan. In 2030, Plan Sponsor D decides to apply the special rule for new hires to the full-time employee class again, offering an HRA to

all full-time employees hired on and after January 1, 2030, on the same terms, while continuing to offer employees hired before that date a traditional group health plan.

(B) *Conclusion.* Plan Sponsor D has permissibly applied the special rule for new hires and is in compliance with the requirements of paragraphs (c)(2) and (3) of this section.

(v) *Example 5: Impermissible second application of the special rule for new hires to the same class of employees—(A) Facts.* The facts are the same as in paragraph (f)(2)(iv) of this section (*Example 4*), except that for 2025, Plan Sponsor D discontinues use of the special rule for new hires by offering all full-time employees an HRA on the same terms. Further, for 2030, Plan Sponsor D wants to continue to offer an HRA on the same terms to all full-time employees hired before January 1, 2030, and to offer all full-time employees hired on or after January 1, 2030, an HRA in a different amount.

(B) *Conclusion.* Plan Sponsor D may not apply the special rule for new hires for 2030 to the class of full-time employees being offered an HRA because the special rule for new hires may only be applied to a class that is being offered a traditional group health plan.

(vi) *Example 6: New full-time employees offered different HRAs in different rating areas—(A) Facts.* Plan Sponsor E has work sites in rating area 1, rating area 2, and rating area 3. For 2021, Plan Sponsor E offers its full-time employees a traditional group health plan. For 2022, Plan Sponsor E offers its full-time employees hired on or after January 1, 2022, in rating area 1 an HRA of \$3,000, its full-time employees hired on or after January 1, 2022, in rating area 2 an HRA of \$5,000, and its full-time employees hired on or after January 1, 2022, in rating area 3 an HRA of \$7,000. Within each class offered an HRA, Plan Sponsor E offers the HRA on the same terms. Plan Sponsor E offers its full-time employees hired prior to January 1, 2022, in each of those classes a traditional group health plan. On the first day of the 2022 plan year, there is one new hire, full-time employee in rating area 1, three new hire, full-time employees in rating area 2, and 10 new hire-full-time employees in rating area 3.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(vi) (*Example 6*) because, under the special rule for new hires in paragraph (d)(5) of this section, the full-time employees in each of the three rating areas newly hired on and after January 1, 2022, may be treated as three new hire subclasses and Plan Sponsor E offers the HRA on the same terms to all participants in the new hire subclasses. Further, the minimum class size requirement does not apply to the new hire subclasses.

(vii) *Example 7: New full-time employee class subdivided based on rating area—(A) Facts.* Plan Sponsor F offers its full-time employees hired on or after January 1, 2022, an HRA on the same terms and it continues to offer its full-time employees hired before that date a traditional group health plan. Plan Sponsor F offers no coverage to its part-time employees. For the 2025 plan year, Plan Sponsor F wants to subdivide the full-time new hire subclass so that those whose work site is in rating area 1 will be offered the traditional group health plan and those whose work site is in rating area 2 will continue to receive the HRA. Plan Sponsor F reasonably expects to employ 219 employees on January 1, 2025. As of January 1, 2025, Plan Sponsor F has 15 full-time employees whose work site is in rating area 2 and who were hired between January 1, 2022, and January 1, 2025.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(2)(vii) (*Example 7*) because the new hire subclass has been subdivided in a manner that is subject to the minimum class size requirement, and the class offered the HRA fails to satisfy the minimum class size requirement. Specifically, once the new hire subclass is subdivided the general rules for applying the minimum class size requirement apply to the employees offered the HRA in the new hire subclass. In this case, because the subdivision of the new hire full-time subclass is based on rating areas; a class based on rating areas is an applicable class subject to the minimum class size requirement; and the employees in one rating area are to be offered the HRA, while the employees in the other rating area are offered the traditional group health plan, the minimum class size requirement would apply on and after the date of the subdivision. Further, the minimum class size requirement would not be satisfied, because the applicable class size minimum for Plan Sponsor F would be 20, and only 15 employees in rating area 2 would be offered the HRA.

(viii) *Example 8: New full-time employee class subdivided based on state—(A) Facts.* The facts are the same as in paragraph (f)(2)(vii) of this section (*Example 7*), except that for the 2025 plan year, Plan Sponsor F intends to subdivide the new hire, full-time class so that those in State 1 will be offered the traditional group health plan and those in State 2 will each be offered an HRA on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(viii) (*Example 8*) because even though the new hire subclass has been subdivided, it has been subdivided in a manner that is not subject to the minimum class size requirement as the subdivision is based on the entire state.

(ix) *Example 9: New full-time employees and part-time employees offered HRA—(A) Facts.* In 2021, Plan Sponsor G offers its full-time employees a traditional group health plan and does not offer coverage to its part-time employees. For the 2022 plan year, Plan Sponsor G offers its full-time employees hired on or after January 1, 2022, and all of its part-time employees, including those hired before January 1, 2022, and those hired on and after January 1, 2022, an HRA on the same terms, and it continues to offer its full-time employees hired before January 1, 2022, a traditional group health plan.

(B) *Conclusion.* The minimum class size requirement applies to the part-time employees offered the HRA in 2022 because the class is being offered an HRA; the special rule for new hires does not apply (because this class was not previously offered a

traditional group health plan) and so it is not a new hire subclass exempt from the minimum class size requirement; another class of employees (that is, full-time hired before January 1, 2022) are being offered a traditional group health plan; and the part-time employee class is generally an applicable classes that is subject to the minimum class size requirement. However, because the full-time, new hire subclass is based on the special rule for new hires, the minimum class size requirement does not apply to full-time new hires offered an HRA in 2022.

(g) *Applicability date.* This section applies to plan years beginning on or after January 1, 2020.

[T.D. 9867, 84 FR 28987, June 20, 2019]

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Title 29 → Subtitle B → Chapter XXV → Subchapter L → Part 2590 → Subpart B → §2590.702-2

Title 29: Labor

PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLANS

Subpart B—Health Coverage Portability, Nondiscrimination, and Renewability

§2590.702-2 Special rule allowing integration of Health Reimbursement Arrangements (HRAs) and other account-based group health plans with individual health insurance coverage and Medicare and prohibiting discrimination in HRAs and other account-based group health plans.

(a) *Scope.* This section applies to health reimbursement arrangements (HRAs) and other account-based group health plans, as defined in §2590.715-2711(d)(6)(i) of this part. For ease of reference, the term “HRA” is used in this section to include other account-based group health plans. For related regulations, see 26 CFR 1.36B-2(c)(3)(i) and (c)(5), 29 CFR 2510.3-1(i), and 45 CFR 155.420.

(b) *Purpose.* This section provides the conditions that an HRA must satisfy in order to be integrated with individual health insurance coverage for purposes of Public Health Service Act (PHS Act) sections 2711 and 2713 and §2590.715-2711(d)(4) of this part (referred to as an individual coverage HRA). This section also allows an individual coverage HRA to be integrated with Medicare for purposes of PHS Act sections 2711 and 2713 and §2590.715-2711(d)(4), subject to the conditions provided in this section (see paragraph (e) of this section). Some of the conditions set forth in this section specifically relate to compliance with PHS Act sections 2711 and 2713 and some relate to the effect of having or being offered an individual coverage HRA on eligibility for the premium tax credit under section 36B of the Code. In addition, this section provides conditions that an individual coverage HRA must satisfy in order to comply with the nondiscrimination provisions in ERISA section 702 and PHS Act section 2705 (which is incorporated in ERISA section 715) and that are consistent with the provisions of 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)), each as amended, that are designed to create a competitive individual market. These conditions are intended to prevent an HRA plan sponsor from intentionally or unintentionally, directly or indirectly, steering any participants or dependents with adverse health factors away from its traditional group health plan, if any, and toward individual health insurance coverage.

(c) *General rule.* An HRA will be considered to be integrated with individual health insurance coverage for purposes of PHS Act sections 2711 and 2713 and §2590.715-2711(d)(4) of this part and will not be considered to discriminate in violation of ERISA section 702 and PHS Act section 2705 solely because it is integrated with individual health insurance coverage, provided that the conditions of this paragraph (c) are satisfied. See paragraph (e) of this section for how these conditions apply to an individual coverage HRA integrated with Medicare. For purposes of this section, medical care expenses means medical care expenses as defined in §2590.715-2711(d)(6)(ii) of this part and Exchange means Exchange as defined in 45 CFR 155.20.

(1) *Enrollment in individual health insurance coverage—(i) In general.* The HRA must require that the participant and any dependent(s) are enrolled in individual health insurance coverage that is subject to and complies with the requirements in PHS Act sections 2711 (and §2590.715-2711(a)(2) of this part) and PHS Act section 2713 (and §2590.715-2713(a)(1) of this part), for each month that the individual(s) are covered by the HRA. For purposes of this paragraph (c), all individual health insurance coverage, except for individual health insurance coverage that consists solely of excepted benefits, is treated as being subject to and complying with PHS Act sections 2711 and 2713. References to individual health insurance coverage in this paragraph (c) do not include individual health insurance coverage that consists solely of excepted benefits.

(ii) *Forfeiture.* The HRA must provide that if any individual covered by the HRA ceases to be covered by individual health insurance coverage, the HRA will not reimburse medical care expenses that are incurred by that individual after the individual health insurance coverage ceases. In addition, if the participant and all dependents covered by the participant's HRA cease to be covered by individual health insurance coverage, the participant must forfeit the HRA. In either case, the HRA must reimburse medical care expenses incurred by the individual prior to the cessation of individual health insurance coverage to the extent the medical care expenses are otherwise covered by the HRA, but the HRA may limit the period to submit medical care expenses for reimbursement to a reasonable specified time period. If a participant or dependent loses coverage under the HRA for a reason other than cessation of individual health insurance coverage, COBRA and other continuation coverage requirements may apply.

(iii) *Grace periods and retroactive termination of individual health insurance coverage.* In the event an individual is initially enrolled in individual health insurance coverage and subsequently timely fails to pay premiums for the coverage, with the result that the individual is in a grace period, the individual is considered to be enrolled in individual health insurance coverage for purposes of this paragraph (c)(1) and the individual coverage HRA must reimburse medical care expenses incurred by the individual during that time period to the extent the medical care expenses are otherwise covered by the HRA. If the individual fails to pay the applicable premium(s) by the end of the grace period and the coverage is cancelled or terminated, including

retroactively, or if the individual health insurance coverage is cancelled or terminated retroactively for some other reason (for example, a rescission), an individual coverage HRA must require that a participant notify the HRA that coverage has been cancelled or terminated and the date on which the cancellation or termination is effective. After the individual coverage HRA has received the notice of cancellation or termination, the HRA may not reimburse medical care expenses incurred on and after the date the individual health insurance coverage was cancelled or terminated, which is considered to be the date of termination of coverage under the HRA.

(2) *No traditional group health plan may be offered to same participants.* To the extent a plan sponsor offers any class of employees (as defined in paragraph (d) of this section) an individual coverage HRA, the plan sponsor may not also offer a traditional group health plan to the same class of employees, except as provided in paragraph (d)(5) of this section. For purposes of this section, a traditional group health plan is any group health plan other than either an account-based group health plan or a group health plan that consists solely of excepted benefits. Therefore, a plan sponsor may not offer a choice between an individual coverage HRA or a traditional group health plan to any participant or dependent.

(3) *Same terms requirement—(i) In general.* If a plan sponsor offers an individual coverage HRA to a class of employees described in paragraph (d) of this section, the HRA must be offered on the same terms to all participants within the class, except as provided in paragraphs (c)(3)(ii) through (vi) and (d)(5) of this section.

(ii) *Carryover amounts, salary reduction arrangements, and transfer amounts.* Amounts that are not used to reimburse medical care expenses for any plan year that are made available to participants in later plan years are disregarded for purposes of determining whether an HRA is offered on the same terms, provided that the method for determining whether participants have access to unused amounts in future years, and the methodology and formula for determining the amounts of unused funds which they may access in future years, is the same for all participants in a class of employees. In addition, the ability to pay the portion of the premium for individual health insurance coverage that is not covered by the HRA, if any, by using a salary reduction arrangement under section 125 of the Code is considered to be a term of the HRA for purposes of this paragraph (c) (3). Therefore, an HRA is not provided on the same terms unless the salary reduction arrangement, if made available to any participant in a class of employees, is made available on the same terms to all participants (other than former employees, as defined in paragraph (c)(3)(iv) of this section) in the class of employees. Further, to the extent that a participant in an individual coverage HRA was previously covered by another HRA and the current individual coverage HRA makes available amounts that were not used to reimburse medical care expenses under the prior HRA (transferred amounts), the transferred amounts are disregarded for purposes of determining whether the HRA is offered on the same terms, provided that if the HRA makes available transferred amounts, it does so on the same terms for all participants in the class of employees.

(iii) *Permitted variation.* An HRA does not fail to be provided on the same terms solely because the maximum dollar amount made available to participants in a class of employees to reimburse medical care expenses for any plan year increases in accordance with paragraph (c)(3)(iii)(A) or (B) of this section.

(A) *Variation due to number of dependents.* An HRA does not fail to be provided on the same terms to participants in a class of employees solely because the maximum dollar amount made available to those participants to reimburse medical care expenses for any plan year increases as the number of the participant's dependents who are covered under the HRA increases, so long as the same maximum dollar amount attributable to the increase in family size is made available to all participants in that class of employees with the same number of dependents covered by the HRA.

(B) *Variation due to age.* An HRA does not fail to be provided on the same terms to participants in a class of employees solely because the maximum dollar amount made available under the terms of the HRA to those participants to reimburse medical care expenses for any plan year increases as the age of the participant increases, so long as the requirements in paragraphs (c)(3)(iii)(B)(1) and (2) of this section are satisfied. For the purpose of this paragraph (c)(3)(iii)(B), the plan sponsor may determine the age of the participant using any reasonable method for a plan year, so long as the plan sponsor determines each participant's age for the purpose of this paragraph (c)(3)(iii)(B) using the same method for all participants in the class of employees for the plan year and the method is determined prior to the plan year.

(1) The same maximum dollar amount attributable to the increase in age is made available to all participants who are the same age.

(2) The maximum dollar amount made available to the oldest participant(s) is not more than three times the maximum dollar amount made available to the youngest participant(s).

(iv) *Former employees.* An HRA does not fail to be treated as provided on the same terms if the plan sponsor offers the HRA to some, but not all, former employees within a class of employees. However, if a plan sponsor offers the HRA to one or more former employees within a class of employees, the HRA must be offered to the former employee(s) on the same terms as to all other employees within the class, except as provided in paragraph (c)(3)(ii) of this section. For purposes of this section, a former employee is an employee who is no longer performing services for the employer.

(v) *New employees or new dependents.* For a participant whose coverage under the HRA becomes effective later than the first day of the plan year, the HRA does not fail to be treated as being provided on the same terms to the participant if the maximum dollar amount made available to the participant either is the same as the maximum dollar amount made available to participants in the participant's class of employees whose coverage became effective as of the first day of the plan year, or is pro-rated consistent with the portion of the plan year in which the participant is covered by the HRA. Similarly, if the HRA provides for variation in the maximum amount made available to participants in a class of employees based on the number of a

participant's dependents covered by the HRA, and the number of a participant's dependents covered by the HRA changes during a plan year (either increasing or decreasing), the HRA does not fail to be treated as being provided on the same terms to the participant if the maximum dollar amount made available to the participant either is the same as the maximum dollar amount made available to participants in the participant's class of employees who had the same number of dependents covered by the HRA on the first day of the plan year or is pro-rated for the remainder of the plan year after the change in the number of the participant's dependents covered by the HRA consistent with the portion of the plan year in which that number of dependents are covered by the HRA. The method the HRA uses to determine amounts made available for participants whose coverage under the HRA is effective later than the first day of the plan year or who have changes in the number of dependents covered by the HRA during a plan year must be the same for all participants in the class of employees and the method must be determined prior to the beginning of the plan year.

(vi) *HSA-compatible HRAs.* An HRA does not fail to be treated as provided on the same terms if the plan sponsor offers participants in a class of employees a choice between an HSA-compatible individual coverage HRA and an individual coverage HRA that is not HSA compatible, provided both types of HRAs are offered to all participants in the class of employees on the same terms. For the purpose of this paragraph (c)(3)(vi), an HSA-compatible individual coverage HRA is an individual coverage HRA that is limited in accordance with applicable guidance under section 223 of the Code such that an individual covered by such an HRA is not disqualified from being an eligible individual under section 223 of the Code.

