**Section 2001.9 Prohibiting Discrimination Against Participants and Beneficiaries Based on Health Status**

a) Health Factors

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

A) Health status;

B) Medical condition (including both physical and mental illnesses), as defined in 45 CFR 144.103;

C) Claims experience;

D) Receipt of health care;

E) Medical history;

F) Genetic information, as defined in 45 CFR 146.122(a);

G) Evidence of insurability; or

H) Disability.

2) Evidence of insurability includes:

A) Conditions arising out of acts of domestic violence; and

B) 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 45 CFR 146.117, a plan or issuer must treat special enrollees the same as similarly situated individuals who are enrolled when first eligible.) (45 CFR 146.121)

b) Prohibited Discrimination in Rules for Eligibility

1) In General

A) A group health plan, and a health insurance issuer offering health insurance coverage in connection with 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 or group health insurance coverage 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 subsection (b)(2) (explaining how this Section applies to benefits), subsection (b)(3) (allowing plans to impose certain preexisting condition exclusions), subsection (d) (containing rules for establishing groups of similarly situated individuals), subsection (e) (relating to nonconfinement, actively-at-work, and other service requirements), subsection (f) (relating to wellness programs), and subsection (g) (permitting favorable treatment of individuals with adverse health factors).

B) For purposes of this Section, rules for eligibility include, but are not limited to, rules relating to:

i) Enrollment;

ii) The effective date of coverage;

iii) Waiting (or affiliation) periods;

iv) Late and special enrollment;

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

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

vii) Continued eligibility; and

viii) Terminating coverage (including disenrollment) of any individual under the plan. (45 CFR 146.121)

C) This subsection (b)(1) is illustrated by the examples appearing in 45 CFR 146.121(b)(1)(iii).

2) Application to Benefits

A) General Rule

i) Under this Section, a group health plan or group health insurance issuer is not required to provide coverage for any particular benefit to any group of similarly situated individuals.

ii) However, benefits provided under a plan or through group health insurance coverage must be uniformly available to all similarly situated individuals (as described in subsection (d)). Likewise, any restriction on a benefit or benefits must apply uniformly to all similarly situated individuals and must not be directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries (determined based on all the relevant facts and circumstances). Thus, for example, a plan or issuer may limit or exclude benefits in relation to a specific disease or condition, limit or exclude benefits for certain types of treatments or drugs, or limit or exclude benefits based on a determination of whether the benefits are experimental or not medically necessary, but only if the benefit limitation or exclusion applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. In addition, a plan or issuer may impose annual, lifetime or other limits on benefits and may require the satisfaction of a deductible, copayment, coinsurance or other cost-sharing requirement in order to obtain a benefit if the limit or cost-sharing requirement applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. In the case of a cost-sharing requirement, see also subsection (b)(2)(B), which permits variances in the application of a cost-sharing mechanism made available under a wellness program. (Whether any plan provision or practice with respect to benefits complies with this subsection (b)(2)(A) does not affect whether the provision or practice is permitted under any other provision of ERISA, the Americans With Disabilities Act (42 USC 12101 et seq.), or any other law, whether State or federal.)

iii) For purposes of this subsection (b)(2)(A), a plan amendment applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries.

iv) This subsection (b)(2)(A) is illustrated by the examples appearing in 45 CFR 146.121(b)(2)(i)(D).

B) Exception for Wellness Programs

A group health plan or group health insurance issuer may vary benefits, including cost-sharing mechanisms (such as a deductible, copayment or coinsurance), based on whether an individual has met the standards of a wellness program that satisfies the requirements of subsection (f).

C) Specific Rule Relating to Source-of-Injury Exclusions

i) If a group health plan or group health insurance coverage generally provides benefits for a type of injury, the plan or issuer may not deny benefits otherwise provided for treatment of the injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions). This subsection (b)(2)(C)(i) applies in the case of an injury resulting from a medical condition even if the condition is not diagnosed before the injury.

ii) This subsection (b)(2)(C) is illustrated by the examples appearing in 45 CFR 146.121(b)(2)(iii)(B).

