(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; Pub. L. 116–94, div. N, title I, §503(b)(2), Dec. 20, 2019, 133 Stat. 3119.)

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

2019—Subsec. (d)(1). Pub. L. 116–94 struck out ''except as provided in section 4980I(f)(4)'' before ''and notwithstanding any other provision of this title''.

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 2019 AMENDMENT

Amendment by Pub. L. 116–94 applicable to taxable years beginning after Dec. 31, 2019, see section 503(c) of Pub. L. 116–94, set out as a note under section 6051 of this title.

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 under which the financing and delivery of medical care are provided, in whole or in part, through a defined set of providers under contract with the issuer.

(5) Placed for adoption defined

The term ''placement'', or being ''placed'', for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

(6) Family member

The term ''family member'' means, with respect to any individual—

(A) a dependent (as such term is used for purposes of section 9801(f)(2)) of such individual, and

(B) any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual or of an individual described in subparagraph (A).

(7) Genetic information

(A) In general

The term ''genetic information'' means, with respect to any individual, information about—

(i) such individual's genetic tests,

(ii) the genetic tests of family members of such individual, and

(iii) the manifestation of a disease or disorder in family members of such individual.

(B) Inclusion of genetic services and participation in genetic research

Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual.

(C) Exclusions

The term ''genetic information'' shall not include information about the sex or age of any individual.

(8) Genetic test

(A) In general

The term ''genetic test'' means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detects genotypes, mutations, or chromosomal changes.

(B) Exceptions

The term ''genetic test'' does not mean—

(i) an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes, or

(ii) an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(9) Genetic services

The term ''genetic services'' means—

(A) a genetic test;

(B) genetic counseling (including obtaining, interpreting, or assessing genetic information); or

(C) genetic education.

(10) Underwriting purposes

The term ''underwriting purposes'' means, with respect to any group health plan, or health insurance coverage offered in connection with a group health plan—

(A) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the plan or coverage;

(B) the computation of premium or contribution amounts under the plan or coverage;

(C) the application of any pre-existing condition exclusion under the plan or coverage; and

(D) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

(Added Pub. L. 104–191, title IV, §401(a), Aug. 21, 1996, 110 Stat. 2080, §9805; renumbered §9832, Pub. L. 105–34, title XV, §1531(a)(2), Aug. 5, 1997, 111 Stat. 1081; amended Pub. L. 110–233, title I, §103(d), May 21, 2008, 122 Stat. 898.)

REFERENCES IN TEXT

The Employee Retirement Income Security Act of 1974, referred to in subsecs. (b)(2) and (d)(1)(B), is Pub. L. 93–406, Sept. 2, 1974, 88 Stat. 832, as amended. Section 514(b)(2) of the Act is classified to section 1144(b)(2) of Title 29, Labor. Section 609 of the Act is classified to section 1169 of Title 29. Part 6 of subtitle B of title I of the Act is classified generally to part 6 (§1161 et seq.) of subtitle B of subchapter I of chapter 18 of Title 29. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

The date of the enactment of this section, referred to in subsec. (b)(2), is the date of enactment of Pub. L. 104–191, which was approved Aug. 21, 1996.

Section 1882(g)(1) of the Social Security Act, referred to in subsec. (c)(4), is classified to section 1395ss(g)(1) of Title 42, The Public Health and Welfare.

The Public Health Service Act, referred to in subsec. (d)(1)(C), is act July 1, 1944, ch. 373, 58 Stat. 682, as amended. Title XXII of the Act is classified generally to subchapter XX (§300bb–1 et seq.) of chapter 6A of Title 42. For complete classification of this Act to the Code, see Short Title note set out under section 201 of Title 42 and Tables.

AMENDMENTS

2008—Subsec. (d)(6) to (10). Pub. L. 110–233 added pars. (6) to (10).

1997—Pub. L. 105–34 renumbered section 9805 of this title as this section.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by Pub. L. 110–233 applicable with respect to group health plans for plan years beginning after the date that is one year after May 21, 2008, see section 103(f)(2) of Pub. L. 110–233, set out as a note under section 9802 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.

§9833. Regulations

The Secretary, consistent with section 104 of the Health Care Portability and Accountability Act of 1996, may promulgate such regulations as may be necessary or appropriate to carry out the provisions of this chapter. The Secretary may promulgate any interim final rules as the Secretary determines are appropriate to carry out this chapter.

(Added Pub. L. 104–191, title IV, §401(a), Aug. 21, 1996, 110 Stat. 2082; §9806; renumbered §9833, Pub. L. 105–34, title XV, §1531(a)(2), Aug. 5, 1997, 111 Stat. 1081.)

REFERENCES IN TEXT

Section 104 of the Health Care Portability and Accountability Act of 1996, referred to in text, is section 104 of Pub. L. 104–191, which is set out as a note under section 300gg–92 of Title 42, The Public Health and Welfare.

AMENDMENTS

1997—Pub. L. 105–34 renumbered section 9806 of this title as this section.

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.

§9834. Enforcement

For the imposition of tax on any failure of a group health plan to meet the requirements of this chapter, see section 4980D.

(Added Pub. L. 110–233, title I, §103(e)(1), May 21, 2008, 122 Stat. 899.)