(vii) *Examples.* The following examples illustrate the provisions of this paragraph (c)(3), without taking into account the provisions of paragraph (d) of this section. In each example, the HRA is an individual coverage HRA that has a calendar year plan year and may reimburse any medical care expenses, including premiums for individual health insurance coverage (except as provided in paragraph (c)(3)(vii)(E) of this section (*Example 5*)). Further, in each example, assume the HRA is offered on the same terms, except as otherwise specified in the example and that no participants or dependents are Medicare beneficiaries.

(A) *Example 1: Carryover amounts permitted—(1) Facts.* For 2020 and again for 2021, Plan Sponsor A offers all employees \$7,000 each in an HRA, and the HRA provides that amounts that are unused at the end of a plan year may be carried over to the next plan year, with no restrictions on the use of the carryover amounts compared to the use of newly available amounts. At the end of 2020, some employees have used all of the funds in their HRAs, while other employees have balances remaining that range from \$500 to \$1,750 that are carried over to 2021 for those employees.

(2) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(A) (*Example 1*) for 2020 because Plan Sponsor A offers all employees the same amount, \$7,000, in an HRA for that year. The same terms requirement is also satisfied for 2021 because Plan Sponsor A again offers all employees the same amount for that year, and the carryover amounts that some employees have are disregarded in applying the same terms requirement because the amount of the carryover for each employee (that employee's balance) and each employee's access to the carryover amounts is based on the same terms.

(B) *Example 2: Employees hired after the first day of the plan year—(1) Facts.* For 2020, Plan Sponsor B offers all employees employed on January 1, 2020, \$7,000 each in an HRA for the plan year. Employees hired after January 1, 2020, are eligible to enroll in the HRA with an effective date of the first day of the month following their date of hire, as long as they have enrolled in individual health insurance coverage effective on or before that date, and the amount offered to these employees is pro-rated based on the number of months remaining in the plan year, including the month which includes their coverage effective date.

(2) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(B) (*Example 2*) for 2020 because Plan Sponsor B offers all employees employed on the first day of the plan year the same amount, \$7,000, in an HRA for that plan year and all employees hired after January 1, 2020, a pro-rata amount based on the portion of the plan year during which they are enrolled in the HRA.

(C) *Example 3: HRA amounts offered vary based on number of dependents—(1) Facts.* For 2020, Plan Sponsor C offers its employees the following amounts in an HRA: \$1,500, if the employee is the only individual covered by the HRA; \$3,500, if the employee and one dependent are covered by the HRA; and \$5,000, if the employee and more than one dependent are covered by the HRA.

(2) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(C) (*Example 3*) because paragraph (c)(3)(iii)(A) of this section allows the maximum dollar amount made available in an HRA to increase as the number of the participant's dependents covered by the HRA increases and Plan Sponsor C makes the same amount available to each employee with the same number of dependents covered by the HRA.

(D) *Example 4: HRA amounts offered vary based on increases in employees' ages—(1) Facts.* For 2020, Plan Sponsor D offers its employees the following amounts in an HRA: \$1,000 each for employees age 25 to 35; \$2,000 each for employees age 36 to 45; \$2,500 each for employees age 46 to 55; and \$4,000 each for employees over age 55.

(2) *Conclusion.* The same terms requirement of this paragraph (c)(3) is not satisfied in this paragraph (c)(3)(vii)(D) (*Example 4*) because the terms of the HRA provide the oldest participants (those over age 55) with more than three times the amount made available to the youngest participants (those ages 25 to 35), in violation of paragraph (c)(3)(iii)(B)(2) of this section.

(E) *Example 5: Application of same terms requirement to premium only HRA—(1) Facts.* For 2020, Plan Sponsor E offers its employees an HRA that reimburses only premiums for individual health insurance coverage, up to \$10,000 for the year. Employee A enrolls in individual health insurance coverage with a \$5,000 premium for the year and is reimbursed \$5,000 from the HRA. Employee B enrolls in individual health insurance coverage with an \$8,000 premium for the year and is reimbursed \$8,000 from the HRA.

(2) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(E) (*Example 5*) because Plan Sponsor E offers the HRA on the same terms to all employees, notwithstanding that some employees receive a greater amount of reimbursement than others based on the cost of the individual health insurance coverage selected by the employee.

(4) *Opt out.* Under the terms of the HRA, a participant who is otherwise eligible for coverage must be permitted to opt out of and waive future reimbursements on behalf of the participant and all dependents eligible for the HRA from the HRA once, and only once, with respect to each plan year. The HRA may establish timeframes for enrollment in (and opting out of) the HRA but, in general, the opportunity to opt out must be provided in advance of the first day of the plan year. For participants who become eligible to participate in the HRA on a date other than the first day of the plan year (or who become eligible fewer than 90 days

prior to the plan year or for whom the notice under paragraph (c)(6) of this section is required to be provided as set forth in paragraph (c)(6)(i)(C) of this section), or for a dependent who newly becomes eligible during the plan year, this opportunity must be provided during the applicable HRA enrollment period(s) established by the HRA for these individuals. Further, under the terms of the HRA, upon termination of employment, for a participant who is covered by the HRA, either the remaining amounts in the HRA must be forfeited or the participant must be permitted to permanently opt out of and waive future reimbursements from the HRA on behalf of the participant and all dependents covered by the HRA.

(5) *Reasonable procedures for coverage substantiation*—(i) *Substantiation of individual health insurance coverage for the plan year.* The HRA must implement, and comply with, reasonable procedures to substantiate that participants and each dependent covered by the HRA are, or will be, enrolled in individual health insurance coverage for the plan year (or for the portion of the plan year the individual is covered by the HRA, if applicable). The HRA may establish the date by which this substantiation must be provided, but, in general, the date may be no later than the first day of the plan year. However, for a participant who is not eligible to participate in the HRA on the first day of the plan year (or who becomes eligible fewer than 90 days prior to the plan year or for whom the notice under paragraph (c)(6) of this section is required to be provided as set forth in paragraph (c)(6)(i)(C) of this section), the HRA may establish the date by which this substantiation must be provided, but that date may be no later than the date the HRA coverage begins. Similarly, for a participant who adds a new dependent during the plan year, the HRA may establish the date by which this substantiation must be provided, but the date may be no later than the date the HRA coverage for the new dependent begins; however, to the extent the dependent's coverage under the HRA is effective retroactively, the HRA may establish a reasonable time by which this substantiation is required, but must require it be provided before the HRA will reimburse any medical care expense for the newly added dependent. The reasonable procedures an HRA may use to implement the substantiation requirement set forth in this paragraph (c)(5)(i) may include a requirement that a participant substantiate enrollment by providing either:

(A) A document from a third party (for example, the issuer or an Exchange) showing that the participant and any dependents covered by the HRA are, or will be, enrolled in individual health insurance coverage (for example, an insurance card or an explanation of benefits document pertaining to the relevant time period or documentation from the Exchange showing that the individual has completed the application and plan selection); or

(B) An attestation by the participant stating that the participant and dependent(s) covered by the HRA are, or will be, enrolled in individual health insurance coverage, the date coverage began or will begin, and the name of the provider of the coverage.

(ii) *Coverage substantiation with each request for reimbursement of medical care expenses.* Following the initial substantiation of coverage, with each new request for reimbursement of an incurred medical care expense for the same plan year, the HRA may not reimburse a participant for any medical care expenses unless, prior to each reimbursement, the participant substantiates that the individual on whose behalf medical care expenses are requested to be reimbursed continues to be enrolled in individual health insurance coverage for the month during which the medical care expenses were incurred. The HRA must implement, and comply with, reasonable procedures to satisfy this requirement. This substantiation may be in the form of a written attestation by the participant, which may be part of the form used to request reimbursement, or a document from a third party (for example, a health insurance issuer) showing that the participant or the dependent, if applicable, are or were enrolled in individual health insurance coverage for the applicable month.

(iii) *Reliance on substantiation.* For purposes of this paragraph (c)(5), an HRA may rely on the participant's documentation or attestation unless the HRA, its plan sponsor, or any other entity acting in an official capacity on behalf of the HRA has actual knowledge that any individual covered by the HRA is not, or will not be, enrolled in individual health insurance coverage for the plan year (or applicable portion of the plan year) or the month, as applicable.

(6) *Notice requirement*—(i) *Timing.* The HRA must provide a written notice to each participant:

(A) At least 90 calendar days before the beginning of each plan year for any participant who is not described in either paragraph (c)(6)(i)(B) or (C) of this section;

(B) No later than the date on which the HRA may first take effect for the participant, for any participant who is not eligible to participate at the beginning of the plan year (or is not eligible to participate at the time the notice is provided at least 90 calendar days before the beginning of the plan year pursuant to paragraph (c)(6)(i)(A) of this section); or

(C) No later than the date on which the HRA may first take effect for the participant, for any participant who is employed by an employer that is first established less than 120 days before the beginning of the first plan year of the HRA; this paragraph (c)(6)(i)(C) applies only with respect to the first plan year of the HRA.

(ii) *Content.* The notice must include all the information described in this paragraph (c)(6)(ii) (and may include any additional information that does not conflict with that information). To the extent that the Departments of the Treasury, Labor and Health and Human Services provide model notice language for certain elements of this required notice, HRAs are permitted, but not required, to use the model language.

(A) A description of the terms of the HRA, including the maximum dollar amount available for each participant (including the self-only HRA amount available for the plan year (or the maximum dollar amount available for the plan year if the HRA provides for reimbursements up to a single dollar amount regardless of whether a participant has self-only or other than self-only coverage)), any rules regarding the proration of the maximum dollar amount applicable to any participant (or dependent, if

applicable) who is not eligible to participate in the HRA for the entire plan year, whether (and which of) the participant's dependents are eligible for the HRA, a statement that there are different kinds of HRAs (including a qualified small employer health reimbursement arrangement) and the HRA being offered is an individual coverage HRA, a statement that the HRA requires the participant and any covered dependents to be enrolled in individual health insurance coverage (or Medicare Part A and B or Medicare Part C, if applicable), a statement that the coverage in which the participant and any covered dependents must be enrolled cannot be short-term, limited-duration insurance or consist solely of excepted benefits, a statement that individual health insurance coverage in which the participant and any covered dependents are enrolled is not subject to the Employee Retirement Income Security Act if the conditions under §2510.3-1(l) of this chapter are satisfied, the date as of which coverage under the HRA may first become effective (both for participants whose coverage will become effective on the first day of the plan year and for participants whose HRA coverage may become effective at a later date), the dates on which the HRA plan year begins and ends, and the dates on which the amounts newly made available under the HRA will be made available.

(B) A statement of the right of the participant to opt out of and waive future reimbursements from the HRA, as set forth under paragraph (c)(4) of this section.

(C) A description of the potential availability of the premium tax credit if the participant opts out of and waives future reimbursements from the HRA and the HRA is not affordable for one or more months under 26 CFR 1.36B-2(c)(5), a statement that even if the participant opts out of and waives future reimbursements from an HRA, the offer will prohibit the participant (and, potentially, the participant's dependents) from receiving a premium tax credit for the participant's coverage (or the dependent's coverage, if applicable) on an Exchange for any month that the HRA is affordable under 26 CFR 1.36B-2(c)(5), a statement describing how the participant may find assistance with determining affordability, a statement that, if the participant is a former employee, the offer of the HRA does not render the participant (or the participant's dependents, if applicable) ineligible for the premium tax credit regardless of whether it is affordable under 26 CFR 1.36B-2(c)(5), and a statement that if the participant or dependent is enrolled in Medicare, he or she is ineligible for the premium tax credit without regard to the offer or acceptance of the HRA;

(D) A statement that if the participant accepts the HRA, the participant may not claim a premium tax credit for the participant's Exchange coverage for any month the HRA may be used to reimburse medical care expenses of the participant, and a premium tax credit may not be claimed for the Exchange coverage of the participant's dependents for any month the HRA may be used to reimburse medical care expenses of the dependents.

(E) A statement that the participant must inform any Exchange to which the participant applies for advance payments of the premium tax credit of the availability of the HRA; the self-only HRA amount available for the HRA plan year (or the maximum dollar amount available for the plan year if the HRA provides for reimbursements up to a single dollar amount regardless of whether a participant has self-only or other than self-only coverage) as set forth in the written notice in accordance with paragraph (c)(6)(ii)(A) of this section; whether the HRA is also available to the participant's dependents and if so, which ones; the date as of which coverage under the HRA may first become effective; the date on which the plan year begins and the date on which it ends; and whether the participant is a current employee or former employee.

(F) A statement that the participant should retain the written notice because it may be needed to determine whether the participant is allowed a premium tax credit on the participant's individual income tax return.

(G) A statement that the HRA may not reimburse any medical care expense unless the substantiation requirement set forth in paragraph (c)(5)(ii) of this section is satisfied and a statement that the participant must also provide the substantiation required by paragraph (c)(5)(i) of this section.

(H) A statement that if the individual health insurance coverage (or coverage under Medicare Part A and B or Medicare Part C) of a participant or dependent ceases, the HRA will not reimburse any medical care expenses that are incurred by the participant or dependent, as applicable, after the coverage ceases, and a statement that the participant must inform the HRA if the participant's or dependent's individual health insurance coverage (or coverage under Medicare Part A and B or Medicare Part C) is cancelled or terminated retroactively and the date on which the cancellation or termination is effective.

(I) The contact information (including a phone number) for an individual or a group of individuals who participants may contact in order to receive additional information regarding the HRA. The plan sponsor may determine which individual or group of individuals is best suited to be the specified contact.

(J) A statement of availability of a special enrollment period to enroll in or change individual health insurance coverage, through or outside of an Exchange, for the participant and any dependents who newly gain access to the HRA and are not already covered by the HRA.

(d) *Classes of employees*—(1) *In general.* This paragraph (d) sets forth the rules for determining classes of employees. Paragraph (d)(2) of this section sets forth the specific classes of employees; paragraph (d)(3) of this section sets forth a minimum class size requirement that applies in certain circumstances; paragraph (d)(4) of this section sets forth rules regarding the definition of "full-time employees," "part-time employees," and "seasonal employees"; paragraph (d)(5) of this section sets forth a special rule for new hires; and paragraph (d)(6) of this section addresses student premium reduction arrangements. For purposes of this section, including determining classes under this paragraph (d), the employer is the common law employer and is determined without regard to the rules under sections 414(b), (c), (m), and (o) of the Code that would treat the common law employer as a single employer with certain other entities.

(2) *List of classes.* Participants may be treated as belonging to a class of employees based on whether they are, or are not, included in the classes described in this paragraph (d)(2). If the individual coverage HRA is offered to former employees, former employees are considered to be in the same class in which they were included immediately before separation from service. Before each plan year, a plan sponsor must determine for the plan year which classes of employees it intends to treat separately and the definition of the relevant class(es) it will apply, to the extent these regulations permit a choice. After the classes and the definitions of the classes are established for a plan year, a plan sponsor may not make changes to the classes of employees or the definitions of those relevant classes with respect to that plan year.

(i) Full-time employees, defined at the election of the plan sponsor to mean either full-time employees under section 4980H of the Code (and 26 CFR 54.4980H-1(a)(21)) or employees who are not part-time employees (as described in 26 CFR 1.105-11(c)(2)(iii)(C));

(ii) Part-time employees, defined at the election of the plan sponsor to mean either employees who are not full-time employees under section 4980H of the Code (and under 26 CFR 54.4980H-1(a)(21) (which defines full-time employee)) or employees who are part-time employees as described in 26 CFR 1.105-11(c)(2)(iii)(C);

(iii) Employees who are paid on a salary basis;

(iv) Non-salaried employees (such as, for example, hourly employees);

(v) Employees whose primary site of employment is in the same rating area as defined in 45 CFR 147.102(b);

(vi) Seasonal employees, defined at the election of the plan sponsor to mean seasonal employees as described in either 26 CFR 54.4980H-1(a)(38) or 26 CFR 1.105-11(c)(2)(iii)(C);

(vii) Employees included in a unit of employees covered by a particular collective bargaining agreement (or an appropriate related participation agreement) in which the plan sponsor participates (as described in 26 CFR 1.105-11(c)(2)(iii)(D));

(viii) Employees who have not satisfied a waiting period for coverage (if the waiting period complies with §2590.715-2708 of this part);

(ix) Non-resident aliens with no U.S.-based income (as described in 26 CFR 1.105-11(c)(2)(iii)(E));

(x) Employees who, under all the facts and circumstances, are employees of an entity that hired the employees for temporary placement at an entity that is not the common law employer of the employees and that is not treated as a single employer with the entity that hired the employees for temporary placement under section 414(b), (c), (m), or (o) of the Code; or

(xi) A group of participants described as a combination of two or more of the classes of employees set forth in paragraphs (d)(2)(i) through (x) of this section.

