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 § 146.111(b).

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

Example. (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).

[69 FR 78794, Dec. 30, 2004]

§ 146.119 HMO affiliation period as an alternative to a preexisting condition exclusion.

(a) *In general.* A group health plan offering health insurance coverage through an HMO, or an HMO that offers health insurance coverage in connection with a group health plan, may impose an affiliation period only if each of the following requirements is satisfied—

(1) No preexisting condition exclusion is imposed with respect to any coverage offered by the HMO in connection with the particular group health plan.

(2) No premium is charged to a participant or beneficiary for the affiliation period.

(3) The affiliation period for the HMO coverage is imposed consistent with the requirements of § 146.121 (prohibiting discrimination based on a health factor).

(4) The affiliation period does not exceed 2 months (or 3 months in the case of a late enrollee).

(5) The affiliation period begins on the enrollment date, or in the case of a late enrollee, the affiliation period begins on the day that would be the first day of coverage but for the affiliation period.

(6) The affiliation period for enrollment in the HMO under a plan runs concurrently with any waiting period.

(b) *Examples.* The rules of paragraph (a) of this section are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan. Benefits under the plan are provided through an HMO, which imposes a two-month affiliation period. In order to be eligible under the plan, employees must have worked for the employer for six months. Individual *A* begins working for the employer on February 1.

(ii) *Conclusion.* In this *Example 1,* Individual *A*'s enrollment date is February 1 (see § 146.111(a)(2)), and both the waiting period and the affiliation period begin on this date and run concurrently. Therefore, the affiliation period ends on March 31, the waiting period ends on July 31, and *A* is eligible to have coverage begin on August 1.

Example 2. (i) *Facts.* A group health plan has two benefit package options, a fee-for-service option and an HMO option. The HMO

imposes a 1-month affiliation period. Individual *B* is enrolled in the fee-for-service option for more than one month and then decides to switch to the HMO option at open season.

(ii) *Conclusion.* In this *Example 2,* the HMO may not impose the affiliation period with respect to *B* because any affiliation period would have to begin on *B*'s enrollment date in the plan rather than the date that *B* enrolled in the HMO option. Therefore, the affiliation period would have expired before *B* switched to the HMO option.

Example 3. (i) *Facts.* An employer sponsors a group health plan that provides benefits through an HMO. The plan imposes a two-month affiliation period with respect to salaried employees, but it does not impose an affiliation period with respect to hourly employees.

(ii) *Conclusion.* In this *Example 3,* the plan may impose the affiliation period with respect to salaried employees without imposing any affiliation period with respect to hourly employees (unless, under the circumstances, treating salaried and hourly employees differently does not comply with the requirements of §146.121).

(c) *Alternatives to affiliation period.* An HMO may use alternative methods in lieu of an affiliation period to address adverse selection, as approved by the State insurance commissioner or other official designated to regulate HMOs. However, an arrangement that is in the nature of a preexisting condition exclusion cannot be an alternative to an affiliation period. Nothing in this part requires a State to receive proposals for or approve alternatives to affiliation periods.

[69 FR 78797, Dec. 30, 2004]

§146.120 Interaction with the Family and Medical Leave Act. [Reserved]

§146.121 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), as defined in §144.103 of this chapter;

(iii) Claims experience;

(iv) Receipt of health care;

(v) Medical history;

(vi) Genetic information, as defined in §144.103 of this chapter;

(vii) Evidence of insurability; or

(viii) Disability.

(2) Evidence of insurability includes—

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

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

(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