§ 1.36B–3 Computing the premium assistance credit amount.

(a) *In general.* A taxpayer's premium assistance credit amount for a taxable year is the sum of the premium assistance amounts determined under paragraph (d) of this section for all coverage months for individuals in the taxpayer's family.

(b) *Definitions.* For purposes of this section—

(1) The cost of a qualified health plan is the premium the plan charges; and

(2) The term *coverage family* means, in each month, the members of a taxpayer's family for whom the month is a coverage month.

(c) *Coverage month*—(1) *In general.* A month is a coverage month for an individual if—

(i) As of the first day of the month, the individual is enrolled in a qualified health plan through an Exchange;

(ii) The taxpayer pays the taxpayer's share of the premium for the individual's coverage under the plan for the month by the unextended due date for filing the taxpayer's income tax return for that taxable year, or the full premium for the month is paid by advance credit payments; and

(iii) The individual is not eligible for the full calendar month for minimum essential coverage (within the meaning of §1.36B–2(c)) other than coverage described in section 5000A(f)(1)(C) (relating to coverage in the individual market).

(2) *Certain individuals enrolled during a month.* If an individual enrolls in a qualified health plan and the enrollment is effective on the date of the individual's birth, adoption, or placement for adoption or in foster care, or on the effective date of a court order, the individual is treated as enrolled as of the first day of that month for purposes of this paragraph (c).

(3) *Premiums paid for a taxpayer.* Premiums another person pays for coverage of the taxpayer, taxpayer's spouse, or dependent are treated as paid by the taxpayer.

(4) *Appeals of coverage eligibility.* A taxpayer who is eligible for advance credit payments pursuant to an eligibility appeal decision implemented under 45 CFR 155.545(c)(1)(ii) for coverage of a member of the taxpayer's coverage family who, based on the appeal decision, retroactively enrolls in a qualified health plan is considered to have met the requirement in paragraph (c)(1)(ii) of this section for a month if the taxpayer pays the taxpayer's share of the premiums for coverage under the plan for the month on or before the 120th day following the date of the appeals decision.

(5) *Examples.* The following examples illustrate the provisions of this paragraph (c):

Example 1. (i) Taxpayer M is single with no dependents. In December 2013, M enrolls in a qualified health plan for 2014 and the Exchange approves advance credit payments. M pays M's share of the premiums. On May 15, 2014, M enlists in the U.S. Army and is eligible immediately for government-sponsored minimum essential coverage.

(ii) Under paragraph (c)(1) of this section, January through May 2014 are coverage months for M. June through December 2014 are not coverage months because M is eligible for minimum essential coverage for those months. Thus, under paragraph (a) of this section, M's premium assistance credit amount for 2014 is the sum of the premium assistance amounts for the months January through May.

Example 2. (i) Taxpayer N has one dependent, S. S is eligible for government-sponsored minimum essential coverage. N is not eligible for minimum essential coverage. N enrolls in a qualified health plan for 2014 and the Exchange approves advance credit payments. On August 1, 2014, S loses eligibility for minimum essential coverage. N terminates enrollment in the qualified health plan that covers only N and enrolls in a qualified health plan that covers N and S for August through December 2014. N pays all premiums not covered by advance credit payments.

(ii) Under paragraph (c)(1) of this section, January through December of 2014 are coverage months for N and August through December are coverage months for N and S. N's premium assistance credit amount for 2014 is the sum of the premium assistance amounts for these coverage months.

Example 3. (i) O and P are the divorced parents of T. Under the divorce agreement between O and P, T resides with P and P claims T as a dependent. However, O must pay premiums for health insurance for T. P enrolls T in a qualified health plan for 2014. O pays the portion of T's qualified health plan premiums not covered by advance credit payments.

(ii) Because P claims T as a dependent, P (and not O) may claim a premium tax credit for coverage for T. See §1.36B–2(a). Under paragraph (c)(2) of this section, the premiums that O pays for coverage for T are

treated as paid by P. Thus, the months when T is covered by a qualified health plan and not eligible for other minimum essential coverage are coverage months under paragraph (c)(1) of this section in computing P's premium tax credit under paragraph (a) of this section.

