(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

Sec.
9831. General exceptions.
9832. Definitions.
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9834. Enforcement.

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-

ers medical expenses of the eligible employee's family members, the age of such family members), or

(ii) the number of family members of the eligible employee the medical expenses of which are covered under such arrangement.

The variation permitted under the preceding sentence shall be determined by reference to the same insurance policy with respect to all eligible employees.

(D) Rules relating to maximum dollar limitation

(i) Amount prorated in certain cases

In the case of an individual who is not covered by an arrangement for the entire year, the limitation under subparagraph (B)(iii) for such year shall be an amount which bears the same ratio to the amount which would (but for this clause) be in effect for such individual for such year under subparagraph (B)(iii) as the number of months for which such individual is covered by the arrangement for such year bears to 12.

(ii) Inflation adjustment

In the case of any year beginning after 2016, each of the dollar amounts in subparagraph (B)(iii) shall be increased by an amount equal to—

(I) such dollar amount, multiplied by

(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting ''calendar year 2015'' for ''calendar year 2016'' in subparagraph (A)(ii) thereof.

If any dollar amount increased under the preceding sentence is not a multiple of $50, such dollar amount shall be rounded to the next lowest multiple of $50.

(3) Other definitions

For purposes of this subsection—

(A) Eligible employee

The term ''eligible employee'' means any employee of an eligible employer, except that the terms of the arrangement may exclude from consideration employees described in any clause of section 105(h)(3)(B) (applied by substituting ''90 days'' for ''3 years'' in clause (i) thereof).

(B) Eligible employer

The term ''eligible employer'' means an employer that—

(i) is not an applicable large employer as defined in section 4980H(c)(2), and

(ii) does not offer a group health plan to any of its employees.

(C) Permitted benefit

The term ''permitted benefit'' means, with respect to any eligible employee, the maximum dollar amount of payments and reimbursements which may be made under the terms of the qualified small employer health reimbursement arrangement for the year with respect to such employee.

(4) Notice

(A) In general

An employer funding a qualified small employer health reimbursement arrangement for any year shall, not later than 90 days before the beginning of such year (or, in the case of an employee who is not eligible to participate in the arrangement as of the beginning of such year, the date on which such employee is first so eligible), provide a written notice to each eligible employee which includes the information described in subparagraph (B).

(B) Contents of notice

The notice required under subparagraph (A) shall include each of the following:

(i) A statement of the amount which would be such eligible employee's permitted benefit under the arrangement for the year.

(ii) A statement that the eligible employee should provide the information described in clause (i) to any health insurance exchange to which the employee applies for advance payment of the premium assistance tax credit.

(iii) A statement that if the employee is not covered under minimum essential coverage for any month the employee may be subject to tax under section 5000A for such month and reimbursements under the arrangement may be includible in gross income.

(Added Pub. L. 104–191, title IV, § 401(a), Aug. 21, 1996, 110 Stat. 2080, § 9804; renumbered § 9831 and amended Pub. L. 105–34, title XV, § 1531(a)(2), (b)(1)(B)–(E), Aug. 5, 1997, 111 Stat. 1081, 1084, 1085; Pub. L. 114–255, div. C, title XVIII, § 18001(a)(1), Dec. 13, 2016, 130 Stat. 1338; Pub. L. 115–97, title I, § 11002(d)(1)(TT), Dec. 22, 2017, 131 Stat. 2061.)

INFLATION ADJUSTED ITEMS FOR CERTAIN YEARS

For inflation adjustment of certain items in this section, see Revenue Procedures listed in a table under section 1 of this title.

AMENDMENTS

2017—Subsec. (d)(2)(D)(ii)(II). Pub. L. 115–97 substituted ''for 'calendar year 2016' in subparagraph (A)(ii)'' for ''for 'calendar year 1992' in subparagraph (B)''.

2016—Subsec. (d). Pub. L. 114–255 added subsec. (d).

1997—Pub. L. 105–34 renumbered section 9804 of this title as this section and substituted reference to section 9832 of this title for reference to section 9805 of this title in subsecs. (b) and (c)(1) to (3).

EFFECTIVE DATE OF 2017 AMENDMENT

Amendment by Pub. L. 115–97 applicable to taxable years beginning after Dec. 31, 2017, see section 11002(e) of Pub. L. 115–97, set out as a note under section 1 of this title.

EFFECTIVE DATE OF 2016 AMENDMENT

Amendment by Pub. L. 114–255 applicable to years beginning after Dec. 31, 2016, see section 18001(a)(7) of Pub. L. 114–255, set out as a note under section 36B of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–34 applicable with respect to group health plans for plan years beginning on or

after Jan. 1, 1998, see section 1531(c) of Pub. L. 105–34, set out as a note under section 4980D of this title.

EFFECTIVE DATE

Section applicable to plan years beginning after June 30, 1997, see section 401(c) of Pub. L. 104–191, set out as a note under section 9801 of this title.

§ 9832. Definitions

(a) Group health plan

For purposes of this chapter, the term ''group health plan'' has the meaning given to such term by section 5000(b)(1).

(b) Definitions relating to health insurance

For purposes of this chapter—

(1) Health insurance coverage

(A) In general

Except as provided in subparagraph (B), the term ''health insurance coverage'' means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

(B) No application to certain excepted benefits

In applying subparagraph (A), excepted benefits described in subsection (c)(1) shall not be treated as benefits consisting of medical care.

(2) Health insurance issuer

The term ''health insurance issuer'' means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974, as in effect on the date of the enactment of this section). Such term does not include a group health plan.

(3) Health maintenance organization

The term ''health maintenance organization'' means—

(A) a federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act (42 U.S.C. 300e(a))),

(B) an organization recognized under State law as a health maintenance organization, or

(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

(c) Excepted benefits

For purposes of this chapter, the term ''excepted benefits'' means benefits under one or more (or any combination thereof) of the following:

(1) Benefits not subject to requirements

(A) Coverage only for accident, or disability income insurance, or any combination thereof.

(B) Coverage issued as a supplement to liability insurance.

(C) Liability insurance, including general liability insurance and automobile liability insurance.

(D) Workers' compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for on-site medical clinics.

(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(2) Benefits not subject to requirements if offered separately

(A) Limited scope dental or vision benefits.

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(C) Such other similar, limited benefits as are specified in regulations.

(3) Benefits not subject to requirements if offered as independent, noncoordinated benefits

(A) Coverage only for a specified disease or illness.

(B) Hospital indemnity or other fixed indemnity insurance.

(4) Benefits not subject to requirements if offered as separate insurance policy

Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan.

(d) Other definitions

For purposes of this chapter—

(1) COBRA continuation provision

The term ''COBRA continuation provision'' means any of the following:

(A) Section 4980B, other than subsection (f)(1) thereof insofar as it relates to pediatric vaccines.

(B) Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.), other than section 609 of such Act.

(C) Title XXII of the Public Health Service Act.

(2) Governmental plan

The term ''governmental plan'' has the meaning given such term by section 414(d).

(3) Medical care

The term ''medical care'' has the meaning given such term by section 213(d) determined without regard to—

(A) paragraph (1)(C) thereof, and

(B) so much of paragraph (1)(D) thereof as relates to qualified long-term care insurance.

(4) Network plan

The term ''network plan'' means health insurance coverage of a health insurance issuer