(3) *Minimum class size requirement—(i) In general.* If a class of employees is subject to the minimum class size requirement as set forth in this paragraph (d)(3), the class must consist of at least a minimum number of employees (as described in paragraphs (d)(3)(iii) and (iv) of this section), otherwise, the plan sponsor may not treat that class as a separate class of employees. Paragraph (d)(3)(ii) of this section sets forth the circumstances in which the minimum class size requirement applies to a class of employees, paragraph (d)(3)(iii) of this section sets forth the rules for determining the applicable class size minimum, and paragraph (d)(3)(iv) of this section sets forth the rules for a plan sponsor to determine if it satisfies the minimum class size requirement with respect to a class of employees.

(ii) *Circumstances in which minimum class size requirement applies—(A)* The minimum class size requirement applies only if a plan sponsor offers a traditional group health plan to one or more classes of employees and offers an individual coverage HRA to one or more other classes of employees.

(B) The minimum class size requirement does not apply to a class of employees offered a traditional group health plan or a class of employees offered no coverage.

(C) The minimum class size requirement applies to a class of employees offered an individual coverage HRA if the class is full-time employees, part-time employees, salaried employees, non-salaried employees, or employees whose primary site of employment is in the same rating area (described in paragraph (d)(2)(i), (ii), (iii), (iv), or (v) of this section, respectively, and referred to collectively as the applicable classes or individually as an applicable class), except that:

(1) In the case of the class of employees whose primary site of employment is in the same rating area (as described in paragraph (d)(2)(v) of this section), the minimum class size requirement does not apply if the geographic area defining the class is a State or a combination of two or more entire States; and

(2) In the case of the classes of employees that are full-time employees and part-time employees (as described in paragraphs (d)(2)(i) and (ii) of this section, respectively), the minimum class size requirement applies only to those classes (and the classes are only applicable classes) if the employees in one such class are offered a traditional group health plan while the employees in the other such class are offered an individual coverage HRA. In such a case, the minimum class size requirement applies only to the class offered an individual coverage HRA.

(D) A class of employees offered an individual coverage HRA is also subject to the minimum class size requirement if the class is a class of employees created by combining at least one of the applicable classes (as defined in paragraph (d)(3)(ii)(C) of this section) with any other class, except that the minimum class size requirement shall not apply to a class that is the result of a combination of one of the applicable classes and a class of employees who have not satisfied a waiting period (as described in paragraph (d)(2)(viii) of this section).

(iii) *Determination of the applicable class size minimum—(A) In general.* The minimum number of employees that must be in a class of employees that is subject to the minimum class size requirement (the applicable class size minimum) is determined prior to the beginning of the plan year for each plan year of the individual coverage HRA and is:

(1) 10, for an employer with fewer than 100 employees;

(2) A number, rounded down to a whole number, equal to 10 percent of the total number of employees, for an employer with 100 to 200 employees; and

(3) 20, for an employer with more than 200 employees.

(B) *Determining employer size.* For purposes of this paragraph (d)(3), the number of employees of an employer is determined in advance of the plan year of the HRA based on the number of employees that the employer reasonably expects to employ on the first day of the plan year.

(iv) *Determining if a class satisfies the applicable class size minimum.* For purposes of this paragraph (d)(3), whether a class of employees satisfies the applicable class size minimum for a plan year of the individual coverage HRA is based on the number of employees in the class offered the individual coverage HRA as of the first day of the plan year. Therefore, this determination is not based on the number of employees that actually enroll in the individual coverage HRA, and this determination is not affected by changes in the number of employees in the class during the plan year.

(4) *Consistency requirement.* For any plan year, a plan sponsor may define “full-time employee,” “part-time employee,” and “seasonal employee” in accordance with the relevant provisions of sections 105(h) or 4980H of the Code, as set forth in paragraphs (d)(2)(i), (ii), and (vi) of this section, if:

(i) To the extent applicable under the HRA for the plan year, each of the three classes of employees are defined in accordance with section 105(h) of the Code or each of the three classes of employees are defined in accordance with section 4980H of the Code for the plan year; and

(ii) The HRA plan document sets forth the applicable definitions prior to the beginning of the plan year to which the definitions will apply.

(5) *Special rule for new hires—(i) In general.* Notwithstanding paragraphs (c)(2) and (3) of this section, a plan sponsor that offers a traditional group health plan to a class of employees may prospectively offer the employees in that class of employees who are hired on or after a certain future date (the new hire date) an individual coverage HRA (with this group of employees referred to as the new hire subclass), while continuing to offer employees in that class of employees who are hired before the new hire date a traditional group health plan (with the rule set forth in this sentence referred to as the special rule for new hires). For the new hire subclass, the individual coverage HRA must be offered on the same terms to all participants within the subclass, in accordance with paragraph (c)(3) of this section. In accordance with paragraph (c)(2) of this section, a plan sponsor may not offer a choice between an individual coverage HRA or a traditional group health plan to any employee in the new hire subclass or to any employee in the class who is not a member of the new hire subclass.

(ii) *New hire date.* A plan sponsor may set the new hire date for a class of employees prospectively as any date on or after January 1, 2020. A plan sponsor may set different new hire dates prospectively for separate classes of employees.

(iii) *Discontinuation of use of special rule for new hires and multiple applications of the special rule for new hires.* A plan sponsor may discontinue use of the special rule for new hires at any time for any class of employees. In that case, the new hire subclass is no longer treated as a separate subclass of employees. In the event a plan sponsor applies the special rule for new hires to a class of employees and later discontinues use of the rule to the class of employees, the plan sponsor may later apply the rule if the application of the rule would be permitted under the rules for initial application of the special rule for new hires. If a plan sponsor, in accordance with the requirements for the special rule for new hires, applies the rule to a class of employees subsequent to any prior application and discontinuance of the rule to that class, the new hire date must be prospective.

(iv) *Application of the minimum class size requirement under the special rule for new hires.* The minimum class size requirement set forth in paragraph (d)(3) of this section does not apply to the new hire subclass. However, if a plan sponsor subdivides the new hire subclass subsequent to creating the new hire subclass, the minimum class size requirement set forth in paragraph (d)(3) of this section applies to any class of employees created by subdividing the new hire subclass, if the minimum class size requirement otherwise applies.

(6) *Student employees offered student premium reduction arrangements.* For purposes of this section, if an institution of higher education (as defined in the Higher Education Act of 1965) offers a student employee a student premium reduction arrangement, the employee is not considered to be part of the class of employees to which the employee would otherwise belong. For the purpose of this paragraph (d)(6) and paragraph (f)(1) of this section, a student premium reduction arrangement is defined as any program offered by an institution of higher education under which the cost of insured or self-insured student

health coverage is reduced for certain students through a credit, offset, reimbursement, stipend or similar arrangement. A student employee offered a student premium reduction arrangement is also not counted for purposes of determining the applicable class size minimum under paragraph (d)(3)(iii) of this section. If a student employee is not offered a student premium reduction arrangement (including if the student employee is offered an individual coverage HRA instead), the student employee is considered to be part of the class of employees to which the employee otherwise belongs and is counted for purposes of determining the applicable class size minimum under paragraph (d)(3)(iii) of this section.

(e) *Integration of Individual Coverage HRAs with Medicare*—(1) *General rule.* An individual coverage HRA will be considered to be integrated with Medicare (and deemed to comply with PHS Act sections 2711 and 2713 and §2590.715-2711 (d)(4) of this part), provided that the conditions of paragraph (c) of this section are satisfied, subject to paragraph (e)(2) of this section. Nothing in this section requires that a participant and his or her dependents all have the same type of coverage; therefore, an individual coverage HRA may be integrated with Medicare for some individuals and with individual health insurance coverage for others, including, for example, a participant enrolled in Medicare Part A and B or Part C and his or her dependents enrolled in individual health insurance coverage.

(2) *Application of conditions in paragraph (c) of this section*—(i) *In general.* Except as provided in paragraph (e)(2)(ii) of this section, in applying the conditions of paragraph (c) of this section with respect to integration with Medicare, a reference to "individual health insurance coverage" is deemed to refer to coverage under Medicare Part A and B or Part C. References in this section to integration of an HRA with Medicare refer to integration of an individual coverage HRA with Medicare Part A and B or Part C.

(ii) *Exceptions.* For purposes of the statement regarding ERISA under the notice content element under paragraph (c)(6)(ii)(A) of this section and the statement regarding the availability of a special enrollment period under the notice content element under paragraph (c)(6)(ii)(J) of this section, the term individual health insurance coverage means only individual health insurance coverage and does not also mean coverage under Medicare Part A and B or Part C.

(f) *Examples*—(1) *Examples regarding classes and the minimum class size requirement.* The following examples illustrate the provisions of paragraph (c)(3) of this section, taking into account the provisions of paragraphs (d)(1) through (4) and (d)(6) of this section. In each example, the HRA is an individual coverage HRA that may reimburse any medical care expenses, including premiums for individual health insurance coverage and it is assumed that no participants or dependents are Medicare beneficiaries.

(i) *Example 1: Collectively bargained employees offered traditional group health plan; non-collectively bargained employees offered HRA*—(A) *Facts.* For 2020, Plan Sponsor A offers its employees covered by a collective bargaining agreement a traditional group health plan (as required by the collective bargaining agreement) and all other employees (non-collectively bargained employees) each an HRA on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(i) (*Example 1*) because collectively bargained and non-collectively bargained employees may be treated as different classes of employees, one of which may be offered a traditional group health plan and the other of which may be offered an individual coverage HRA, and Plan Sponsor A offers the HRA on the same terms to all participants who are non-collectively bargained employees. The minimum class size requirement does not apply to this paragraph (f)(1)(i) (*Example 1*) even though Plan Sponsor A offers one class a traditional group health plan and one class the HRA because collectively bargained and non-collectively bargained employees are not applicable classes that are subject to the minimum class size requirement.

(ii) *Example 2: Collectively bargained employees in one unit offered traditional group health plan and in another unit offered HRA*—(A) *Facts.* For 2020, Plan Sponsor B offers its employees covered by a collective bargaining agreement with Local 100 a traditional group health plan (as required by the collective bargaining agreement), and its employees covered by a collective bargaining agreement with Local 200 each an HRA on the same terms (as required by the collective bargaining agreement).

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(ii) (*Example 2*) because the employees covered by the collective bargaining agreements with the two separate bargaining units (Local 100 and Local 200) may be treated as two different classes of employees and Plan Sponsor B offers an HRA on the same terms to the participants covered by the agreement with Local 200. The minimum class size requirement does not apply to this paragraph (f)(1)(ii) (*Example 2*) even though Plan Sponsor B offers the Local 100 employees a traditional group health plan and the Local 200 employees an HRA because collectively bargained employees are not applicable classes that are subject to the minimum class size requirement.

(iii) *Example 3: Employees in a waiting period offered no coverage; other employees offered an HRA*—(A) *Facts.* For 2020, Plan Sponsor C offers its employees who have completed a waiting period that complies with the requirements for waiting periods in §2590.715-2708 of this part each an HRA on the same terms and does not offer coverage to its employees who have not completed the waiting period.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(iii) (*Example 3*) because employees who have completed a waiting period and employees who have not completed a waiting period may be treated as different classes and Plan Sponsor C offers the HRA on the same terms to all participants who have completed the waiting period. The minimum class size requirement does not apply to this paragraph (f)(1)(iii) (*Example 3*) because Plan Sponsor C does not offer at least one class of employees a traditional group health plan and because the class of employees who have not completed a waiting period and the class of employees who have completed a waiting period are not applicable classes that are subject to the minimum class size requirement.

(iv) *Example 4: Employees in a waiting period offered an HRA; other employees offered a traditional group health plan*—(A) *Facts.* For 2020, Plan Sponsor D offers its employees who have completed a waiting period that complies with the requirements for waiting periods in §2590.715-2708 of this part a traditional group health plan and offers its employees who have not completed the waiting period each an HRA on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(iv) (*Example 4*) because employees who have completed a waiting period and employees who have not completed a waiting period may be treated as different classes and Plan Sponsor D offers an HRA on the same terms to all participants who have not completed the waiting period. The minimum class size requirement does not apply to this paragraph (f)(1)(iv) (*Example 4*) even though Plan Sponsor D offers employees who have completed a waiting period a traditional group health plan and employees who have not completed a waiting period an HRA because the class of employees who have not

completed a waiting period is not an applicable class that is subject to the minimum class size requirement (nor is the class made up of employees who have completed the waiting period).

(v) *Example 5: Staffing firm employees temporarily placed with customers offered an HRA; other employees offered a traditional group health plan—(A) Facts.* Plan Sponsor E is a staffing firm that places certain of its employees on temporary assignments with customers that are not the common law employers of Plan Sponsor E's employees or treated as a single employer with Plan Sponsor E under section 414(b), (c), (m), or (o) of the Code (unrelated entities); other employees work in Plan Sponsor E's office managing the staffing business (non-temporary employees). For 2020, Plan Sponsor E offers its employees who are on temporary assignments with customers each an HRA on the same terms. All other employees are offered a traditional group health plan.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(v) (*Example 5*) because the employees who are hired for temporary placement at an unrelated entity and non-temporary employees of Plan Sponsor E may be treated as different classes of employees and Plan Sponsor E offers an HRA on the same terms to all participants temporarily placed with customers. The minimum class size requirement does not apply to this paragraph (f)(1)(v) (*Example 5*) even though Plan Sponsor E offers one class a traditional group health plan and one class the HRA because the class of employees hired for temporary placement is not an applicable class that is subject to the minimum class size requirement (nor is the class made up of non-temporary employees).

(vi) *Example 6: Staffing firm employees temporarily placed with customers in rating area 1 offered an HRA; other employees offered a traditional group health plan—(A) Facts.* The facts are the same as in paragraph (f)(1)(v) of this section (*Example 5*), except that Plan Sponsor E has work sites in rating area 1 and rating area 2, and it offers its 10 employees on temporary assignments with a work site in rating area 1 an HRA on the same terms. Plan Sponsor E has 200 other employees in rating areas 1 and 2, including its non-temporary employees in rating areas 1 and 2 and its employees on temporary assignments with a work site in rating area 2, all of whom are offered a traditional group health plan.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(vi) (*Example 6*) because, even though the employees who are temporarily placed with customers generally may be treated as employees of a different class, because Plan Sponsor E is also using a rating area to identify the class offered the HRA (which is an applicable class for the minimum class size requirement) and is offering one class the HRA and another class the traditional group health plan, the minimum class size requirement applies to the class offered the HRA, and the class offered the HRA fails to satisfy the minimum class size requirement. Because Plan Sponsor E employs 210 employees, the applicable class size minimum is 20, and the HRA is offered to only 10 employees.

(vii) *Example 7: Employees in State 1 offered traditional group health plan; employees in State 2 offered HRA—(A) Facts.* Plan Sponsor F employs 45 employees whose work site is in State 1 and 7 employees whose primary site of employment is in State 2. For 2020, Plan Sponsor F offers its 45 employees in State 1 a traditional group health plan, and each of its 7 employees in State 2 an HRA on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(vii) (*Example 7*) because Plan Sponsor F offers the HRA on the same terms to all employees with a work site in State 2 and that class is a permissible class under paragraph (d) of this section. This is because employees whose work sites are in different rating areas may be considered different classes and a plan sponsor may create a class of employees by combining classes of employees, including by combining employees whose work site is in one rating area with employees whose work site is in a different rating area, or by combining all employees whose work site is in a state. The minimum class size requirement does not apply to this paragraph (f)(1)(vii) (*Example 7*) because the minimum class size requirement does not apply if the geographic area defining a class of employees is a state or a combination of two or more entire states.

(viii) *Example 8: Full-time seasonal employees offered HRA; all other full-time employees offered traditional group health plan; part-time employees offered no coverage—(A) Facts.* Plan Sponsor G employs 6 full-time seasonal employees, 75 full-time employees who are not seasonal employees, and 5 part-time employees. For 2020, Plan Sponsor G offers each of its 6 full-time seasonal employees an HRA on the same terms, its 75 full-time employees who are not seasonal employees a traditional group health plan, and offers no coverage to its 5 part-time employees.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(viii) (*Example 8*) because full-time seasonal employees and full-time employees who are not seasonal employees may be considered different classes and Plan Sponsor G offers the HRA on the same terms to all full-time seasonal employees. The minimum class size requirement does not apply to the class offered the HRA in this paragraph (f)(1)(viii) (*Example 8*) because part-time employees are not offered coverage and full-time employees are not an applicable class subject to the minimum class size requirement if part-time employees are not offered coverage.