Example 4. Q, an American Indian, enrolls in a qualified health plan for 2014. Q's tribe pays the portion of Q's qualified health plan premiums not covered by advance credit payments. Under paragraph (c)(2) of this section, the premiums that Q's tribe pays for Q are treated as paid by Q. Thus, the months when Q is covered by a qualified health plan and not eligible for other minimum essential coverage are coverage months under paragraph (c)(1) of this section in computing Q's premium tax credit under paragraph (a) of this section.

(d) *Premium assistance amount*—(1) *Premium assistance amount.* The premium assistance amount for a coverage month is the lesser of—

(i) The premiums for the month, reduced by any amounts that were refunded in the same taxable year as the premium liability is incurred, for one or more qualified health plans in which a taxpayer or a member of the taxpayer's family enrolls (enrollment premiums); or

(ii) The excess of the adjusted monthly premium for the applicable benchmark plan (benchmark plan premium) over 1/12 of the product of a taxpayer's household income and the applicable percentage for the taxable year (the taxpayer's contribution amount).

(2) *Examples.* The following examples illustrate the rules of paragraph (d)(1) of this section.

Example 1. Taxpayer Q is single and has no dependents. Q enrolls in a qualified health plan with a monthly premium of $400. Q's monthly benchmark plan premium is $500, and his monthly contribution amount is $80. Q's premium assistance amount for a coverage month is $400 (the lesser of $400, Q's monthly enrollment premium, and $420, the difference between Q's monthly benchmark plan premium and Q's contribution amount).

Example 2. (i) Taxpayer R is single and has no dependents. R enrolls in a qualified health plan with a monthly premium of $450. The difference between R's benchmark plan premium and contribution amount for the month is $420.

(ii) The issuer of R's qualified health plan is notified that R died on September 20. The issuer terminates coverage as of that date and refunds the remaining portion of the September enrollment premiums ($150) for R's coverage.

(iii) R's premium assistance amount for each coverage month from January through August is $420 (the lesser of $450 and $420). Under paragraph (d)(1) of this section, R's premium assistance amount for September is the lesser of the enrollment premiums for the month, reduced by any amounts that were refunded ($300 ($450–$150)) or the difference between the benchmark plan premium and the contribution amount for the month ($420). R's premium assistance amount for September is $300, the lesser of $420 and $300.

Example 3. The facts are the same as in *Example 2* of this paragraph (d)(2), except that the qualified health plan issuer does not refund any enrollment premiums for September. Under paragraph (d)(1) of this section, R's premium assistance amount for September is $420, the lesser of $450 and $420.

(e) *Adjusted monthly premium.* The adjusted monthly premium is the premium an issuer would charge for the applicable benchmark plan to cover all members of the taxpayer's coverage family, adjusted only for the age of each member of the coverage family as allowed under section 2701 of the Public Health Service Act (42 U.S.C. 300gg). The adjusted monthly premium is determined without regard to any premium discount or rebate under the wellness discount demonstration project under section 2705(d) of the Public Health Service Act (42 U.S.C. 300gg-4(d)) and may not include any adjustments for tobacco use. The adjusted monthly premium for a coverage month is determined as of the first day of the month.

(f) *Applicable benchmark plan*—(1) *In general.* Except as otherwise provided in this paragraph (f), the applicable benchmark plan for each coverage month is the second-lowest-cost silver plan (as described in section 1302(d)(1)(B) of the Affordable Care Act (42 U.S.C. 18022(d)(1)(B))) offered to the taxpayer's coverage family through the Exchange for the rating area where the taxpayer resides for—

(i) Self-only coverage for a taxpayer—

(A) Who computes tax under section 1(c) (unmarried individuals other than surviving spouses and heads of household) and is not allowed a deduction under section 151 for a dependent for the taxable year;

(B) Who purchases only self-only coverage for one individual; or

(C) Whose coverage family includes only one individual; and

(ii) Family coverage for all other taxpayers.

(2) *Family coverage.* The applicable benchmark plan for family coverage is the second lowest-cost silver plan that would cover the members of the taxpayer's coverage family (such as a plan covering two adults if the members of a taxpayer's coverage family are two adults).

