

(c) *Notice of special enrollment.* At or before the time an employee is initially offered the opportunity to enroll in a group health plan, the plan must furnish the employee with a notice of special enrollment that complies with the requirements of this paragraph (c).

(1) *Description of special enrollment rights.* The notice of special enrollment must include a description of special enrollment rights. The following model language may be used to satisfy this requirement:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within [insert "30 days" or any longer period that applies under the plan] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within [insert "30 days" or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact [insert the name, title, telephone number, and any additional contact information of the appropriate plan representative].

(2) *Additional information that may be required.* The notice of special enrollment must also include, if applicable, the notice described in paragraph (a)(3)(iv) of this section (the notice required to be furnished to an individual declining coverage if the plan requires the reason for declining coverage to be in writing).

(d) *Treatment of special enrollees—*(1) If an individual requests enrollment while the individual is entitled to special enrollment under either paragraph (a) or (b) of this section, the individual is a special enrollee, even if the request for enrollment coincides with a late enrollment opportunity under the plan. Therefore, the individual cannot be treated as a late enrollee.

(2) Special enrollees must be offered all the benefit packages available to similarly situated individuals who enroll when first eligible. For this purpose, any difference in benefits or cost-sharing requirements for different individuals constitutes a different benefit package. In addition, a special enrollee cannot be required to pay more for coverage than a similarly situated individual who enrolls in the same coverage when first eligible. The length of any preexisting condition exclusion that may be applied to a special enrollee cannot exceed the length of any preexisting condition exclusion that is applied to similarly situated individuals who enroll when first eligible. For rules prohibiting the application of a preexisting condition exclusion to certain newborns, adopted children, and children placed for adoption, see § 54.9801-3(b).

(3) The rules of this section are illustrated by the following example:

Example 2. (i) *Facts.* Employer *Y* maintains a group health plan that has an enrollment period for late enrollees every November 1 through November 30 with coverage effective the following January 1. On October 18, Individual *B* loses coverage under another group health plan and satisfies the requirements of paragraphs (a)(2), (3), and (4) of this section. *B* submits a completed application for coverage on November 2.

(ii) *Conclusion.* In this *Example*, *B* is a special enrollee. Therefore, even though *B*'s request for enrollment coincides with an open enrollment period, *B*'s coverage is required to be made effective no later than December 1 (rather than the plan's January 1 effective date for late enrollees).

[T.D. 9166, 69 FR 78746, Dec. 30, 2004]

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

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

- (i) Health status;
- (ii) Medical condition (including both physical and mental illnesses);
- (iii) Claims experience;
- (iv) Receipt of health care;
- (v) Medical history;
- (vi) Genetic information;
- (vii) Evidence of insurability; or
- (viii) Disability.

(2) Evidence of insurability includes—

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

(ii) [Reserved]. For further guidance, see § 54.9802-1T(a)(2)(ii).

(b) *Prohibited discrimination in rules for eligibility*—(1) *In general.* (i) A group health plan may not establish any rule for eligibility (including continued eligibility) of any individual to enroll for benefits under the terms of the plan that discriminates based on any health factor that relates to that individual or a dependent of that individual. This rule is subject to the provisions of paragraph (b)(2) of this section (explaining how this rule applies to benefits), paragraph (b)(3) of this section (allowing plans to impose certain pre-existing condition exclusions), paragraph (d) of this section (containing rules for establishing groups of similarly situated individuals), paragraph (e) of this section (relating to non-confinement, actively-at-work, and other service requirements), paragraph (f) of this section (relating to bona fide wellness programs), and paragraph (g) of this section (permitting favorable treatment of individuals with adverse health factors).

(ii) [Reserved]. For further guidance, see § 54.9802-1T(b)(1)(ii).

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

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

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

Example 2. [Reserved]

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

(B) [Reserved]. For further guidance, see § 54.9802-1T(b)(2)(i)(B).

(C) [Reserved]. For further guidance, see § 54.9802-1T(b)(2)(i)(C).

(D) [Reserved]. For further guidance, see § 54.9802-1T(b)(2)(i)(D).

(ii) *Cost-sharing mechanisms and wellness programs.* A group health plan with a cost-sharing mechanism (such as a deductible, copayment, or coinsurance) that requires a higher payment from an individual, based on a health factor of that individual or a dependent of that individual, than for a similarly situated individual under the plan (and thus does not apply uniformly to all similarly situated individuals) does not violate the requirements of this paragraph (b)(2) if the payment differential is based on whether an individual has complied with the requirements of a bona fide wellness program.

(iii) *Specific rule relating to source-of-injury exclusions.* [Reserved]. For further guidance, see § 54.9802-1T(b)(2)(iii).

(3) *Relationship to section 9801(a), (b), and (d).* [Reserved]. For further guidance, see § 54.9802-1T(b)(3).

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

(ii) [Reserved]. For further guidance, see § 54.9802-1T(c)(1)(ii).

(2) *Rules relating to premium rates*—(i) *Group rating based on health factors not restricted under this section.* Nothing in this section restricts the aggregate amount that an employer may be charged for coverage under a group health plan.

(ii) *List billing based on a health factor prohibited.* [Reserved]. For further guidance, see § 54.9802-1T(c)(2)(ii).

(3) *Exception for bona fide wellness programs.* Notwithstanding paragraphs (c)(1) and (2) of this section, a plan may establish a premium or contribution differential based on whether an individual has complied with the requirements of a bona fide wellness program.

(d) *Similarly situated individuals.* [Reserved]. For further guidance, see § 54.9802-1T(d).

(e) *Nonconfinement and actively-at-work provisions.* [Reserved]. For further guidance, see § 54.9802-1T(e).

(f) *Bona fide wellness programs.* [Reserved]

(g) *Benign discrimination permitted.* [Reserved]. For further guidance, see § 54.9802-1T(g).

(h) *No effect on other laws.* [Reserved]. For further guidance, see § 54.9802-1T(h).

(i) *Effective dates.* (1) Final rules apply May 8, 2001. This section applies May 8, 2001.

(2) *Cross-reference to temporary rules applicable for plan years beginning on or after July 1, 2001.* See § 54.9802-1T(i)(2), which makes the rules of that section applicable for plan years beginning on or after July 1, 2001.

(3) *Cross-reference to temporary transitional rules for individuals previously denied coverage based on a health factor.* See § 54.9802-1T(i)(3) for transitional rules that apply with respect to individuals previously denied coverage under a group health plan based on a health factor.

[T.D. 8931, 66 FR 1396, Jan. 8, 2001, as amended at 66 FR 14077, Mar. 9, 2001]

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

(a) *Health factors.* (1) [Reserved]. For further guidance, see § 54.9802-1(a).

(2) Evidence of insurability includes—

(i) [Reserved]. For further guidance, see § 54.9802-1(a)(2)(i).

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

(3) The decision whether health coverage is elected for an individual (including the time chosen to enroll, such as under special enrollment or late enrollment) is not, itself, within the scope of any health factor. (However, under section 9801(f) a plan must treat special enrollees the same as similarly situated individuals who are enrolled when first eligible.)

(b) *Prohibited discrimination in rules for eligibility—(1) In general.* (i) [Reserved]. For further guidance, see § 54.9802-1(b)(1)(i).

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

(A) Enrollment;

(B) The effective date of coverage;

(C) Waiting (or affiliation) periods;

(D) Late and special enrollment;

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

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

(G) Continued eligibility; and

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

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

Example 1. [Reserved]. For further guidance, see § 54.9802-1(b)(iii). *Example 1.*

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

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

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

(ii) *Conclusion.* In this *Example 3*, excluding from the plan individuals who participate in