(ix) *Example 9: Full-time employees in rating area 1 offered traditional group health plan; full-time employees in rating area 2 offered HRA; part-time employees offered no coverage—(A) Facts.* Plan Sponsor H employs 17 full-time employees and 10 part-time employees whose work site is in rating area 1 and 552 full-time employees whose work site is in rating area 2. For 2020, Plan Sponsor H offers its 17 full-time employees in rating area 1 a traditional group health plan and each of its 552 full-time employees in rating area 2 an HRA on the same terms. Plan Sponsor H offers no coverage to its 10 part-time employees in rating area 1. Plan Sponsor H reasonably expects to employ 569 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(ix) (*Example 9*) because employees whose work sites are in different rating areas may be considered different classes and Plan Sponsor H offers the HRA on the same terms to all full-time employees in rating area 2. The minimum class size requirement applies to the class offered the HRA in this paragraph (f)(1)(ix) (*Example 9*) because the minimum class size requirement applies to a class based on a geographic area unless the geographic area is a state or a combination of two or more entire states. However, the minimum class size requirement applies only to the class offered the HRA, and Plan Sponsor H offers the HRA to the 552 full-time employees in rating area 2 on the first day of the plan year, satisfying the minimum class size requirement (because the applicable class size minimum for Plan Sponsor H is 20).

(x) *Example 10: Employees in rating area 1 offered HRA; employees in rating area 2 offered traditional group health plan—(A) Facts.* The facts are the same as in paragraph (f)(1)(ix) of this section (*Example 9*) except that Plan Sponsor H offers its 17 full-time employees in rating area 1 the HRA and offers its 552 full-time employees in rating area 2 the traditional group health plan.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(x) (*Example 10*) because, even though employees whose work sites are in different rating areas generally may be considered different classes and Plan Sponsor H offers the HRA on the same terms to all participants in rating area 1, the HRA fails to satisfy the minimum class size requirement. Specifically, the minimum class size requirement applies to this paragraph (f)(1)(x) (*Example 10*) because the minimum class size requirement applies to a class based on a geographic area unless the geographic area is a state or a combination of two or more entire states. Further, the applicable class size minimum for Plan Sponsor H is 20 employees, and the HRA is only offered to the 17 full-time employees in rating area 1 on the first day of the HRA plan year.

(xi) *Example 11: Employees in State 1 and rating area 1 of State 2 offered HRA; employees in all other rating areas of State 2 offered traditional group health plan—(A) Facts.* For 2020, Plan Sponsor I offers an HRA on the same terms to a total of 200 employees it employs with work sites in

State 1 and in rating area 1 of State 2. Plan Sponsor I offers a traditional group health plan to its 150 employees with work sites in other rating areas in State 2. Plan Sponsor I reasonably expects to employ 350 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xi) (*Example 11*). Plan Sponsor I may treat all of the employees with a work site in State 1 and rating area 1 of State 2 as a class of employees because employees whose work sites are in different rating areas may be considered different classes and a plan sponsor may create a class of employees by combining classes of employees, including by combining employees whose work site is in one rating area with a class of employees whose work site is in a different rating area. The minimum class size requirement applies to the class of employees offered the HRA (made up of employees in State 1 and in rating area 1 of State 2) because the minimum class size requirement applies to a class based on a geographic area unless the geographic area is a state or a combination of two or more entire states. In this case, the class is made up of a state plus a rating area which is not the entire state. However, this class satisfies the minimum class size requirement because the applicable class size minimum for Plan Sponsor I is 20, and Plan Sponsor I offered the HRA to 200 employees on the first day of the plan year.

(xii) *Example 12: Salaried employees offered a traditional group health plan; hourly employees offered an HRA—(A) Facts.* Plan Sponsor J has 163 salaried employees and 14 hourly employees. For 2020, Plan Sponsor J offers its 163 salaried employees a traditional group health plan and each of its 14 hourly employees an HRA on the same terms. Plan Sponsor J reasonably expects to employ 177 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(xii) (*Example 12*) because, even though salaried and hourly employees generally may be considered different classes and Plan Sponsor J offers the HRA on the same terms to all hourly employees, the HRA fails to satisfy the minimum class size requirement. Specifically, the minimum class size requirement applies in this paragraph (f)(1)(xii) (*Example 12*) because employees who are paid on a salaried basis and employees who are not paid on a salaried basis are applicable classes subject to the minimum class size requirement. Because Plan Sponsor J reasonably expects to employ between 100 and 200 employees on the first day of the plan year, the applicable class size minimum is 10 percent, rounded down to a whole number. Ten percent of 177 total employees, rounded down to a whole number is 17, and the HRA is offered to only 14 hourly employees.

(xiii) *Example 13: Part-time employees and full-time employees offered different HRAs; no traditional group health plan offered—(A) Facts.* Plan Sponsor K has 50 full-time employees and 7 part-time employees. For 2020, Plan Sponsor K offers its 50 full-time employees \$2,000 each in an HRA otherwise provided on the same terms and each of its 7 part-time employees \$500 in an HRA otherwise provided on the same terms. Plan Sponsor K reasonably expects to employ 57 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xiii) (*Example 13*) because full-time employees and part-time employees may be treated as different classes and Plan Sponsor K offers an HRA on the same terms to all the participants in each class. The minimum class size requirement does not apply to either the full-time class or the part-time class because (although in certain circumstances the minimum class size requirement applies to a class of full-time employees and a class of part-time employees) Plan Sponsor K does not offer any class of employees a traditional group health plan, and the minimum class size requirement applies only when, among other things, at least one class of employees is offered a traditional group health plan while another class is offered an HRA.

(xiv) *Example 14: No employees offered an HRA—(A) Facts.* The facts are the same facts as in paragraph (f)(1)(xiii) of this section (*Example 13*), except that Plan Sponsor K offers its full-time employees a traditional group health plan and does not offer any group health plan (either a traditional group health plan or an HRA) to its part-time employees.

(B) *Conclusion.* The regulations set forth under this section do not apply to Plan Sponsor K because Plan Sponsor K does not offer an individual coverage HRA to any employee.

(xv) *Example 15: Full-time employees offered traditional group health plan; part-time employees offered HRA—(A) Facts.* The facts are the same as in paragraph (f)(1)(xiii) of this section (*Example 13*), except that Plan Sponsor K offers its full-time employees a traditional group health plan and offers each of its part-time employees \$500 in an HRA and otherwise on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(xv) (*Example 15*) because, even though the full-time employees and the part-time employees generally may be treated as different classes, in this paragraph (f)(1)(xv) (*Example 15*), the minimum class size requirement applies to the part-time employees, and it is not satisfied. Specifically, the minimum class size requirement applies to the part-time employees because that requirement applies to an applicable class offered an HRA when one class is offered a traditional group health plan while another class is offered an HRA, and to the part-time and full-time employee classes when one of those classes is offered a traditional group health plan while the other is offered an HRA. Because Plan Sponsor K reasonably expects to employ fewer than 100 employees on the first day of the HRA plan year, the applicable class size minimum for Plan Sponsor K is 10 employees, but Plan Sponsor K offered the HRA only to its 7 part-time employees.

(xvi) *Example 16: Satisfying minimum class size requirement based on employees offered HRA—(A) Facts.* Plan Sponsor L employs 78 full-time employees and 12 part-time employees. For 2020, Plan Sponsor L offers its 78 full-time employees a traditional group health plan and each of its 12 part-time employees an HRA on the same terms. Only 6 part-time employees enroll in the HRA. Plan Sponsor L reasonably expects to employ fewer than 100 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xvi) (*Example 16*) because full-time employees and part-time employees may be treated as different classes. Plan Sponsor L offers an HRA on the same terms to all the participants in the part-time class, and the minimum class size requirement is satisfied. Specifically, whether a class of employees satisfies the applicable class size minimum is determined as of the first day of the plan year based on the number of employees in a class that is offered an HRA, not on the number of employees who enroll in the HRA. The applicable class size minimum for Plan Sponsor L is 10 employees, and Plan Sponsor L offered the HRA to its 12 part-time employees.

(xvii) *Example 17: Student employees offered student premium reduction arrangements and same terms requirement—(A) Facts.* Plan Sponsor M is an institution of higher education that offers each of its part-time employees an HRA on the same terms, except that it offers its part-time employees who are student employees a student premium reduction arrangement, and the student premium reduction arrangement provides different amounts to different part-time student employees.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xvii) (*Example 17*) because Plan Sponsor M offers the HRA on the same terms to its part-time employees who are not students and because the part-time student employees offered a student premium reduction arrangement (and their varying HRAs) are not taken into account as part-time employees for purposes of determining whether a class of employees is offered an HRA on the same terms.

(xiii) *Example 18: Student employees offered student premium reduction arrangements and minimum class size requirement—(A) Facts.* Plan Sponsor N is an institution of higher education with 25 hourly employees. Plan Sponsor N offers 15 of its hourly employees, who are student

employees, a student premium reduction arrangement and it wants to offer its other 10 hourly employees an HRA for 2022. Plan Sponsor N offers its salaried employees a traditional group health plan. Plan Sponsor N reasonably expects to have 250 employees on the first day of the 2022 HRA plan year, 15 of which will have offers of student premium reduction arrangements.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(xviii) (*Example 18*). The minimum class size requirement will apply to the class of hourly employees to which Plan Sponsor N wants to offer the HRA because Plan Sponsor N offers a class of employees a traditional group health plan and another class the HRA, and the minimum class size requirement generally applies to a class of hourly employees offered an HRA. Plan Sponsor N's applicable class size minimum is 20 because Plan Sponsor N reasonably expects to employ 235 employees on the first day of the plan year (250 employees minus 15 employees receiving a student premium reduction arrangement). Plan Sponsor N may not offer the HRA to its hourly employees because the 10 employees offered the HRA as of the first day of the plan year does not satisfy the applicable class size minimum.

(2) *Examples regarding special rule for new hires.* The following examples illustrate the provisions of paragraph (c)(3) of this section, taking into account the provisions of paragraph (d) of this section, in particular the special rule for new hires under paragraph (d)(5) of this section. In each example, the HRA is an individual coverage HRA that has a calendar year plan year and may reimburse any medical care expenses, including premiums for individual health insurance coverage. The examples also assume that no participants or dependents are Medicare beneficiaries.

(i) *Example 1: Application of special rule for new hires to all employees—(A) Facts.* For 2021, Plan Sponsor A offers all employees a traditional group health plan. For 2022, Plan Sponsor A offers all employees hired on or after January 1, 2022, an HRA on the same terms and continues to offer the traditional group health plan to employees hired before that date. On the first day of the 2022 plan year, Plan Sponsor A has 2 new hires who are offered the HRA.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(i) (*Example 1*) because, under the special rule for new hires in paragraph (d)(5) of this section, the employees newly hired on and after January 1, 2022, may be treated as a new hire subclass, Plan Sponsor A offers the HRA on the same terms to all participants in the new hire subclass, and the minimum class size requirement does not apply to the new hire subclass.

(ii) *Example 2: Application of special rule for new hires to full-time employees—(A) Facts.* For 2021, Plan Sponsor B offers a traditional group health plan to its full-time employees and does not offer any coverage to its part-time employees. For 2022, Plan Sponsor B offers full-time employees hired on or after January 1, 2022, an HRA on the same terms, continues to offer its full-time employees hired before that date a traditional group health plan, and continues to offer no coverage to its part-time employees. On the first day of the 2022 plan year, Plan Sponsor B has 2 new hire, full-time employees who are offered the HRA.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(ii) (*Example 2*) because, under the special rule for new hires in paragraph (d)(5) of this section, the full-time employees newly hired on and after January 1, 2022, may be treated as a new hire subclass and Plan Sponsor B offers the HRA on the same terms to all participants in the new hire subclass. The minimum class size requirement does not apply to the new hire subclass.

(iii) *Example 3: Special rule for new hires impermissibly applied retroactively—(A) Facts.* For 2025, Plan Sponsor C offers a traditional group health plan to its full-time employees. For 2026, Plan Sponsor C wants to offer an HRA to its full-time employees hired on and after January 1, 2023, while continuing to offer a traditional group health plan to its full-time employees hired before January 1, 2023.

(B) *Conclusion.* The special rule for new hires under paragraph (d)(5) of this section does not apply in this paragraph (f)(2)(iii) (*Example 3*) because the rule must be applied prospectively. That is, Plan Sponsor C may not, in 2026, choose to apply the special rule for new hires retroactive to 2023. If Plan Sponsor C were to offer an HRA in this way, it would fail to satisfy the conditions under paragraphs (c)(2) and (3) of this section because the new hire subclass would not be treated as a subclass for purposes of applying those rules and, therefore, all full-time employees would be treated as one class to which either a traditional group health plan or an HRA could be offered, but not both.

(iv) *Example 4: Permissible second application of the special rule for new hires to the same class of employees—(A) Facts.* For 2021, Plan Sponsor D offers all of its full-time employees a traditional group health plan. For 2022, Plan Sponsor D applies the special rule for new hires and offers an HRA on the same terms to all employees hired on and after January 1, 2022, and continues to offer a traditional group health plan to full-time employees hired before that date. For 2025, Plan Sponsor D discontinues use of the special rule for new hires, and again offers all full-time employees a traditional group health plan. In 2030, Plan Sponsor D decides to apply the special rule for new hires to the full-time employee class again, offering an HRA to all full-time employees hired on and after January 1, 2030, on the same terms, while continuing to offer employees hired before that date a traditional group health plan.

(B) *Conclusion.* Plan Sponsor D has permissibly applied the special rule for new hires and is in compliance with the requirements of paragraphs (c)(2) and (3) of this section.

(v) *Example 5: Impermissible second application of the special rule for new hires to the same class of employees—(A) Facts.* The facts are the same as in paragraph (f)(2)(iv) of this section (*Example 4*), except that for 2025, Plan Sponsor D discontinues use of the special rule for new hires by offering all full-time employees an HRA on the same terms. Further, for 2030, Plan Sponsor D wants to continue to offer an HRA on the same terms to all full-time employees hired before January 1, 2030, and to offer all full-time employees hired on or after January 1, 2030, an HRA in a different amount.

(B) *Conclusion.* Plan Sponsor D may not apply the special rule for new hires for 2030 to the class of full-time employees being offered an HRA because the special rule for new hires may only be applied to a class that is being offered a traditional group health plan.

(vi) *Example 6: New full-time employees offered different HRAs in different rating areas—(A) Facts.* Plan Sponsor E has work sites in rating area 1, rating area 2, and rating area 3. For 2021, Plan Sponsor E offers its full-time employees a traditional group health plan. For 2022, Plan Sponsor E offers its full-time employees hired on or after January 1, 2022, in rating area 1 an HRA of \$3,000, its full-time employees hired on or after January 1, 2022, in rating area 2 an HRA of \$5,000, and its full-time employees hired on or after January 1, 2022, in rating area 3 an HRA of \$7,000. Within each class offered an HRA, Plan Sponsor E offers the HRA on the same terms. Plan Sponsor E offers its full-time employees hired prior to January 1, 2022, in each of those classes a traditional group health plan. On the first day of the 2022 plan year, there is one new hire, full-time employee in rating area 1, three new hire, full-time employees in rating area 2, and 10 new hire-full-time employees in rating area 3.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(vi) (*Example 6*) because, under the special rule for new hires in paragraph (d)(5) of this section, the full-time employees in each of the three rating areas newly hired on and after January 1, 2022, may be treated as three new hire subclasses and Plan Sponsor E offers the HRA on the same terms to all participants in the new hire subclasses. Further, the minimum class size requirement does not apply to the new hire subclasses.