3) Relationship to 45 CFR 146.111

A) A preexisting condition exclusion is permitted under this Section if it :

i) Complies with 45 CFR 146.111;

ii) Applies uniformly to all similarly situated individuals (as described in subsection (d)); and

iii) Is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. For purposes of this subsection (b)(3)(A)(iii), a plan amendment relating to a preexisting condition exclusion applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries. (45 CFR 146.121)

B) This subsection (b)(3) is illustrated by the examples appearing in 45 CFR 146.121(b)(3)(ii).

c) Prohibited Discrimination in Premiums or Contributions

1) In General

A) A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require an individual, as a condition of enrollment or continued enrollment under the plan or group health insurance coverage, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual (described in subsection (d)) enrolled in the plan or group health insurance coverage based on any health factor that relates to the individual or a dependent of the individual.

B) Discounts, rebates, payments in kind, and any other premium differential mechanisms are taken into account in determining an individual's premium or contribution rate. (For rules relating to cost-sharing mechanisms, see subsection (b)(2) (addressing benefits).)

2) Rules Relating to Premium Rates

A) 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. But see 45 CFR 146.122(b), which prohibits adjustments in group premium or contribution rates based on genetic information.

B) List Billing Based on a Health Factor Prohibited

However, a group health insurance issuer, or a group health plan, may not quote or charge an employer (or an individual) a different premium for an individual in a group of similarly situated individuals based on a health factor. (But see subsection (l) permitting favorable treatment of individuals with adverse health factors.)

C) This subsection (c)(2) is illustrated by the examples appearing in 45 CFR 146.121(c)(2)(iii).

3) Exception for Wellness Programs

Notwithstanding subsections (c)(1) and (c)(2), a plan or issuer may vary the amount of premium or contribution it requires similarly situated individuals to pay based on whether an individual has met the standards of a wellness program that satisfies the requirements of subsections (f) through (k). (45 CFR 146.121)

d) Similarly Situated Individuals

The requirements of this Section apply only within a group of individuals who are treated as similarly situated individuals. A plan or issuer may treat participants as a group of similarly situated individuals separate from beneficiaries. In addition, participants may be treated as two or more distinct groups of similarly situated individuals and beneficiaries may be treated as two or more distinct groups of similarly situated individuals in accordance with this subsection (d). Moreover, if individuals have a choice of two or more benefit packages, individuals choosing one benefit package may be treated as one or more groups of similarly situated individuals distinct from individuals choosing another benefit package.

1) Participants

Subject to subsection (d)(3), a plan or issuer may treat participants as two or more distinct groups of similarly situated individuals if the distinction between or among the groups of participants is based on a bona fide employment-based classification consistent with the employer's usual business practice. Whether an employment-based classification is bona fide is determined on the basis of all the relevant facts and circumstances. Relevant facts and circumstances include whether the employer uses the classification for purposes independent of qualification for health coverage (for example, determining eligibility for other employee benefits or determining other terms of employment). Subject to subsection (d)(3), examples of classifications that, based on all the relevant facts and circumstances, may be bona fide include full-time versus part-time status, different geographic location, membership in a collective bargaining unit, date of hire, length of service, current employee versus former employee status, and different occupations. However, a classification based on any health factor is not a bona fide employment-based classification unless the requirements of subsection (l) are satisfied (permitting favorable treatment of individuals with adverse health factors).

2) Beneficiaries

A) Subject to subsection (d)(3), a plan or issuer may treat beneficiaries as two or more distinct groups of similarly situated individuals if the distinction between or among the groups of beneficiaries is based on any of the following factors:

i) A bona fide employment-based classification of the participant through whom the beneficiary is receiving coverage;

ii) Relationship to the participant (for example, as a spouse or as a dependent child);

iii) Marital status;

iv) With respect to children of a participant, age or student status; or

v) Any other factor if the factor is not a health factor.

B) Subsection (d)(2)(A) does not prevent more favorable treatment of individuals with adverse health factors in accordance with subsection (g).