(3) *Silver-level plan not covering pediatric dental benefits.* If one or more silver-level qualified health plans offered through an Exchange do not cover pediatric dental benefits, the premium for the applicable benchmark plan is determined based on the second lowest-cost option among—

(i) The silver-level qualified health plans that are offered by the Exchange to the members of the coverage family and that provide pediatric dental benefits; and

(ii) The silver-level qualified health plans that are offered by the Exchange to the members of the coverage family that do not provide pediatric dental benefits in conjunction with the second lowest-cost portion of the premium for a stand-alone dental plan (within the meaning of section 1311(d)(2)(B)(ii) of the Affordable Care Act (42 U.S.C. 18031(d)(2)(B)(ii)) offered by the Exchange to the members of the coverage family that is properly allocable to pediatric dental benefits determined under guidance issued by the Secretary of Health and Human Services.

(4) *Family members residing in different locations.* If members of a taxpayer's coverage family reside in different locations, the taxpayer's benchmark plan premium is the sum of the premiums for the applicable benchmark plans for each group of coverage family members residing in different locations, based on the plans offered to the group through the Exchange where the group resides. If all members of a taxpayer's coverage family reside in a single location that is different from where the taxpayer resides, the taxpayer's benchmark plan premium is the premium for the applicable benchmark plan for the coverage family, based on the plans offered through the Exchange to the taxpayer's coverage family for the rating area where the coverage family resides.

(5) *Single or multiple policies needed to cover the family*—(i) *Policy covering a taxpayer's family.* If a silver-level plan or a stand-alone dental plan offers coverage to all members of a taxpayer's coverage family who reside in the same location under a single policy, the premium (or allocable portion thereof, in the case of a stand-alone dental plan) taken into account for the plan for purposes of determining the applicable benchmark plan under paragraphs (f)(1), (f)(2), and (f)(3) of this section is the premium for this single policy.

(ii) *Policy not covering a taxpayer's family.* If a silver-level qualified health plan or a stand-alone dental plan would require multiple policies to cover all members of a taxpayer's coverage family who reside in the same location (for example, because of the relationships within the family), the premium (or allocable portion thereof, in the case of a standalone dental plan) taken into account for the plan for purposes of determining the applicable benchmark plan under paragraphs (f)(1), (f)(2), and (f)(3) of this section is the sum of the premiums (or allocable portion thereof, in the case of a stand-alone dental plan) for self-only policies under the plan for each member of the coverage family who resides in the same location.

(6) *Plan not available for enrollment.* A silver-level qualified health plan or a stand-alone dental plan that is not open to enrollment by a taxpayer or family member at the time the taxpayer or family member enrolls in a qualified health plan is disregarded in determining the applicable benchmark plan.

(7) *Benchmark plan terminates or closes to enrollment during the year.* A silver-level qualified health plan or a stand-alone dental plan that is used for purposes of determining the applicable benchmark plan under this paragraph (f) for a taxpayer does not cease to be the applicable benchmark plan for a taxable year solely because the plan or a lower cost plan terminates or closes to enrollment during the taxable year.

(8) *Only one silver-level plan offered to the coverage family.* If there is only one

silver-level qualified health plan or one stand-alone dental plan offered through an Exchange that would cover all members of a taxpayer's coverage family who reside in the same location (whether under one policy or multiple policies), that plan is used for purposes of determining the taxpayer's applicable benchmark plan.

(9) *Examples.* The following examples illustrate the rules of this paragraph (f). Unless otherwise stated, in each example the plans are open to enrollment to a taxpayer or family member at the time of enrollment and are offered through the Exchange for the rating area where the taxpayer resides:

Example 1. Single taxpayer enrolls in Exchange coverage. Taxpayer A is single, has no dependents, and enrolls in a qualified health plan. The Exchange in the rating area in which A resides offers only silver-level qualified health plans that provide pediatric dental benefits. Under paragraphs (f)(1) and (f)(2) of this section, A's applicable benchmark plan is the second lowest cost silver plan providing self-only coverage for A.

Example 2. Single taxpayer enrolls with dependent child through an Exchange where all qualified health plans provide pediatric dental benefits. Taxpayer B is single and claims her 12-year old daughter, C, as a dependent. B purchases family coverage for herself and C. The Exchange in the rating area in which B and C reside offers qualified health plans that provide pediatric dental benefits but does not offer qualified health plans without pediatric dental benefits. Under paragraphs (f)(1) and (f)(2) of this section, B's applicable benchmark plan is the second lowest-cost silver plan providing family coverage to B and C.