(vii) *Example 7: New full-time employee class subdivided based on rating area—(A) Facts.* Plan Sponsor F offers its full-time employees hired on or after January 1, 2022, an HRA on the same terms and it continues to offer its full-time employees hired before that date a traditional group health plan. Plan Sponsor F offers no coverage to its part-time employees. For the 2025 plan year, Plan Sponsor F wants to subdivide the full-time new hire subclass so that those whose work site is in rating area 1 will be offered the traditional group health plan and those whose work site is in rating area 2 will continue to receive the HRA. Plan Sponsor F reasonably expects to employ 219 employees on January 1, 2025. As of January 1, 2025, Plan Sponsor F has 15 full-time employees whose work site is in rating area 2 and who were hired between January 1, 2022, and January 1, 2025.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(2)(vii) (*Example 7*) because the new hire subclass has been subdivided in a manner that is subject to the minimum class size requirement, and the class offered the HRA fails to satisfy the minimum class size requirement. Specifically, once the new hire subclass is subdivided the general rules for applying the minimum class size requirement apply to the employees offered the HRA in the new hire subclass. In this case, because the subdivision of the new hire full-time subclass is based on rating areas; a class based on rating areas is an applicable class subject to the minimum class size requirement; and the employees in one rating area are to be offered the HRA, while the employees in the other rating area are offered the traditional group health plan, the minimum class size requirement would apply on and after the date of the subdivision. Further, the minimum class size requirement would not be satisfied, because the applicable class size minimum for Plan Sponsor F would be 20, and only 15 employees in rating area 2 would be offered the HRA.

(viii) *Example 8: New full-time employee class subdivided based on state—(A) Facts.* The facts are the same as in paragraph (f)(2)(vii) of this section (*Example 7*), except that for the 2025 plan year, Plan Sponsor F intends to subdivide the new hire, full-time class so that those in State 1 will be offered the traditional group health plan and those in State 2 will each be offered an HRA on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(viii) (*Example 8*) because even though the new hire subclass has been subdivided, it has been subdivided in a manner that is not subject to the minimum class size requirement as the subdivision is based on the entire state.

(ix) *Example 9: New full-time employees and part-time employees offered HRA—(A) Facts.* In 2021, Plan Sponsor G offers its full-time employees a traditional group health plan and does not offer coverage to its part-time employees. For the 2022 plan year, Plan Sponsor G offers its full-time employees hired on or after January 1, 2022, and all of its part-time employees, including those hired before January 1, 2022, and those hired on and after January 1, 2022, an HRA on the same terms, and it continues to offer its full-time employees hired before January 1, 2022, a traditional group health plan.

(B) *Conclusion.* The minimum class size requirement applies to the part-time employees offered the HRA in 2022 because the class is being offered an HRA; the special rule for new hires does not apply (because this class was not previously offered a traditional group health plan) and so it is not a new hire subclass exempt from the minimum class size requirement; another class of employees (that is, full-time hired before January 1, 2022) are being offered a traditional group health plan; and the part-time employee class is generally an applicable classes that is subject to the minimum class size requirement. However, because the full-time, new hire subclass is based on the special rule for new hires, the minimum class size requirement does not apply to full-time new hires offered an HRA in 2022.

(g) *Applicability date.* This section applies to plan years beginning on or after January 1, 2020.

[84 FR 29001, June 20, 2019]

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§146.123 Special rule allowing integration of Health Reimbursement Arrangements (HRAs) and other account-based group health plans with individual health insurance coverage and Medicare and prohibiting discrimination in HRAs and other account-based group health plans.

(a) *Scope.* This section applies to health reimbursement arrangements (HRAs) and other account-based group health plans, as defined in §147.126(d)(6)(i) of this subchapter. For ease of reference, the term "HRA" is used in this section to include other account-based group health plans. For related regulations, see 26 CFR 1.36B-2(c)(3)(i) and (c)(5), 29 CFR 2510.3-1(l), and 45 CFR 155.420.

(b) *Purpose.* This section provides the conditions that an HRA must satisfy in order to be integrated with individual health insurance coverage for purposes of Public Health Service Act (PHS Act) sections 2711 and 2713 and §147.126(d)(4) of this subchapter (referred to as an individual coverage HRA). This section also allows an individual coverage HRA to be integrated with Medicare for purposes of PHS Act sections 2711 and 2713 and §147.126(d)(4) of this subchapter, subject to the conditions provided in this section (see paragraph (e) of this section). Some of the conditions set forth in this section specifically relate to compliance with PHS Act sections 2711 and 2713 and some relate to the effect of having or being offered an individual coverage HRA on eligibility for the premium tax credit under section 36B of the Internal Revenue Code (Code). In addition, this section provides conditions that an individual coverage HRA must satisfy in order to comply with the nondiscrimination provisions in PHS Act section 2705 and that are consistent with the provisions of 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)), each as amended, that are designed to create a competitive individual market. These conditions are intended to prevent an HRA plan sponsor from intentionally or unintentionally, directly or indirectly, steering any participants or dependents with adverse health factors away from its traditional group health plan, if any, and toward individual health insurance coverage.

(c) *General rule.* An HRA will be considered to be integrated with individual health insurance coverage for purposes of PHS Act sections 2711 and 2713 and §147.126(d)(4) of this subchapter and will not be considered to discriminate in violation of PHS Act section 2705 solely because it is integrated with individual health insurance coverage, provided that the conditions of this paragraph (c) are satisfied. See paragraph (e) of this section for how these conditions apply to an individual coverage HRA integrated with Medicare. For purposes of this section, medical care expenses means medical care expenses as defined in §147.126(d)(6)(ii) of this subchapter and Exchange means Exchange as defined in §155.20 of this subchapter.

(1) *Enrollment in individual health insurance coverage—(i) In general.* The HRA must require that the participant and any dependent(s) are enrolled in individual health insurance coverage that is subject to and complies with the requirements in PHS Act sections 2711 (and §147.126(a)(2) of this subchapter) and PHS Act section 2713 (and §147.130(a)(1) of this subchapter), for each month that the individual(s) are covered by the HRA. For purposes of this paragraph (c), all individual health insurance coverage, except for individual health insurance coverage that consists solely of excepted benefits, is treated as being subject to and complying with PHS Act sections 2711 and 2713. References to individual health insurance coverage in this paragraph (c) do not include individual health insurance coverage that consists solely of excepted benefits.

(ii) *Forfeiture.* The HRA must provide that if any individual covered by the HRA ceases to be covered by individual health insurance coverage, the HRA will not reimburse medical care expenses that are incurred by that individual after the individual health insurance coverage ceases. In addition, if the participant and all dependents covered by the participant's HRA cease to be covered by individual health insurance coverage, the participant must forfeit the HRA. In either case, the HRA must reimburse medical care expenses incurred by the individual prior to the cessation of individual health insurance coverage to the extent the medical care expenses are otherwise covered by the HRA, but the HRA may limit the period to submit medical care expenses for reimbursement to a reasonable specified time period. If a participant or dependent loses coverage under the HRA for a reason other than cessation of individual health insurance coverage, COBRA and other continuation coverage requirements may apply.

(iii) *Grace periods and retroactive termination of individual health insurance coverage.* In the event an individual is initially enrolled in individual health insurance coverage and subsequently timely fails to pay premiums for the coverage, with the result that the individual is in a grace period, the individual is considered to be enrolled in individual health insurance coverage for purposes of this paragraph (c)(1) and the individual coverage HRA must reimburse medical care expenses incurred by the individual during that time period to the extent the medical care expenses are otherwise covered by the HRA. If the individual fails to pay the applicable premium(s) by the end of the grace period and the coverage is cancelled or terminated, including retroactively, or if the individual health insurance coverage is cancelled or terminated retroactively for some other reason (for example, a rescission), an individual coverage HRA must require that a participant notify the HRA that coverage has been cancelled or terminated and the date on which the cancellation or termination is effective. After the individual coverage HRA has received the notice of cancellation or termination, the HRA may not reimburse medical care expenses incurred on and after the date the individual health insurance coverage was cancelled or terminated, which is considered to be the date of termination of coverage under the HRA.

(2) *No traditional group health plan may be offered to same participants.* To the extent a plan sponsor offers any class of employees (as defined in paragraph (d) of this section) an individual coverage HRA, the plan sponsor may not also offer a traditional group health plan to the same class of employees, except as provided in paragraph (d)(5) of this section. For purposes of this section, a traditional group health plan is any group health plan other than either an account-based group health plan or a group health plan that consists solely of excepted benefits. Therefore, a plan sponsor may not offer a choice between an individual coverage HRA or a traditional group health plan to any participant or dependent.

(3) *Same terms requirement*—(i) *In general.* If a plan sponsor offers an individual coverage HRA to a class of employees described in paragraph (d) of this section, the HRA must be offered on the same terms to all participants within the class, except as provided in paragraphs (c)(3)(ii) through (vi) and (d)(5) of this section.

(ii) *Carryover amounts, salary reduction arrangements, and transfer amounts.* Amounts that are not used to reimburse medical care expenses for any plan year that are made available to participants in later plan years are disregarded for purposes of determining whether an HRA is offered on the same terms, provided that the method for determining whether participants have access to unused amounts in future years, and the methodology and formula for determining the amounts of unused funds which they may access in future years, is the same for all participants in a class of employees. In addition, the ability to pay the portion of the premium for individual health insurance coverage that is not covered by the HRA, if any, by using a salary reduction arrangement under section 125 of the Code is considered to be a term of the HRA for purposes of this paragraph (c)(3). Therefore, an HRA is not provided on the same terms unless the salary reduction arrangement, if made available to any participant in a class of employees, is made available on the same terms to all participants (other than former employees, as defined in paragraph (c)(3)(iv) of this section) in the class of employees. Further, to the extent that a participant in an individual coverage HRA was previously covered by another HRA and the current individual coverage HRA makes available amounts that were not used to reimburse medical care expenses under the prior HRA (transferred amounts), the transferred amounts are disregarded for purposes of determining whether the HRA is offered on the same terms, provided that if the HRA makes available transferred amounts, it does so on the same terms for all participants in the class of employees.

(iii) *Permitted variation.* An HRA does not fail to be provided on the same terms solely because the maximum dollar amount made available to participants in a class of employees to reimburse medical care expenses for any plan year increases in accordance with paragraph (c)(3)(iii)(A) or (B) of this section.

(A) *Variation due to number of dependents.* An HRA does not fail to be provided on the same terms to participants in a class of employees solely because the maximum dollar amount made available to those participants to reimburse medical care expenses for any plan year increases as the number of the participant's dependents who are covered under the HRA increases, so long as the same maximum dollar amount attributable to the increase in family size is made available to all participants in that class of employees with the same number of dependents covered by the HRA.

(B) *Variation due to age.* An HRA does not fail to be provided on the same terms to participants in a class of employees solely because the maximum dollar amount made available under the terms of the HRA to those participants to reimburse medical care expenses for any plan year increases as the age of the participant increases, so long as the requirements in paragraphs (c)(3)(iii)(B)(1) and (2) of this section are satisfied. For the purpose of this paragraph (c)(3)(iii)(B), the plan sponsor may determine the age of the participant using any reasonable method for a plan year, so long as the plan sponsor determines each participant's age for the purpose of this paragraph (c)(3)(iii)(B) using the same method for all participants in the class of employees for the plan year and the method is determined prior to the plan year.

(1) The same maximum dollar amount attributable to the increase in age is made available to all participants who are the same age.

(2) The maximum dollar amount made available to the oldest participant(s) is not more than three times the maximum dollar amount made available to the youngest participant(s).

(iv) *Former employees.* An HRA does not fail to be treated as provided on the same terms if the plan sponsor offers the HRA to some, but not all, former employees within a class of employees. However, if a plan sponsor offers the HRA to one or more former employees within a class of employees, the HRA must be offered to the former employee(s) on the same terms as to all other employees within the class, except as provided in paragraph (c)(3)(ii) of this section. For purposes of this section, a former employee is an employee who is no longer performing services for the employer.

(v) *New employees or new dependents.* For a participant whose coverage under the HRA becomes effective later than the first day of the plan year, the HRA does not fail to be treated as being provided on the same terms to the participant if the maximum dollar amount made available to the participant either is the same as the maximum dollar amount made available to participants in the participant's class of employees whose coverage became effective as of the first day of the plan year, or is pro-rated consistent with the portion of the plan year in which the participant is covered by the HRA. Similarly, if the HRA provides for variation in the maximum amount made available to participants in a class of employees based on the number of a participant's dependents covered by the HRA, and the number of a participant's dependents covered by the HRA changes during a plan year (either increasing or decreasing), the HRA does not fail to be treated as being provided on the same terms to the participant if the maximum dollar amount made available to the participant either is the same as the maximum dollar amount made available to participants in the participant's class of employees who had the same number of dependents covered by the HRA on the first day of the plan year or is pro-rated for the remainder of the plan year after the change in the number of the participant's dependents covered by the HRA consistent with the portion of the plan year in which that number of dependents are covered by the HRA. The method the HRA uses to determine amounts made available for participants whose coverage under the HRA is effective later than the first day of the plan year or who have changes in the number of dependents covered by the HRA during a plan year must be the same for all participants in the class of employees and the method must be determined prior to the beginning of the plan year.

(vi) *HSA-compatible HRAs.* An HRA does not fail to be treated as provided on the same terms if the plan sponsor offers participants in a class of employees a choice between an HSA-compatible individual coverage HRA and an individual coverage HRA that is not HSA compatible, provided both types of HRAs are offered to all participants in the class of employees on the

same terms. For the purpose of this paragraph (c)(3)(vi), an HSA-compatible individual coverage HRA is an individual coverage HRA that is limited in accordance with applicable guidance under section 223 of the Code such that an individual covered by such an HRA is not disqualified from being an eligible individual under section 223 of the Code.

(vii) *Examples.* The following examples illustrate the provisions of this paragraph (c)(3), without taking into account the provisions of paragraph (d) of this section. In each example, the HRA is an individual coverage HRA that has a calendar year plan year and may reimburse any medical care expenses, including premiums for individual health insurance coverage (except as provided in paragraph (c)(3)(vii)(E) of this section (*Example 5*)). Further, in each example, assume the HRA is offered on the same terms, except as otherwise specified in the example and that no participants or dependents are Medicare beneficiaries.

(A) *Example 1: Carryover amounts permitted—(1) Facts.* For 2020 and again for 2021, Plan Sponsor A offers all employees \$7,000 each in an HRA, and the HRA provides that amounts that are unused at the end of a plan year may be carried over to the next plan year, with no restrictions on the use of the carryover amounts compared to the use of newly available amounts. At the end of 2020, some employees have used all of the funds in their HRAs, while other employees have balances remaining that range from \$500 to \$1,750 that are carried over to 2021 for those employees.

(2) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(A) (*Example 1*) for 2020 because Plan Sponsor A offers all employees the same amount, \$7,000, in an HRA for that year. The same terms requirement is also satisfied for 2021 because Plan Sponsor A again offers all employees the same amount for that year, and the carryover amounts that some employees have are disregarded in applying the same terms requirement because the amount of the carryover for each employee (that employee's balance) and each employee's access to the carryover amounts is based on the same terms.

(B) *Example 2: Employees hired after the first day of the plan year—(1) Facts.* For 2020, Plan Sponsor B offers all employees employed on January 1, 2020, \$7,000 each in an HRA for the plan year. Employees hired after January 1, 2020, are eligible to enroll in the HRA with an effective date of the first day of the month following their date of hire, as long as they have enrolled in individual health insurance coverage effective on or before that date, and the amount offered to these employees is pro-rated based on the number of months remaining in the plan year, including the month which includes their coverage effective date.

(2) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(B) (*Example 2*) for 2020 because Plan Sponsor B offers all employees employed on the first day of the plan year the same amount, \$7,000, in an HRA for that plan year and all employees hired after January 1, 2020, a pro-rata amount based on the portion of the plan year during which they are enrolled in the HRA.

(C) *Example 3: HRA amounts offered vary based on number of dependents—(1) Facts.* For 2020, Plan Sponsor C offers its employees the following amounts in an HRA: \$1,500, if the employee is the only individual covered by the HRA; \$3,500, if the employee and one dependent are covered by the HRA; and \$5,000, if the employee and more than one dependent are covered by the HRA.

(2) *Conclusion.* The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(C) (*Example 3*) because paragraph (c)(3)(iii)(A) of this section allows the maximum dollar amount made available in an HRA to increase as the number of the participant's dependents covered by the HRA increases and Plan Sponsor C makes the same amount available to each employee with the same number of dependents covered by the HRA.

(D) *Example 4: HRA amounts offered vary based on increases in employees' ages—(1) Facts.* For 2020, Plan Sponsor D offers its employees the following amounts in an HRA: \$1,000 each for employees age 25 to 35; \$2,000 each for employees age 36 to 45; \$2,500 each for employees age 46 to 55; and \$4,000 each for employees over age 55.