3) Discrimination Directed at Individuals

Notwithstanding subsections (d)(1) and (d)(2), if the creation or modification of an employment or coverage classification is directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries, the classification is not permitted under this subsection (d) unless it is permitted under subsection (g) (permitting favorable treatment of individuals with adverse health factors). Thus, if an employer modified an employment-based classification to single out, based on a health factor, individual participants and beneficiaries and deny them health coverage, the new classification would not be permitted under this Section. (45 CFR 146.121)

4) This subsection (d) is illustrated by the examples appearing at 45 CFR 146.121(d)(4).

e) Nonconfinement and Actively-at-Work Provisions

1) Nonconfinement Provisions

A) General Rule

Under subsections (b) and (c), a plan or issuer may not establish a rule for eligibility (as described in subsection (b)(1)(B)) or set any individual's premium or contribution rate based on whether an individual is confined to a hospital or other health care institution. In addition, under subsections (b) and (c), a plan or issuer may not establish a rule for eligibility or set any individual's premium or contribution rate based on an individual's ability to engage in normal life activities, except to the extent permitted under subsections (e)(2)(B) and (e)(3) (permitting plans and issuers, under certain circumstances, to distinguish among employees based on the performance of services).

B) Subsection (e)(1)(A) is illustrated by the examples appearing at 45 CFR 146.121(e)(1)(ii).

2) Actively-at-Work and Continuous Service Provisions

A) General Rule

i) Under subsections (b) and (c) and subject to the exception for the first day of work described in subsection (e)(2)(B), a plan or issuer may not establish a rule for eligibility (as described in subsection (b)(1)(B)) or set any individual's premium or contribution rate based on whether an individual is actively at work (including whether an individual is continuously employed), unless absence from work due to any health factor (such as being absent from work on sick leave) is treated, for purposes of the plan or health insurance coverage, as being actively at work.

ii) Subsection (e)(2)(A)(i) is illustrated by the examples appearing at 45 CFR 146.121(e)(2)(B).

B) Exception for the First Day of Work

i) Notwithstanding the general rule in subsection (e)(2)(A), a plan or issuer may establish a rule for eligibility that requires an individual to begin work for the employer sponsoring the plan (or, in the case of a multiemployer plan, to begin a job in covered employment) before coverage becomes effective, provided that such a rule for eligibility applies regardless of the reason for the absence.

ii) This subsection (e)(2)(B) is illustrated by the examples appearing at 45 CFR 146.121(e)(2)(ii)(B).

3) Relationship to Plan Provisions Defining Similarly Situated Individuals

A) Notwithstanding subsection (e), a plan or issuer may establish rules for eligibility or set any individual's premium or contribution rate in accordance with the rules relating to similarly situated individuals in subsection (d). Accordingly, a plan or issuer may distinguish in rules for eligibility under the plan between full-time and part-time employees, between permanent and temporary or seasonal employees, between current and former employees, and between employees currently performing services and employees no longer performing services for the employer, subject to subsection (d). However, other federal or Illinois laws (including the COBRA continuation provisions and the Family and Medical Leave Act of 1993 (29 USC 2601 et seq.)) may require an employee or the employee's dependents to be offered coverage and set limits on the premium or contribution rate even though the employee is not performing services. (45 CFR 146.121)

B) Subsection (e)(3)(A) is illustrated by the examples appearing at 45 CFR 146.121(e)(3)(ii).

f) Nondiscriminatory Wellness Programs – In General

A wellness program is a program of health promotion or disease prevention. Subsections (b)(2)(B) and (c)(3) provide exceptions to the general prohibitions against discrimination based on a health factor for plan provisions that vary benefits (including cost-sharing mechanisms) or the premium or contribution for similarly situated individuals in connection with a wellness program that satisfies the requirements of subsections (f) through (k). The following definitions govern in applying the provisions of subsections (f) through (k):

1) Reward

Except where expressly provided otherwise, references in this Section to an individual obtaining a reward include both obtaining a reward (such as a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism, an additional benefit, or any financial or other incentive) and avoiding a penalty (such as the absence of a premium surcharge or other financial or nonfinancial disincentive). References in this Section to a plan providing a reward include both providing a reward (such as a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism, an additional benefit, or any financial or other incentive) and imposing a penalty (such as a surcharge or other financial or nonfinancial disincentive).

