

(Added Pub. L. 111-148, title I, § 1563(f), formerly § 1562(f), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 270, 911.)

REFERENCES IN TEXT

The Public Health Service Act, referred to in text, is act July 1, 1944, ch. 373, 58 Stat. 682. Part A of title XXVII of the Act is classified generally to part A (§ 300gg et seq.) of subchapter XXV of chapter 6A of Title 42, The Public Health and Welfare. Sections 2716 and 2718 of title XXVII of the Act are classified to sections 300gg-16 and 300gg-18, respectively, of Title 42. For complete classification of this Act to the Code, see Short Title note set out under section 201 of this Title 42 and Tables.

The Patient Protection and Affordable Care Act, referred to in text, is Pub. L. 111-148, Mar. 23, 2010, 124 Stat. 119. For complete classification of this Act to the Code, see Short Title note set out under section 18001 of Title 42, The Public Health and Welfare, and Tables.

Subchapter C—General Provisions

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AMENDMENTS

2008—Pub. L. 110-233, title I, § 103(e)(2), May 21, 2008, 122 Stat. 899, added item 9834.

1997—Pub. L. 105-34, title XV, § 1531(a)(3), Aug. 5, 1997, 111 Stat. 1081, added subchapter heading and analysis.

§ 9831. General exceptions

(a) Exception for certain plans

The requirements of this chapter shall not apply to—

- (1) any governmental plan, and
- (2) any group health plan for any plan year if, on the first day of such plan year, such plan has less than 2 participants who are current employees.

(b) Exception for certain benefits

The requirements of this chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9832(c)(1).

(c) Exception for certain benefits if certain conditions met

(1) Limited, excepted benefits

The requirements of this chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9832(c)(2) if the benefits—

- (A) are provided under a separate policy, certificate, or contract of insurance; or
- (B) are otherwise not an integral part of the plan.

(2) Noncoordinated, excepted benefits

The requirements of this chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9832(c)(3) if all of the following conditions are met:

- (A) The benefits are provided under a separate policy, certificate, or contract of insurance.
- (B) There is no coordination between the provision of such benefits and any exclusion

of benefits under any group health plan maintained by the same plan sponsor.

(C) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor.

(3) Supplemental excepted benefits

The requirements of this chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9832(c)(4) if the benefits are provided under a separate policy, certificate, or contract of insurance.

(d) Exception for qualified small employer health reimbursement arrangements

(1) In general

For purposes of this title (except as provided in section 4980I(f)(4) and notwithstanding any other provision of this title), the term “group health plan” shall not include any qualified small employer health reimbursement arrangement.

(2) Qualified small employer health reimbursement arrangement

For purposes of this subsection—

(A) In general

The term “qualified small employer health reimbursement arrangement” means an arrangement which—

- (i) is described in subparagraph (B), and
- (ii) is provided on the same terms to all eligible employees of the eligible employer.

(B) Arrangement described

An arrangement is described in this subparagraph if—

- (i) such arrangement is funded solely by an eligible employer and no salary reduction contributions may be made under such arrangement,
- (ii) such arrangement provides, after the employee provides proof of coverage, for the payment of, or reimbursement of, an eligible employee for expenses for medical care (as defined in section 213(d)) incurred by the eligible employee or the eligible employee’s family members (as determined under the terms of the arrangement), and
- (iii) the amount of payments and reimbursements described in clause (ii) for any year do not exceed \$4,950 (\$10,000 in the case of an arrangement that also provides for payments or reimbursements for family members of the employee).

(C) Certain variation permitted

For purposes of subparagraph (A)(ii), an arrangement shall not fail to be treated as provided on the same terms to each eligible employee merely because the employee’s permitted benefit under such arrangement varies in accordance with the variation in the price of an insurance policy in the relevant individual health insurance market based on—

- (i) the age of the eligible employee (and, in the case of an arrangement which cov-