(2) *Conclusion.* The same terms requirement of this paragraph (c)(3) is not satisfied in this paragraph (c)(3)(vii)(D) (*Example 4*) because the terms of the HRA provide the oldest participants (those over age 55) with more than three times the amount made available to the youngest participants (those ages 25 to 35), in violation of paragraph (c)(3)(iii)(B)(2) of this section.

(E) *Example 5: Application of same terms requirement to premium only HRA—(1) Facts.* For 2020, Plan Sponsor E offers its employees an HRA that reimburses only premiums for individual health insurance coverage, up to \$10,000 for the year. Employee A enrolls in individual health insurance coverage with a \$5,000 premium for the year and is reimbursed \$5,000 from the HRA. Employee B enrolls in individual health insurance coverage with an \$8,000 premium for the year and is reimbursed \$8,000 from the HRA.

(2) [Reserved]

Conclusion. The same terms requirement of this paragraph (c)(3) is satisfied in this paragraph (c)(3)(vii)(E) (*Example 5*) because Plan Sponsor E offers the HRA on the same terms to all employees, notwithstanding that some employees receive a greater amount of reimbursement than others based on the cost of the individual health insurance coverage selected by the employee.

(4) *Opt out.* Under the terms of the HRA, a participant who is otherwise eligible for coverage must be permitted to opt out of and waive future reimbursements on behalf of the participant and all dependents eligible for the HRA from the HRA once, and only once, with respect to each plan year. The HRA may establish timeframes for enrollment in (and opting out of) the HRA but, in general, the opportunity to opt out must be provided in advance of the first day of the plan year. For participants who become eligible to participate in the HRA on a date other than the first day of the plan year (or who become eligible fewer than 90 days prior to the plan year or for whom the notice under paragraph (c)(6) of this section is required to be provided as set forth in paragraph (c)(6)(i)(C) of this section), or for a dependent who newly becomes eligible during the plan year, this opportunity must be provided during the applicable HRA enrollment period(s) established by the HRA for these individuals. Further, under the terms of the HRA, upon termination of employment, for a participant who is covered by the HRA, either the remaining amounts in the HRA must be forfeited or the participant must be permitted to permanently opt out of and waive future reimbursements from the HRA on behalf of the participant and all dependents covered by the HRA.

(5) *Reasonable procedures for coverage substantiation—(i) Substantiation of individual health insurance coverage for the plan year.* The HRA must implement, and comply with, reasonable procedures to substantiate that participants and each dependent covered by the HRA are, or will be, enrolled in individual health insurance coverage for the plan year (or for the portion of the plan year the individual is covered by the HRA, if applicable). The HRA may establish the date by which this substantiation must be provided, but, in general, the date may be no later than the first day of the plan year. However, for a participant who is not eligible to participate in the HRA on the first day of the plan year (or who becomes eligible fewer than 90

days prior to the plan year or for whom the notice under paragraph (c)(6) of this section is required to be provided as set forth in paragraph (c)(6)(i)(C) of this section), the HRA may establish the date by which this substantiation must be provided, but that date may be no later than the date the HRA coverage begins. Similarly, for a participant who adds a new dependent during the plan year, the HRA may establish the date by which this substantiation must be provided, but the date may be no later than the date the HRA coverage for the new dependent begins; however, to the extent the dependent's coverage under the HRA is effective retroactively, the HRA may establish a reasonable time by which this substantiation is required, but must require it be provided before the HRA will reimburse any medical care expense for the newly added dependent. The reasonable procedures an HRA may use to implement the substantiation requirement set forth in this paragraph (c)(5)(i) may include a requirement that a participant substantiate enrollment by providing either:

(A) A document from a third party (for example, the issuer or an Exchange) showing that the participant and any dependents covered by the HRA are, or will be, enrolled in individual health insurance coverage (for example, an insurance card or an explanation of benefits document pertaining to the relevant time period or documentation from the Exchange showing that the individual has completed the application and plan selection); or

(B) An attestation by the participant stating that the participant and dependent(s) covered by the HRA are, or will be, enrolled in individual health insurance coverage, the date coverage began or will begin, and the name of the provider of the coverage.

(ii) *Coverage substantiation with each request for reimbursement of medical care expenses.* Following the initial substantiation of coverage, with each new request for reimbursement of an incurred medical care expense for the same plan year, the HRA may not reimburse a participant for any medical care expenses unless, prior to each reimbursement, the participant substantiates that the individual on whose behalf medical care expenses are requested to be reimbursed continues to be enrolled in individual health insurance coverage for the month during which the medical care expenses were incurred. The HRA must implement, and comply with, reasonable procedures to satisfy this requirement. This substantiation may be in the form of a written attestation by the participant, which may be part of the form used to request reimbursement, or a document from a third party (for example, a health insurance issuer) showing that the participant or the dependent, if applicable, are or were enrolled in individual health insurance coverage for the applicable month.

(iii) *Reliance on substantiation.* For purposes of this paragraph (c)(5), an HRA may rely on the participant's documentation or attestation unless the HRA, its plan sponsor, or any other entity acting in an official capacity on behalf of the HRA has actual knowledge that any individual covered by the HRA is not, or will not be, enrolled in individual health insurance coverage for the plan year (or applicable portion of the plan year) or the month, as applicable.

(6) *Notice requirement—(i) Timing.* The HRA must provide a written notice to each participant:

(A) At least 90 calendar days before the beginning of each plan year for any participant who is not described in either paragraph (c)(6)(i)(B) or (C) of this section;

(B) No later than the date on which the HRA may first take effect for the participant, for any participant who is not eligible to participate at the beginning of the plan year (or is not eligible to participate at the time the notice is provided at least 90 calendar days before the beginning of the plan year pursuant to paragraph (c)(6)(i)(A) of this section); or

(C) No later than the date on which the HRA may first take effect for the participant, for any participant who is employed by an employer that is first established less than 120 days before the beginning of the first plan year of the HRA; this paragraph (c)(6)(i)(C) applies only with respect to the first plan year of the HRA.

(ii) *Content.* The notice must include all the information described in this paragraph (c)(6)(ii) (and may include any additional information that does not conflict with that information). To the extent that the Departments of the Treasury, Labor and Health and Human Services provide model notice language for certain elements of this required notice, HRAs are permitted, but not required, to use the model language.

(A) A description of the terms of the HRA, including the maximum dollar amount available for each participant (including the self-only HRA amount available for the plan year (or the maximum dollar amount available for the plan year if the HRA provides for reimbursements up to a single dollar amount regardless of whether a participant has self-only or other than self-only coverage)), any rules regarding the proration of the maximum dollar amount applicable to any participant (or dependent, if applicable) who is not eligible to participate in the HRA for the entire plan year, whether (and which of) the participant's dependents are eligible for the HRA, a statement that there are different kinds of HRAs (including a qualified small employer health reimbursement arrangement) and the HRA being offered is an individual coverage HRA, a statement that the HRA requires the participant and any covered dependents to be enrolled in individual health insurance coverage (or Medicare Part A and B or Medicare Part C, if applicable), a statement that the coverage in which the participant and any covered dependents must be enrolled cannot be short-term, limited-duration insurance or consist solely of excepted benefits, if the HRA is subject to the Employee Retirement Income Security Act (ERISA), a statement that individual health insurance coverage in which the participant and any covered dependents are enrolled is not subject to ERISA, if the conditions under 29 CFR 2510.3-1(l) are satisfied, the date as of which coverage under the HRA may first become effective (both for participants whose coverage will become effective on the first day of the plan year and for participants whose HRA coverage may become effective at a later date), the dates on which the HRA plan year begins and ends, and the dates on which the amounts newly made available under the HRA will be made available.

(B) A statement of the right of the participant to opt out of and waive future reimbursements from the HRA, as set forth under paragraph (c)(4) of this section.

(C) A description of the potential availability of the premium tax credit if the participant opts out of and waives future reimbursements from the HRA and the HRA is not affordable for one or more months under 26 CFR 1.36B-2(c)(5), a statement that even if the participant opts out of and waives future reimbursements from an HRA, the offer will prohibit the participant (and, potentially, the participant's dependents) from receiving a premium tax credit for the participant's coverage (or the dependent's coverage, if applicable) on an Exchange for any month that the HRA is affordable under 26 CFR 1.36B-2(c)(5), a statement describing how the participant may find assistance with determining affordability, a statement that, if the participant is a former employee, the offer of the HRA does not render the participant (or the participant's dependents, if applicable) ineligible for the premium tax credit regardless of whether it is affordable under 26 CFR 1.36B-2(c)(5), and a statement that if the participant or dependent is enrolled in Medicare, he or she is ineligible for the premium tax credit without regard to the offer or acceptance of the HRA;

(D) A statement that if the participant accepts the HRA, the participant may not claim a premium tax credit for the participant's Exchange coverage for any month the HRA may be used to reimburse medical care expenses of the participant, and a premium tax credit may not be claimed for the Exchange coverage of the participant's dependents for any month the HRA may be used to reimburse medical care expenses of the dependents.

(E) A statement that the participant must inform any Exchange to which the participant applies for advance payments of the premium tax credit of the availability of the HRA; the self-only HRA amount available for the HRA plan year (or the maximum dollar amount available for the plan year if the HRA provides for reimbursements up to a single dollar amount regardless of whether a participant has self-only or other than self-only coverage) as set forth in the written notice in accordance with paragraph (c)(6)(ii)(A) of this section; whether the HRA is also available to the participant's dependents and if so, which ones; the date as of which coverage under the HRA may first become effective; the date on which the plan year begins and the date on which it ends; and whether the participant is a current employee or former employee.

(F) A statement that the participant should retain the written notice because it may be needed to determine whether the participant is allowed a premium tax credit on the participant's individual income tax return.

(G) A statement that the HRA may not reimburse any medical care expense unless the substantiation requirement set forth in paragraph (c)(5)(ii) of this section is satisfied and a statement that the participant must also provide the substantiation required by paragraph (c)(5)(i) of this section.

(H) A statement that if the individual health insurance coverage (or coverage under Medicare Part A and B or Medicare Part C) of a participant or dependent ceases, the HRA will not reimburse any medical care expenses that are incurred by the participant or dependent, as applicable, after the coverage ceases, and a statement that the participant must inform the HRA if the participant's or dependent's individual health insurance coverage (or coverage under Medicare Part A and B or Medicare Part C) is cancelled or terminated retroactively and the date on which the cancellation or termination is effective.

(I) The contact information (including a phone number) for an individual or a group of individuals who participants may contact in order to receive additional information regarding the HRA. The plan sponsor may determine which individual or group of individuals is best suited to be the specified contact.

(J) A statement of availability of a special enrollment period to enroll in or change individual health insurance coverage, through or outside of an Exchange, for the participant and any dependents who newly gain access to the HRA and are not already covered by the HRA.

(d) *Classes of employees*—(1) *In general.* This paragraph (d) sets forth the rules for determining classes of employees. Paragraph (d)(2) of this section sets forth the specific classes of employees; paragraph (d)(3) of this section sets forth a minimum class size requirement that applies in certain circumstances; paragraph (d)(4) of this section sets forth rules regarding the definition of "full-time employees," "part-time employees," and "seasonal employees"; paragraph (d)(5) of this section sets forth a special rule for new hires; and paragraph (d)(6) of this section addresses student premium reduction arrangements. For purposes of this section, including determining classes under this paragraph (d), the employer is the common law employer and is determined without regard to the rules under sections 414(b), (c), (m), and (o) of the Code that would treat the common law employer as a single employer with certain other entities.

(2) *List of classes.* Participants may be treated as belonging to a class of employees based on whether they are, or are not, included in the classes described in this paragraph (d)(2). If the individual coverage HRA is offered to former employees, former employees are considered to be in the same class in which they were included immediately before separation from service. Before each plan year, a plan sponsor must determine for the plan year which classes of employees it intends to treat separately and the definition of the relevant class(es) it will apply, to the extent these regulations permit a choice. After the classes and the definitions of the classes are established for a plan year, a plan sponsor may not make changes to the classes of employees or the definitions of those relevant classes with respect to that plan year.

(i) Full-time employees, defined at the election of the plan sponsor to mean either full-time employees under section 4980H of the Code (and 26 CFR 54.4980H-1(a)(21)) or employees who are not part-time employees (as described in 26 CFR 1.105-11(c)(2)(iii)(C));

(ii) Part-time employees, defined at the election of the plan sponsor to mean either employees who are not full-time employees under section 4980H of the Code (and under 26 CFR 54.4980H-1(a)(21) (which defines full-time employee)) or employees who are part-time employees as described in 26 CFR 1.105-11(c)(2)(iii)(C);

(iii) Employees who are paid on a salary basis;

(iv) Non-salaried employees (such as, for example, hourly employees);

(v) Employees whose primary site of employment is in the same rating area as defined in §147.102(b) of this subchapter;

(vi) Seasonal employees, defined at the election of the plan sponsor to mean seasonal employees as described in either 26 CFR 54.4980H-1(a)(38) or 26 CFR 1.105-11(c)(2)(iii)(C);

(vii) Employees included in a unit of employees covered by a particular collective bargaining agreement (or an appropriate related participation agreement) in which the plan sponsor participates (as described in 26 CFR 1.105-11(c)(2)(iii)(D));

(viii) Employees who have not satisfied a waiting period for coverage (if the waiting period complies with §147.116 of this subchapter);

(ix) Non-resident aliens with no U.S.-based income (as described in 26 CFR 1.105-11(c)(2)(iii)(E));

(x) Employees who, under all the facts and circumstances, are employees of an entity that hired the employees for temporary placement at an entity that is not the common law employer of the employees and that is not treated as a single employer with the entity that hired the employees for temporary placement under section 414(b), (c), (m), or (o) of the Code; or

(xi) A group of participants described as a combination of two or more of the classes of employees set forth in paragraphs (d)(2)(i) through (x) of this section.

(3) *Minimum class size requirement*—(i) *In general.* If a class of employees is subject to the minimum class size requirement as set forth in this paragraph (d)(3), the class must consist of at least a minimum number of employees (as described in paragraphs (d)(3)(iii) and (iv) of this section), otherwise, the plan sponsor may not treat that class as a separate class of employees. Paragraph (d)(3)(ii) of this section sets forth the circumstances in which the minimum class size requirement applies to a class of employees, paragraph (d)(3)(iii) of this section sets forth the rules for determining the applicable class size minimum, and paragraph (d)(3)(iv) of this section sets forth the rules for a plan sponsor to determine if it satisfies the minimum class size requirement with respect to a class of employees.

(ii) *Circumstances in which minimum class size requirement applies*—(A) The minimum class size requirement applies only if a plan sponsor offers a traditional group health plan to one or more classes of employees and offers an individual coverage HRA to one or more other classes of employees.

(B) The minimum class size requirement does not apply to a class of employees offered a traditional group health plan or a class of employees offered no coverage.

(C) The minimum class size requirement applies to a class of employees offered an individual coverage HRA if the class is full-time employees, part-time employees, salaried employees, non-salaried employees, or employees whose primary site of employment is in the same rating area (described in paragraph (d)(2)(i), (ii), (iii), (iv), or (v) of this section, respectively, and referred to collectively as the applicable classes or individually as an applicable class), except that:

(1) In the case of the class of employees whose primary site of employment is in the same rating area (as described in paragraph (d)(2)(v) of this section), the minimum class size requirement does not apply if the geographic area defining the class is a State or a combination of two or more entire States; and

(2) In the case of the classes of employees that are full-time employees and part-time employees (as described in paragraphs (d)(2)(i) and (ii) of this section, respectively), the minimum class size requirement applies only to those classes (and the classes are only applicable classes) if the employees in one such class are offered a traditional group health plan while the employees in the other such class are offered an individual coverage HRA. In such a case, the minimum class size requirement applies only to the class offered an individual coverage HRA.

(D) A class of employees offered an individual coverage HRA is also subject to the minimum class size requirement if the class is a class of employees created by combining at least one of the applicable classes (as defined in paragraph (d)(3)(ii)(C) of this section) with any other class, except that the minimum class size requirement shall not apply to a class that is the result of a combination of one of the applicable classes and a class of employees who have not satisfied a waiting period (as described in paragraph (d)(2)(viii) of this section).

(iii) *Determination of the applicable class size minimum*—(A) *In general.* The minimum number of employees that must be in a class of employees that is subject to the minimum class size requirement (the applicable class size minimum) is determined prior to the beginning of the plan year for each plan year of the individual coverage HRA and is:

(1) 10, for an employer with fewer than 100 employees;

(2) A number, rounded down to a whole number, equal to 10 percent of the total number of employees, for an employer with 100 to 200 employees; and

(3) 20, for an employer with more than 200 employees.