2) Participatory Wellness Programs

If none of the conditions for obtaining a reward under a wellness program is based on an individual satisfying a standard that is related to a health factor (or if a wellness program does not provide a reward), the wellness program is a participatory wellness program. Examples of participatory wellness programs are:

A) A program that reimburses employees for all or part of the cost for membership in a fitness center;

B) A diagnostic testing program that provides a reward for participation in that program and does not base any part of the reward on outcomes;

C) A program that encourages preventive care through the waiver of the copayment or deductible requirement under a group health plan for the costs of, for example, prenatal care or well-baby visits. (Note that, with respect to non-grandfathered plans, 45 CFR 147.130 requires benefits for certain preventive health services without the imposition of cost sharing.);

D) A program that reimburses employees for the costs of participating, or that otherwise provides a reward for participating, in a smoking cessation program without regard to whether the employee quits smoking;

E) A program that provides a reward to employees for attending a monthly, no-cost health education seminar; and

F) A program that provides a reward to employees who complete a health risk assessment regarding current health status, without any further action (educational or otherwise) required by the employee with regard to the health issues identified as part of the assessment. (See also 45 CFR 146.122 for rules prohibiting collection of genetic information.)

3) Health-Contingent Wellness Programs

A health-contingent wellness program is a program that requires an individual to satisfy a standard related to a health factor to obtain a reward (or requires an individual to undertake more than a similarly situated individual based on a health factor in order to obtain the same reward). A health-contingent wellness program may be an activity-only wellness program or an outcome-based wellness program.

4) Activity-Only Wellness Programs

An activity-only wellness program is a type of health-contingent wellness program that requires an individual to perform or complete an activity related to a health factor in order to obtain a reward but does not require the individual to attain or maintain a specific health outcome. Examples include walking, diet or exercise programs, which some individuals may be unable to participate in or complete (or have difficulty participating in or completing) due to a health factor, such as severe asthma, pregnancy or a recent surgery. See subsection (h) for requirements applicable to activity-only wellness programs.

5) Outcome-Based Wellness Programs

An outcome-based wellness program is a type of health-contingent wellness program that requires an individual to attain or maintain a specific health outcome (such as not smoking or attaining certain results on biometric screenings) in order to obtain a reward. To comply with the rules of subsections (f) through (k), an outcome-based wellness program typically has two tiers. That is, for individuals who do not attain or maintain the specific health outcome, compliance with an educational program or an activity may be offered as an alternative to achieve the same reward. This alternative pathway, however, does not mean that the overall program, which has an outcome-based component, is not an outcome-based wellness program. That is, if a measurement, test or screening is used as part of an initial standard and individuals who meet the standard are granted the reward, the program is considered an outcome-based wellness program. For example, if a wellness program tests individuals for specified medical conditions or risk factors (including biometric screening such as testing for high cholesterol, high blood pressure, abnormal body mass index, or high glucose level) and provides a reward to individuals identified as within a normal or healthy range for these medical conditions or risk factors, while requiring individuals who are identified as outside the normal or healthy range (or at risk) to take additional steps (such as meeting with a health coach, taking a health or fitness course, adhering to a health improvement action plan, complying with a walking or exercise program, or complying with a health care provider's plan of care) to obtain the same reward, the program is an outcome-based wellness program. See subsection (i) for requirements applicable to outcome-based wellness programs. (45 CFR 146.121)

g) Requirement for Participatory Wellness Programs

A participatory wellness program, as described in subsection (f)(2), does not violate the provisions of this Section only if participation in the program is made available to all similarly situated individuals, regardless of health status.

h) Requirements for Activity-Only Wellness Programs

A health-contingent wellness program that is an activity-only wellness program, as described in subsection (f)(4), does not violate the provisions of this Section only if all of the following requirements are satisfied:

1) Frequency of Opportunity to Qualify

The program must give individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year.

2) Size of Reward

The reward for the activity-only wellness program, together with the reward for other health-contingent wellness programs with respect to the plan, must not exceed the applicable percentage (as defined in subsection (j)) of the total cost of employee-only coverage under the plan. However, if, in addition to employees, any class of dependents (such as spouses, or spouses and dependent children) may participate in the wellness program, the reward must not exceed the applicable percentage of the total cost of the coverage in which an employee and any dependents are enrolled. For purposes of this subsection (h)(2), the cost of coverage is determined based on the total amount of employer and employee contributions towards the cost of coverage for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage.

3) Reasonable Design

The program must be reasonably designed to promote health or prevent disease. A program satisfies this standard if it has a reasonable chance of improving the health of, or preventing disease in, participating individuals, and it is not overly burdensome, is not a subterfuge for discriminating based on a health factor, and is not highly suspect in the method chosen to promote health or prevent disease. This determination is based on all the relevant facts and circumstances.

4) Uniform Availability and Reasonable Alternative Standards

The full reward under the activity-only wellness program must be available to all similarly situated individuals.