(B) *Determining employer size.* For purposes of this paragraph (d)(3), the number of employees of an employer is determined in advance of the plan year of the HRA based on the number of employees that the employer reasonably expects to employ on the first day of the plan year.

(iv) *Determining if a class satisfies the applicable class size minimum.* For purposes of this paragraph (d)(3), whether a class of employees satisfies the applicable class size minimum for a plan year of the individual coverage HRA is based on the number of employees in the class offered the individual coverage HRA as of the first day of the plan year. Therefore, this determination is not based on the number of employees that actually enroll in the individual coverage HRA, and this determination is not affected by changes in the number of employees in the class during the plan year.

(4) *Consistency requirement.* For any plan year, a plan sponsor may define "full-time employee," "part-time employee," and "seasonal employee" in accordance with the relevant provisions of sections 105(h) or 4980H of the Code, as set forth in paragraphs (d)(2)(i), (ii), and (vi) of this section, if:

(i) To the extent applicable under the HRA for the plan year, each of the three classes of employees are defined in accordance with section 105(h) of the Code or each of the three classes of employees are defined in accordance with section 4980H of the Code for the plan year; and

(ii) The HRA plan document sets forth the applicable definitions prior to the beginning of the plan year to which the definitions will apply.

(5) *Special rule for new hires—(i) In general.* Notwithstanding paragraphs (c)(2) and (3) of this section, a plan sponsor that offers a traditional group health plan to a class of employees may prospectively offer the employees in that class of employees who are hired on or after a certain future date (the new hire date) an individual coverage HRA (with this group of employees referred to as the new hire subclass), while continuing to offer employees in that class of employees who are hired before the new hire date a traditional group health plan (with the rule set forth in this sentence referred to as the special rule for new hires). For the new hire subclass, the individual coverage HRA must be offered on the same terms to all participants within the subclass, in accordance with paragraph (c)(3) of this section. In accordance with paragraph (c)(2) of this section, a plan sponsor may not offer a choice between an individual coverage HRA or a traditional group health plan to any employee in the new hire subclass or to any employee in the class who is not a member of the new hire subclass.

(ii) *New hire date.* A plan sponsor may set the new hire date for a class of employees prospectively as any date on or after January 1, 2020. A plan sponsor may set different new hire dates prospectively for separate classes of employees.

(iii) *Discontinuation of use of special rule for new hires and multiple applications of the special rule for new hires.* A plan sponsor may discontinue use of the special rule for new hires at any time for any class of employees. In that case, the new hire subclass is no longer treated as a separate subclass of employees. In the event a plan sponsor applies the special rule for new hires to a class of employees and later discontinues use of the rule to the class of employees, the plan sponsor may later apply the rule if the application of the rule would be permitted under the rules for initial application of the special rule for new hires. If a plan sponsor, in accordance with the requirements for the special rule for new hires, applies the rule to a class of employees subsequent to any prior application and discontinuance of the rule to that class, the new hire date must be prospective.

(iv) *Application of the minimum class size requirement under the special rule for new hires.* The minimum class size requirement set forth in paragraph (d)(3) of this section does not apply to the new hire subclass. However, if a plan sponsor subdivides the new hire subclass subsequent to creating the new hire subclass, the minimum class size requirement set forth in paragraph (d)(3) of this section applies to any class of employees created by subdividing the new hire subclass, if the minimum class size requirement otherwise applies.

(6) *Student employees offered student premium reduction arrangements.* For purposes of this section, if an institution of higher education (as defined in the Higher Education Act of 1965) offers a student employee a student premium reduction arrangement, the employee is not considered to be part of the class of employees to which the employee would otherwise belong. For the purpose of this paragraph (d)(6) and paragraph (f)(1) of this section, a student premium reduction arrangement is defined as any program offered by an institution of higher education under which the cost of insured or self-insured student health coverage is reduced for certain students through a credit, offset, reimbursement, stipend or similar arrangement. A student employee offered a student premium reduction arrangement is also not counted for purposes of determining the applicable class size minimum under paragraph (d)(3)(iii) of this section. If a student employee is not offered a student premium reduction arrangement (including if the student employee is offered an individual coverage HRA instead), the student employee is considered to be part of the class of employees to which the employee otherwise belongs and is counted for purposes of determining the applicable class size minimum under paragraph (d)(3)(iii) of this section.

(e) *Integration of Individual Coverage HRAs with Medicare—(1) General rule.* An individual coverage HRA will be considered to be integrated with Medicare (and deemed to comply with PHS Act sections 2711 and 2713 and §147.126(d)(4) of this subchapter), provided that the conditions of paragraph (c) of this section are satisfied, subject to paragraph (e)(2) of this section. Nothing in this section requires that a participant and his or her dependents all have the same type of coverage;

therefore, an individual coverage HRA may be integrated with Medicare for some individuals and with individual health insurance coverage for others, including, for example, a participant enrolled in Medicare Part A and B or Part C and his or her dependents enrolled in individual health insurance coverage.

(2) *Application of conditions in paragraph (c) of this section*—(i) *In general.* Except as provided in paragraph (e)(2)(ii) of this section, in applying the conditions of paragraph (c) of this section with respect to integration with Medicare, a reference to “individual health insurance coverage” is deemed to refer to coverage under Medicare Part A and B or Part C. References in this section to integration of an HRA with Medicare refer to integration of an individual coverage HRA with Medicare Part A and B or Part C.

(ii) *Exceptions.* For purposes of the statement regarding ERISA under the notice content element under paragraph (c)(6)(ii)(A) of this section and the statement regarding the availability of a special enrollment period under the notice content element under paragraph (c)(6)(ii)(J) of this section, the term individual health insurance coverage means only individual health insurance coverage and does not also mean coverage under Medicare Part A and B or Part C.

(f) *Examples*—(1) *Examples regarding classes and the minimum class size requirement.* The following examples illustrate the provisions of paragraph (c)(3) of this section, taking into account the provisions of paragraphs (d)(1) through (4) and (d)(6) of this section. In each example, the HRA is an individual coverage HRA that may reimburse any medical care expenses, including premiums for individual health insurance coverage and it is assumed that no participants or dependents are Medicare beneficiaries.

(i) *Example 1: Collectively bargained employees offered traditional group health plan; non-collectively bargained employees offered HRA*—(A) *Facts.* For 2020, Plan Sponsor A offers its employees covered by a collective bargaining agreement a traditional group health plan (as required by the collective bargaining agreement) and all other employees (non-collectively bargained employees) each an HRA on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(i) (*Example 1*) because collectively bargained and non-collectively bargained employees may be treated as different classes of employees, one of which may be offered a traditional group health plan and the other of which may be offered an individual coverage HRA, and Plan Sponsor A offers the HRA on the same terms to all participants who are non-collectively bargained employees. The minimum class size requirement does not apply to this paragraph (f)(1)(i) (*Example 1*) even though Plan Sponsor A offers one class a traditional group health plan and one class the HRA because collectively bargained and non-collectively bargained employees are not applicable classes that are subject to the minimum class size requirement.

(ii) *Example 2: Collectively bargained employees in one unit offered traditional group health plan and in another unit offered HRA*—(A) *Facts.* For 2020, Plan Sponsor B offers its employees covered by a collective bargaining agreement with Local 100 a traditional group health plan (as required by the collective bargaining agreement), and its employees covered by a collective bargaining agreement with Local 200 each an HRA on the same terms (as required by the collective bargaining agreement).

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(ii) (*Example 2*) because the employees covered by the collective bargaining agreements with the two separate bargaining units (Local 100 and Local 200) may be treated as two different classes of employees and Plan Sponsor B offers an HRA on the same terms to the participants covered by the agreement with Local 200. The minimum class size requirement does not apply to this paragraph (f)(1)(ii) (*Example 2*) even though Plan Sponsor B offers the Local 100 employees a traditional group health plan and the Local 200 employees an HRA because collectively bargained employees are not applicable classes that are subject to the minimum class size requirement.

(iii) *Example 3: Employees in a waiting period offered no coverage; other employees offered an HRA*—(A) *Facts.* For 2020, Plan Sponsor C offers its employees who have completed a waiting period that complies with the requirements for waiting periods in §147.116 of this subchapter each an HRA on the same terms and does not offer coverage to its employees who have not completed the waiting period.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(iii) (*Example 3*) because employees who have completed a waiting period and employees who have not completed a waiting period may be treated as different classes and Plan Sponsor C offers the HRA on the same terms to all participants who have completed the waiting period. The minimum class size requirement does not apply to this paragraph (f)(1)(iii) (*Example 3*) because Plan Sponsor C does not offer at least one class of employees a traditional group health plan and because the class of employees who have not completed a waiting period and the class of employees who have completed a waiting period are not applicable classes that are subject to the minimum class size requirement.

(iv) *Example 4: Employees in a waiting period offered an HRA; other employees offered a traditional group health plan*—(A) *Facts.* For 2020, Plan Sponsor D offers its employees who have completed a waiting period that complies with the requirements for waiting periods in §147.116 of this subchapter a traditional group health plan and offers its employees who have not completed the waiting period each an HRA on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(iv) (*Example 4*) because employees who have completed a waiting period and employees who have not completed a waiting period may be treated as different classes and Plan Sponsor D offers an HRA on the same terms to all participants who have not completed the waiting period. The minimum class size requirement does not apply to this paragraph (f)(1)(iv) (*Example 4*) even though Plan Sponsor D offers employees who have completed a waiting period a traditional group health plan and employees who have not completed a waiting period an HRA because the class of employees who have not completed a waiting period is not an applicable class that is subject to the minimum class size requirement (nor is the class made up of employees who have completed the waiting period).

(v) *Example 5: Staffing firm employees temporarily placed with customers offered an HRA; other employees offered a traditional group health plan*—(A) *Facts.* Plan Sponsor E is a staffing firm that places certain of its employees on temporary assignments with customers that are not the common law employers of Plan Sponsor E's employees or treated as a single employer with Plan Sponsor E under section 414(b), (c), (m), or (o) of the Code (unrelated entities); other employees work in Plan Sponsor E's office managing the staffing business (non-temporary employees). For 2020, Plan Sponsor E offers its employees who are on temporary assignments with customers each an HRA on the same terms. All other employees are offered a traditional group health plan.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(v) (*Example 5*) because the employees who are hired for temporary placement at an unrelated entity and non-temporary employees of Plan Sponsor E may be treated as different classes of employees and Plan Sponsor E offers an HRA on the same terms to all participants temporarily placed with customers. The minimum class size requirement does not apply to this paragraph (f)(1)(v) (*Example 5*) even though Plan Sponsor E offers one class a traditional group health plan and

one class the HRA because the class of employees hired for temporary placement is not an applicable class that is subject to the minimum class size requirement (nor is the class made up of non-temporary employees).

(vi) *Example 6: Staffing firm employees temporarily placed with customers in rating area 1 offered an HRA; other employees offered a traditional group health plan—(A) Facts.* The facts are the same as in paragraph (f)(1)(v) of this section (*Example 5*), except that Plan Sponsor E has work sites in rating area 1 and rating area 2, and it offers its 10 employees on temporary assignments with a work site in rating area 1 an HRA on the same terms. Plan Sponsor E has 200 other employees in rating areas 1 and 2, including its non-temporary employees in rating areas 1 and 2 and its employees on temporary assignments with a work site in rating area 2, all of whom are offered a traditional group health plan.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(vi) (*Example 6*) because, even though the employees who are temporarily placed with customers generally may be treated as employees of a different class, because Plan Sponsor E is also using a rating area to identify the class offered the HRA (which is an applicable class for the minimum class size requirement) and is offering one class the HRA and another class the traditional group health plan, the minimum class size requirement applies to the class offered the HRA, and the class offered the HRA fails to satisfy the minimum class size requirement. Because Plan Sponsor E employs 210 employees, the applicable class size minimum is 20, and the HRA is offered to only 10 employees.

(vii) *Example 7: Employees in State 1 offered traditional group health plan; employees in State 2 offered HRA—(A) Facts.* Plan Sponsor F employs 45 employees whose work site is in State 1 and 7 employees whose primary site of employment is in State 2. For 2020, Plan Sponsor F offers its 45 employees in State 1 a traditional group health plan, and each of its 7 employees in State 2 an HRA on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(vii) (*Example 7*) because Plan Sponsor F offers the HRA on the same terms to all employees with a work site in State 2 and that class is a permissible class under paragraph (d) of this section. This is because employees whose work sites are in different rating areas may be considered different classes and a plan sponsor may create a class of employees by combining classes of employees, including by combining employees whose work site is in one rating area with employees whose work site is in a different rating area, or by combining all employees whose work site is in a state. The minimum class size requirement does not apply to this paragraph (f)(1)(vii) (*Example 7*) because the minimum class size requirement does not apply if the geographic area defining a class of employees is a state or a combination of two or more entire states.

(viii) *Example 8: Full-time seasonal employees offered HRA; all other full-time employees offered traditional group health plan; part-time employees offered no coverage—(A) Facts.* Plan Sponsor G employs 6 full-time seasonal employees, 75 full-time employees who are not seasonal employees, and 5 part-time employees. For 2020, Plan Sponsor G offers each of its 6 full-time seasonal employees an HRA on the same terms, its 75 full-time employees who are not seasonal employees a traditional group health plan, and offers no coverage to its 5 part-time employees.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(viii) (*Example 8*) because full-time seasonal employees and full-time employees who are not seasonal employees may be considered different classes and Plan Sponsor G offers the HRA on the same terms to all full-time seasonal employees. The minimum class size requirement does not apply to the class offered the HRA in this paragraph (f)(1)(viii) (*Example 8*) because part-time employees are not offered coverage and full-time employees are not an applicable class subject to the minimum class size requirement if part-time employees are not offered coverage.

(ix) *Example 9: Full-time employees in rating area 1 offered traditional group health plan; full-time employees in rating area 2 offered HRA; part-time employees offered no coverage—(A) Facts.* Plan Sponsor H employs 17 full-time employees and 10 part-time employees whose work site is in rating area 1 and 552 full-time employees whose work site is in rating area 2. For 2020, Plan Sponsor H offers its 17 full-time employees in rating area 1 a traditional group health plan and each of its 552 full-time employees in rating area 2 an HRA on the same terms. Plan Sponsor H offers no coverage to its 10 part-time employees in rating area 1. Plan Sponsor H reasonably expects to employ 569 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(ix) (*Example 9*) because employees whose work sites are in different rating areas may be considered different classes and Plan Sponsor H offers the HRA on the same terms to all full-time employees in rating area 2. The minimum class size requirement applies to the class offered the HRA in this paragraph (f)(1)(ix) (*Example 9*) because the minimum class size requirement applies to a class based on a geographic area unless the geographic area is a state or a combination of two or more entire states. However, the minimum class size requirement applies only to the class offered the HRA, and Plan Sponsor H offers the HRA to the 552 full-time employees in rating area 2 on the first day of the plan year, satisfying the minimum class size requirement (because the applicable class size minimum for Plan Sponsor H is 20).

(x) *Example 10: Employees in rating area 1 offered HRA; employees in rating area 2 offered traditional group health plan—(A) Facts.* The facts are the same as in paragraph (f)(1)(ix) of this section (*Example 9*) except that Plan Sponsor H offers its 17 full-time employees in rating area 1 the HRA and offers its 552 full-time employees in rating area 2 the traditional group health plan.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(x) (*Example 10*) because, even though employees whose work sites are in different rating areas generally may be considered different classes and Plan Sponsor H offers the HRA on the same terms to all participants in rating area 1, the HRA fails to satisfy the minimum class size requirement. Specifically, the minimum class size requirement applies to this paragraph (f)(1)(x) (*Example 10*) because the minimum class size requirement applies to a class based on a geographic area unless the geographic area is a state or a combination of two or more entire states. Further, the applicable class size minimum for Plan Sponsor H is 20 employees, and the HRA is only offered to the 17 full-time employees in rating area 1 on the first day of the HRA plan year.

(xi) *Example 11: Employees in State 1 and rating area 1 of State 2 offered HRA; employees in all other rating areas of State 2 offered traditional group health plan—(A) Facts.* For 2020, Plan Sponsor I offers an HRA on the same terms to a total of 200 employees it employs with work sites in State 1 and in rating area 1 of State 2. Plan Sponsor I offers a traditional group health plan to its 150 employees with work sites in other rating areas in State 2. Plan Sponsor I reasonably expects to employ 350 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xi) (*Example 11*). Plan Sponsor I may treat all of the employees with a work site in State 1 and rating area 1 of State 2 as a class of employees because employees whose work sites are in different rating areas may be considered different classes and a plan sponsor may create a class of employees by combining classes of employees, including by combining employees whose work site is in one rating area with a class of employees whose work site is in a different rating area. The minimum class size requirement applies to the class of employees offered the HRA (made up of employees in State 1 and in rating area 1 of State 2) because the minimum class size requirement applies to a class based on a geographic area unless the geographic area is a state or a combination of two or more entire states. In this case, the class is made up of a state plus a rating area which is not the entire state. However, this class satisfies the minimum class size requirement because the applicable class size minimum for Plan Sponsor I is 20, and Plan Sponsor I offered the HRA to 200 employees on the first day of the plan year.

(xii) *Example 12: Salaried employees offered a traditional group health plan; hourly employees offered an HRA—(A) Facts.* Plan Sponsor J has 163 salaried employees and 14 hourly employees. For 2020, Plan Sponsor J offers its 163 salaried employees a traditional group health plan and each of its 14 hourly employees an HRA on the same terms. Plan Sponsor J reasonably expects to employ 177 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(xii) (*Example 12*) because, even though salaried and hourly employees generally may be considered different classes and Plan Sponsor J offers the HRA on the same terms to all hourly employees, the HRA fails to satisfy the minimum class size requirement. Specifically, the minimum class size requirement applies in this paragraph (f)(1)(xii) (*Example 12*) because employees who are paid on a salaried basis and employees who are not paid on a salaried basis are applicable classes subject to the minimum class size requirement. Because Plan Sponsor J reasonably expects to employ between 100 and 200 employees on the first day of the plan year, the applicable class size minimum is 10 percent, rounded down to a whole number. Ten percent of 177 total employees, rounded down to a whole number is 17, and the HRA is offered to only 14 hourly employees.

(xiii) *Example 13: Part-time employees and full-time employees offered different HRAs; no traditional group health plan offered—(A) Facts.* Plan Sponsor K has 50 full-time employees and 7 part-time employees. For 2020, Plan Sponsor K offers its 50 full-time employees \$2,000 each in an HRA otherwise provided on the same terms and each of its 7 part-time employees \$500 in an HRA otherwise provided on the same terms. Plan Sponsor K reasonably expects to employ 57 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xiii) (*Example 13*) because full-time employees and part-time employees may be treated as different classes and Plan Sponsor K offers an HRA on the same terms to all the participants in each class. The minimum class size requirement does not apply to either the full-time class or the part-time class because (although in certain circumstances the minimum class size requirement applies to a class of full-time employees and a class of part-time employees) Plan Sponsor K does not offer any class of employees a traditional group health plan, and the minimum class size requirement applies only when, among other things, at least one class of employees is offered a traditional group health plan while another class is offered an HRA.

(xiv) *Example 14: No employees offered an HRA—(A) Facts.* The facts are the same facts as in paragraph (f)(1)(xiii) of this section (*Example 13*), except that Plan Sponsor K offers its full-time employees a traditional group health plan and does not offer any group health plan (either a traditional group health plan or an HRA) to its part-time employees.

(B) *Conclusion.* The regulations set forth under this section do not apply to Plan Sponsor K because Plan Sponsor K does not offer an individual coverage HRA to any employee.

(xv) *Example 15: Full-time employees offered traditional group health plan; part-time employees offered HRA—(A) Facts.* The facts are the same as in paragraph (f)(1)(xiii) of this section (*Example 13*), except that Plan Sponsor K offers its full-time employees a traditional group health plan and offers each of its part-time employees \$500 in an HRA and otherwise on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(xv) (*Example 15*) because, even though the full-time employees and the part-time employees generally may be treated as different classes, in this paragraph (f)(1)(xv) (*Example 15*), the minimum class size requirement applies to the part-time employees, and it is not satisfied. Specifically, the minimum class size requirement applies to the part-time employees because that requirement applies to an applicable class offered an HRA when one class is offered a traditional group health plan while another class is offered an HRA, and to the part-time and full-time employee classes when one of those classes is offered a traditional group health plan while the other is offered an HRA. Because Plan Sponsor K reasonably expects to employ fewer than 100 employees on the first day of the HRA plan year, the applicable class size minimum for Plan Sponsor K is 10 employees, but Plan Sponsor K offered the HRA only to its 7 part-time employees.

(xvi) *Example 16: Satisfying minimum class size requirement based on employees offered HRA—(A) Facts.* Plan Sponsor L employs 78 full-time employees and 12 part-time employees. For 2020, Plan Sponsor L offers its 78 full-time employees a traditional group health plan and each of its 12 part-time employees an HRA on the same terms. Only 6 part-time employees enroll in the HRA. Plan Sponsor L reasonably expects to employ fewer than 100 employees on the first day of the HRA plan year.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xvi) (*Example 16*) because full-time employees and part-time employees may be treated as different classes, Plan Sponsor L offers an HRA on the same terms to all the participants in the part-time class, and the minimum class size requirement is satisfied. Specifically, whether a class of employees satisfies the applicable class size minimum is determined as of the first day of the plan year based on the number of employees in a class that is offered an HRA, not on the number of employees who enroll in the HRA. The applicable class size minimum for Plan Sponsor L is 10 employees, and Plan Sponsor L offered the HRA to its 12 part-time employees.

(xvii) *Example 17: Student employees offered student premium reduction arrangements and same terms requirement—(A) Facts.* Plan Sponsor M is an institution of higher education that offers each of its part-time employees an HRA on the same terms, except that it offers its part-time employees who are student employees a student premium reduction arrangement, and the student premium reduction arrangement provides different amounts to different part-time student employees.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(1)(xvii) (*Example 17*) because Plan Sponsor M offers the HRA on the same terms to its part-time employees who are not students and because the part-time student employees offered a student premium reduction arrangement (and their varying HRAs) are not taken into account as part-time employees for purposes of determining whether a class of employees is offered an HRA on the same terms.

(xiii) *Example 18: Student employees offered student premium reduction arrangements and minimum class size requirement—(A) Facts.* Plan Sponsor N is an institution of higher education with 25 hourly employees. Plan Sponsor N offers 15 of its hourly employees, who are student employees, a student premium reduction arrangement and it wants to offer its other 10 hourly employees an HRA for 2022. Plan Sponsor N offers its salaried employees a traditional group health plan. Plan Sponsor N reasonably expects to have 250 employees on the first day of the 2022 HRA plan year, 15 of which will have offers of student premium reduction arrangements.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(1)(xviii) (*Example 18*). The minimum class size requirement will apply to the class of hourly employees to which Plan Sponsor N wants to offer the HRA because Plan Sponsor N offers a class of employees a traditional group health plan and another class the HRA, and the minimum class size requirement generally applies to a class of hourly employees offered an HRA. Plan Sponsor N's applicable class size minimum is 20 because Plan Sponsor N reasonably expects to employ 235 employees on the first day of the plan year (250 employees minus 15 employees receiving a student premium reduction arrangement). Plan Sponsor N may not offer the HRA to its hourly employees because the 10 employees offered the HRA as of the first day of the plan year does not satisfy the applicable class size minimum.

(2) *Examples regarding special rule for new hires.* The following examples illustrate the provisions of paragraph (c)(3) of this section, taking into account the provisions of paragraph (d) of this section, in particular the special rule for new hires under paragraph (d)(5) of this section. In each example, the HRA is an individual coverage HRA that has a calendar year plan year and may reimburse any medical care expenses, including premiums for individual health insurance coverage. The examples also assume that no participants or dependents are Medicare beneficiaries.

(i) *Example 1: Application of special rule for new hires to all employees—(A) Facts.* For 2021, Plan Sponsor A offers all employees a traditional group health plan. For 2022, Plan Sponsor A offers all employees hired on or after January 1, 2022, an HRA on the same terms and continues to offer the traditional group health plan to employees hired before that date. On the first day of the 2022 plan year, Plan Sponsor A has 2 new hires who are offered the HRA.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(i) (*Example 1*) because, under the special rule for new hires in paragraph (d)(5) of this section, the employees newly hired on and after January 1, 2022, may be treated as a new hire subclass, Plan Sponsor A offers the HRA on the same terms to all participants in the new hire subclass, and the minimum class size requirement does not apply to the new hire subclass.

(ii) *Example 2: Application of special rule for new hires to full-time employees—(A) Facts.* For 2021, Plan Sponsor B offers a traditional group health plan to its full-time employees and does not offer any coverage to its part-time employees. For 2022, Plan Sponsor B offers full-time employees hired on or after January 1, 2022, an HRA on the same terms, continues to offer its full-time employees hired before that date a traditional group health plan, and continues to offer no coverage to its part-time employees. On the first day of the 2022 plan year, Plan Sponsor B has 2 new hire, full-time employees who are offered the HRA.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(ii) (*Example 2*) because, under the special rule for new hires in paragraph (d)(5) of this section, the full-time employees newly hired on and after January 1, 2022, may be treated as a new hire subclass and Plan Sponsor B offers the HRA on the same terms to all participants in the new hire subclass. The minimum class size requirement does not apply to the new hire subclass.

(iii) *Example 3: Special rule for new hires impermissibly applied retroactively—(A) Facts.* For 2025, Plan Sponsor C offers a traditional group health plan to its full-time employees. For 2026, Plan Sponsor C wants to offer an HRA to its full-time employees hired on and after January 1, 2023, while continuing to offer a traditional group health plan to its full-time employees hired before January 1, 2023.

(B) *Conclusion.* The special rule for new hires under paragraph (d)(5) of this section does not apply in this paragraph (f)(2)(iii) (*Example 3*) because the rule must be applied prospectively. That is, Plan Sponsor C may not, in 2026, choose to apply the special rule for new hires retroactive to 2023. If Plan Sponsor C were to offer an HRA in this way, it would fail to satisfy the conditions under paragraphs (c)(2) and (3) of this section because the new hire subclass would not be treated as a subclass for purposes of applying those rules and, therefore, all full-time employees would be treated as one class to which either a traditional group health plan or an HRA could be offered, but not both.

(iv) *Example 4: Permissible second application of the special rule for new hires to the same class of employees—(A) Facts.* For 2021, Plan Sponsor D offers all of its full-time employees a traditional group health plan. For 2022, Plan Sponsor D applies the special rule for new hires and offers an HRA on the same terms to all employees hired on and after January 1, 2022, and continues to offer a traditional group health plan to full-time employees hired before that date. For 2025, Plan Sponsor D discontinues use of the special rule for new hires, and again offers all full-time employees a traditional group health plan. In 2030, Plan Sponsor D decides to apply the special rule for new hires to the full-time employee class again, offering an HRA to all full-time employees hired on and after January 1, 2030, on the same terms, while continuing to offer employees hired before that date a traditional group health plan.

(B) *Conclusion.* Plan Sponsor D has permissibly applied the special rule for new hires and is in compliance with the requirements of paragraphs (c) (2) and (3) of this section.

(v) *Example 5: Impermissible second application of the special rule for new hires to the same class of employees—(A) Facts.* The facts are the same as in paragraph (f)(2)(iv) of this section (*Example 4*), except that for 2025, Plan Sponsor D discontinues use of the special rule for new hires by offering all full-time employees an HRA on the same terms. Further, for 2030, Plan Sponsor D wants to continue to offer an HRA on the same terms to all full-time employees hired before January 1, 2030, and to offer all full-time employees hired on or after January 1, 2030, an HRA in a different amount.

(B) *Conclusion.* Plan Sponsor D may not apply the special rule for new hires for 2030 to the class of full-time employees being offered an HRA because the special rule for new hires may only be applied to a class that is being offered a traditional group health plan.

(vi) *Example 6: New full-time employees offered different HRAs in different rating areas—(A) Facts.* Plan Sponsor E has work sites in rating area 1, rating area 2, and rating area 3. For 2021, Plan Sponsor E offers its full-time employees a traditional group health plan. For 2022, Plan Sponsor E offers its full-time employees hired on or after January 1, 2022, in rating area 1 an HRA of \$3,000, its full-time employees hired on or after January 1, 2022, in rating area 2 an HRA of \$5,000, and its full-time employees hired on or after January 1, 2022, in rating area 3 an HRA of \$7,000. Within each class offered an HRA, Plan Sponsor E offers the HRA on the same terms. Plan Sponsor E offers its full-time employees hired prior to January 1, 2022, in each of those classes a traditional group health plan. On the first day of the 2022 plan year, there is one new hire, full-time employee in rating area 1, three new hire, full-time employees in rating area 2, and 10 new hire-full-time employees in rating area 3.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(vi) (*Example 6*) because, under the special rule for new hires in paragraph (d)(5) of this section, the full-time employees in each of the three rating areas newly hired on and after January 1, 2022, may be treated as three new hire subclasses and Plan Sponsor E offers the HRA on the same terms to all participants in the new hire subclasses. Further, the minimum class size requirement does not apply to the new hire subclasses.

(vii) *Example 7: New full-time employee class subdivided based on rating area—(A) Facts.* Plan Sponsor F offers its full-time employees hired on or after January 1, 2022, an HRA on the same terms and it continues to offer its full-time employees hired before that date a traditional group health plan. Plan Sponsor F offers no coverage to its part-time employees. For the 2025 plan year, Plan Sponsor F wants to subdivide the full-time new hire subclass so that those whose work site is in rating area 1 will be offered the traditional group health plan and those whose work site is in rating area 2 will continue to receive the HRA. Plan Sponsor F reasonably expects to employ 219 employees on January 1, 2025. As of January 1, 2025, Plan Sponsor F has 15 full-time employees whose work site is in rating area 2 and who were hired between January 1, 2022, and January 1, 2025.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is not satisfied in this paragraph (f)(2)(vii) (*Example 7*) because the new hire subclass has been subdivided in a manner that is subject to the minimum class size requirement, and the class offered the HRA fails to satisfy the minimum class size requirement. Specifically, once the new hire subclass is subdivided the general rules for applying the minimum class size requirement apply to the employees offered the HRA in the new hire subclass. In this case, because the subdivision of the new hire full-time subclass is based on rating areas; a class based on rating areas is an applicable class subject to the minimum class size requirement; and the employees in one rating area are to be offered the HRA, while the employees in the other rating area are offered the traditional group health plan, the minimum class size requirement would apply on and after the date of the subdivision. Further, the minimum class size requirement would not be satisfied, because the applicable class size minimum for Plan Sponsor F would be 20, and only 15 employees in rating area 2 would be offered the HRA.

(viii) *Example 8: New full-time employee class subdivided based on state—(A) Facts.* The facts are the same as in paragraph (f)(2)(vii) of this section (*Example 7*), except that for the 2025 plan year, Plan Sponsor F intends to subdivide the new hire, full-time class so that those in State 1 will be offered the traditional group health plan and those in State 2 will each be offered an HRA on the same terms.

(B) *Conclusion.* The same terms requirement of paragraph (c)(3) of this section is satisfied in this paragraph (f)(2)(viii) (*Example 8*) because even though the new hire subclass has been subdivided, it has been subdivided in a manner that is not subject to the minimum class size requirement as the subdivision is based on the entire state.

(ix) *Example 9: New full-time employees and part-time employees offered HRA—(A) Facts.* In 2021, Plan Sponsor G offers its full-time employees a traditional group health plan and does not offer coverage to its part-time employees. For the 2022 plan year, Plan Sponsor G offers its full-time employees hired on or after January 1, 2022, and all of its part-time employees, including those hired before January 1, 2022, and those hired on and after January 1, 2022, an HRA on the same terms, and it continues to offer its full-time employees hired before January 1, 2022, a traditional group health plan.

(B) *Conclusion.* The minimum class size requirement applies to the part-time employees offered the HRA in 2022 because the class is being offered an HRA; the special rule for new hires does not apply (because this class was not previously offered a traditional group health plan) and so it is not a new hire subclass exempt from the minimum class size requirement; another class of employees (that is, full-time hired before January 1, 2022) are being offered a traditional group health plan; and the part-time employee class is generally an applicable classes that is subject to the minimum class size requirement. However, because the full-time, new hire subclass is based on the special rule for new hires, the minimum class size requirement does not apply to full-time new hires offered an HRA in 2022.

(g) *Applicability date.* This section applies to plan years beginning on or after January 1, 2020.

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