A) Under this subsection (h)(4), a reward under an activity-only wellness program is not available to all similarly situated individuals for a period unless the program meets both of the following requirements:

i) The program allows a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

ii) The program allows a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

B) While plans and issuers are not required to determine a particular reasonable alternative standard in advance of an individual's request for one, if an individual is described in either subsection (h)(4)(A)(i) or (ii), a reasonable alternative standard must be furnished by the plan or issuer upon the individual's request or the condition for obtaining the reward must be waived.

C) All the facts and circumstances are taken into account in determining whether a plan or issuer has furnished a reasonable alternative standard, including but not limited to the following:

i) If the reasonable alternative standard is completion of an educational program, the plan or issuer must make the educational program available or assist the employee in finding such a program (instead of requiring an individual to find such a program unassisted), and may not require an individual to pay for the cost of the program;

ii) The time commitment required must be reasonable (for example, requiring attendance nightly at a one-hour class would be unreasonable);

iii) If the reasonable alternative standard is a diet program, the plan or issuer is not required to pay for the cost of food but must pay any membership or participation fee;

iv) If an individual's personal physician states that a plan standard (including, if applicable, the recommendations of the plan's medical professional) is not medically appropriate for that individual, the plan or issuer must provide a reasonable alternative standard that accommodates the recommendations of the individual's personal physician with regard to medical appropriateness. Plans and issuers may impose standard cost sharing under the plan or coverage for medical items and services furnished pursuant to the physician's recommendations.

D) To the extent that a reasonable alternative standard under an activity-only wellness program is, itself, an activity-only wellness program, it must comply with the requirements of this subsection (h) in the same manner as if it were an initial program standard. (Thus, for example, if a plan or issuer provides a walking program as a reasonable alternative standard to a running program, individuals for whom it is unreasonably difficult due to a medical condition to complete the walking program (or for whom it is medically inadvisable to attempt to complete the walking program) must be provided a reasonable alternative standard to the walking program.) To the extent that a reasonable alternative standard under an activity-only wellness program is, itself, an outcome-based wellness program, it must comply with the requirements of subsection (i), including subsection (i)(4)(D).

E) If reasonable under the circumstances, a plan or issuer may seek verification, such as a statement from an individual's personal physician, that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy, the otherwise applicable standard of an activity-only wellness program. Plans and issuers may seek verification with respect to requests for a reasonable alternative standard for which it is reasonable to determine that medical judgment is required to evaluate the validity of the request.

5) Notice of Availability of Reasonable Alternative Standard

The plan or issuer must disclose in all plan materials describing the terms of an activity-only wellness program the availability of a reasonable alternative standard to qualify for the reward (and, if applicable, the possibility of waiver of the otherwise applicable standard), including contact information for obtaining a reasonable alternative standard and a statement that recommendations of an individual's personal physician will be accommodated. If plan materials merely mention that such a program is available, without describing its terms, this disclosure is not required. Sample language is provided in subsection (k), as well as in certain examples of this Section. (45 CFR 146.121)

6) The provisions of this subsection (h) are illustrated by the example appearing at 45 CFR 146.121(f)(4)(vi).

i) Requirements for Outcome-Based Wellness Programs

A health-contingent wellness program that is an outcome-based wellness program, as described in subsection (f)(5), does not violate the provisions of this Section only if all of the following requirements are satisfied:

1) Frequency of Opportunity to Qualify

The program must give individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year.

2) Size of Reward

The reward for the outcome-based wellness program, together with the reward for other health-contingent wellness programs with respect to the plan, must not exceed the applicable percentage (as defined in subsection (j)) of the total cost of employee-only coverage under the plan. However, if, in addition to employees, any class of dependents (such as spouses, or spouses and dependent children) may participate in the wellness program, the reward must not exceed the applicable percentage of the total cost of the coverage in which an employee and any dependents are enrolled. For purposes of this subsection (i)(2), the cost of coverage is determined based on the total amount of employer and employee contributions towards the cost of coverage for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage.

3) Reasonable Design

The program must be reasonably designed to promote health or prevent disease. A program satisfies this standard if it has a reasonable chance of improving the health of, or preventing disease in, participating individuals, and it is not overly burdensome, is not a subterfuge for discriminating based on a health factor, and is not highly suspect in the method chosen to promote health or prevent disease. This determination is based on all the relevant facts and circumstances. To ensure that an outcome-based wellness program is reasonably designed to improve health and does not act as a subterfuge for underwriting or reducing benefits based on a health factor, a reasonable alternative standard to qualify for the reward must be provided to any individual who does not meet the initial standard based on a measurement, test or screening that is related to a health factor, as explained in subsection (i)(4).

4) Uniform Availability and Reasonable Alternative Standards

The full reward under the outcome-based wellness program must be available to all similarly situated individuals.

A) Under this subsection (i)(4), a reward under an outcome-based wellness program is not available to all similarly situated individuals for a period unless the program allows a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual who does not meet the initial standard based on the measurement, test or screening, as described in this subsection (i)(4).

B) While plans and issuers are not required to determine a particular reasonable alternative standard in advance of an individual's request for one, if an individual is described in subsection (i)(4)(A), a reasonable alternative standard must be furnished by the plan or issuer upon the individual's request or the condition for obtaining the reward must be waived.

C) All the facts and circumstances are taken into account in determining whether a plan or issuer has furnished a reasonable alternative standard, including but not limited to the following:

i) If the reasonable alternative standard is completion of an educational program, the plan or issuer must make the educational program available or assist the employee in finding such a program (instead of requiring an individual to find such a program unassisted), and may not require an individual to pay for the cost of the program.

ii) The time commitment required must be reasonable (for example, requiring attendance nightly at a one-hour class would be unreasonable).

iii) If the reasonable alternative standard is a diet program, the plan or issuer is not required to pay for the cost of food but must pay any membership or participation fee.

iv) If an individual's personal physician states that a plan standard (including, if applicable, the recommendations of the plan's medical professional) is not medically appropriate for that individual, the plan or issuer must provide a reasonable alternative standard that accommodates the recommendations of the individual's personal physician with regard to medical appropriateness. Plans and issuers may impose standard cost sharing under the plan or coverage for medical items and services furnished pursuant to the physician's recommendations.

D) To the extent that a reasonable alternative standard under an outcome-based wellness program is, itself, an activity-only wellness program, it must comply with the requirements of subsection (h) in the same manner as if it were an initial program standard. To the extent that a reasonable alternative standard under an outcome-based wellness program is, itself, another outcome-based wellness program, it must comply with the requirements of this subsection (i), subject to the following special rules:

i) The reasonable alternative standard cannot be a requirement to meet a different level of the same standard without additional time to comply that takes into account the individual's circumstances. For example, if the initial standard is to achieve a BMI less than 30, the reasonable alternative standard cannot be to achieve a BMI less than 31 on that same date. However, if the initial standard is to achieve a BMI less than 30, a reasonable alternative standard for the individual could be to reduce the individual's BMI by a small amount or small percentage, over a realistic period of time, such as within a year.

ii) An individual must be given the opportunity to comply with the recommendations of the individual's personal physician as a second reasonable alternative standard to meeting the reasonable alternative standard defined by the plan or issuer, but only if the physician joins in the request. The individual can make a request to involve a personal physician's recommendations at any time and the personal physician can adjust the physician's recommendations at any time, consistent with medical appropriateness.

E) It is not reasonable to seek verification, such as a statement from an individual's personal physician, under an outcome-based wellness program that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy, the otherwise applicable standard as a condition of providing a reasonable alternative to the initial standard. However, if a plan or issuer provides an alternative standard to the otherwise applicable measurement, test or screening that involves an activity that is related to a health factor, then the rules of subsection (h) for activity-only wellness programs apply to that component of the wellness program and the plan or issuer may, if reasonable under the circumstances, seek verification that it is unreasonably difficult due to a medical condition for an individual to perform or complete the activity (or it is medically inadvisable to attempt to perform or complete the activity). (For example, if an outcome-based wellness program requires participants to maintain a certain healthy weight and provides a diet and exercise program for individuals who do not meet the targeted weight, a plan or issuer may seek verification, as described in subsection (i)(4)(D), if reasonable under the circumstances, that a second reasonable alternative standard is needed for certain individuals because, for those individuals, it would be unreasonably difficult due to a medical condition to comply, or medically inadvisable to attempt to comply, with the diet and exercise program, due to a medical condition.)

5) Notice of Availability of Reasonable Alternative Standard

The plan or issuer must disclose in all plan materials describing the terms of an outcome-based wellness program, and in any disclosure that an individual did not satisfy an initial outcome-based standard, the availability of a reasonable alternative standard to qualify for the reward (and, if applicable, the possibility of waiver of the otherwise applicable standard), including contact information for obtaining a reasonable alternative standard and a statement that recommendations of an individual's personal physician will be accommodated. If plan materials merely mention that such a program is available, without describing its terms, this disclosure is not required. Sample language is provided in subsection (k), as well as in certain examples of this Section. (45 CFR 146.121)

6) This subsection (i) is illustrated by the examples at 45 CFR 146.121(f)(4).

j) Applicable Percentage

For purposes of subsections (f) through (k), the applicable percentage is provided

in Section 356z.17(e)(iii) of the Code.

k) Sample Language

The following language, or substantially similar language, can be used to satisfy the notice requirement of subsection (h)(5) or (i)(5): "Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at [insert contact information] and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status." (45 CFR 146.121)

l) More Favorable Treatment of Individuals with Adverse Health Factors Permitted

1) In Rules for Eligibility

A) Nothing in this Section prevents a group health plan or group health insurance issuer from establishing more favorable rules for eligibility (described in subsection (b)(1)) for individuals with an adverse health factor, such as disability, than for individuals without the adverse health factor. Moreover, nothing in this Section prevents a plan or issuer from charging a higher premium or contribution with respect to individuals with an adverse health factor if they would not be eligible for the coverage were it not for the adverse health factor. (However, other laws, including Illinois insurance laws, may set or limit premium rates; these laws are not affected by this Section.)

B) This subsection (l)(1) is illustrated by the examples appearing at 45 CFR 146.121(g)(1)(ii).

2) In Premiums or Contributions

A) Nothing in this Section prevents a group health plan or group health insurance issuer from charging individuals a premium or contribution that is less than the premium (or contribution) for similarly situated individuals if the lower charge is based on an adverse health factor, such as disability. (45 CFR 146.121)

B) This subsection (l)(2) is illustrated by the examples appearing at 45 CFR 146.121(g)(2)(ii).

m) No Effect on Other Laws

Compliance with this Section is not determinative of compliance with any other provision of the PHS Act (including the COBRA continuation provisions) or any other Illinois or federal law, such as the Americans With Disabilities Act. Therefore, although this Section would not prohibit a plan or issuer from treating one group of similarly situated individuals differently from another (such as providing different benefit packages to current and former employees), other federal or Illinois laws may require that two separate groups of similarly situated individuals be treated the same for certain purposes (such as making the same benefit package available to COBRA qualified beneficiaries as is made available to active employees). In addition, although this Section generally does not impose new disclosure obligations on plans and issuers, this Section does not affect any other laws, including those that require accurate disclosures and prohibit intentional misrepresentation. (45 CFR 146.121)

n) Applicability Dates

1) Generally

This Section applies for plan years beginning on or after July 1, 2007.

2) Special Rule for Self-Funded Nonfederal Governmental Plans Exempted Under 45 CFR 146.180

A) If coverage has been denied to any individual because the sponsor of a self-funded nonfederal governmental plan has elected under 45 CFR 146.180 to exempt the plan from the requirements of this Section, and the plan sponsor subsequently chooses to bring the plan into compliance with the requirements of this Section, the plan:

i) Must notify the individual that the plan will be coming into compliance with the requirements of this Section, specify the effective date of compliance, and inform the individual regarding any enrollment restrictions that may apply under the terms of the plan once the plan is in compliance with this Section (as a matter of administrative convenience, the notice may be disseminated to all employees);

ii) Must give the individual an opportunity to enroll that continues for at least 30 days;

iii) Must permit coverage to be effective as of the first day of plan coverage for which an exemption election under 45 CFR 146.180 (with regard to this Section) is no longer in effect; and

iv) May not treat the individual as a late enrollee or a special enrollee.

B) For purposes of this subsection (n)(2), an individual is considered to have been denied coverage if the individual failed to apply for coverage because, given an exemption election under 45 CFR 146.180, it was reasonable to believe that an application for coverage would have been denied based on a health factor. (45 CFR 146.121)

C) This subsection (n)(2) is illustrated by the examples appearing at 45 CFR 146.121(i)(2)(iii).

(Source: Amended at 45 Ill. Reg. 11816, effective September 17, 2021)