Example 3. Single taxpayer enrolls with dependent child through an Exchange where one or more qualified health plans do not provide pediatric dental benefits. (i) Taxpayer D is single and claims his 10-year old son, E, as a dependent. The Exchange in the rating area in which D and E reside offers three silver-level qualified health plans, one of which provides pediatric dental benefits (S1) and two of which do not (S2 and S3), in which D and E may enroll. The Exchange also offers two stand-alone dental plans (DP1 and DP2) available to D and E. The monthly premiums allocable to essential health benefits for the silver-level plans are as follows:

S1—$650
S2—$620
S3—$590

(ii) The monthly premiums, and the portion of the premium allocable to pediatric dental benefits, for the two dental plans are as follows:

DP1—$50 ($20 allocable to pediatric dental benefits)
DP2—$40 ($15 allocable to pediatric dental benefits).

(iii) Under paragraph (f)(3) of this section, D's applicable benchmark plan is the second lowest cost option among the following offered by the rating area in which D resides: Silver-level qualified health plans providing pediatric dental benefits ($650 for S1) and the silver-level qualified health plans not providing pediatric dental benefits, in conjunction with the second lowest-cost portion of the premium for a stand-alone dental plan properly allocable to pediatric dental benefits ($590 for S3 in conjunction with $20 for DP1 = $610 and $620 for S2 in conjunction with $20 for DP1 = $640). Under paragraph (e) of this section, the adjusted monthly premium for D's applicable benchmark plan is $640.

Example 4. Single taxpayer enrolls with dependent adult through an Exchange where one or more qualified health plans do not provide pediatric dental benefits. (i) The facts are the same as in *Example 3*, except Taxpayer D's coverage family consists of D and D's 22-year old son, F, who is a dependent of D. The monthly premiums allocable to essential health benefits for the silver-level plans are as follows:

S1—$630
S2—$590
S3—$580

(ii) Because no one in D's coverage family is eligible for pediatric dental benefits, $0 of the premium for a stand-alone dental plan is allocable to pediatric dental benefits in determining A's applicable benchmark plan. Consequently, under paragraphs (f)(1), (f)(2), and (f)(3) of this section, D's applicable benchmark plan is the second lowest-cost option among the following options offered by the rating area in which D resides: Silver-level qualified health plans providing pediatric dental benefits ($630 for S1) and the silver-level qualified health plans not providing pediatric dental benefits, in conjunction with the second lowest-cost portion of the premium for a stand-alone dental plan properly allocable to pediatric dental benefits ($580 for S3 in conjunction with $0 for DP1 = $580 and $590 for S2 in conjunction with $0 for DP1 = $590). Under paragraph (e) of this section, the adjusted monthly premium for D's applicable benchmark plan is $590.

Example 5. Single taxpayer enrolls with dependent and nondependent. Taxpayer G is single and resides with his 25-year old daughter, H, and with his 14-year old son, I. G may claim I, but not H, as a dependent. G, H, and I enroll in coverage through the Exchange in the rating area in which they all reside. The

Exchange offers only silver-level plans providing pediatric dental benefits. Under paragraphs (f)(1) and (f)(2) of this section, G's applicable benchmark plan is the second lowest-cost silver plan covering G and I. However, H may qualify for a premium tax credit if H is otherwise eligible. See paragraph (h) of this section.

Example 6. Change in coverage family. Taxpayer J is single and has no dependents when she enrolls in a qualified health plan. The Exchange in the rating area in which she resides offers only silver-level plans that provide pediatric dental benefits. On August 1, J has a child, K, whom she claims as a dependent. J enrolls in a qualified health plan covering J and K effective August 1. Under paragraphs (f)(1) and (f)(2) of this section, J's applicable benchmark plan for January through July is the second lowest-cost silver plan providing self-only coverage for J, and J's applicable benchmark plan for the months August through December is the second lowest-cost silver plan covering J and K.

Example 7. Minimum essential coverage for some coverage months. Taxpayer L claims his 6-year old daughter, M, as a dependent. L and M are enrolled for the entire year in a qualified health plan that offers only silver-level plans that provide pediatric dental benefits. L, but not M, is eligible for government-sponsored minimum essential coverage for September to December. Thus, under paragraph (c)(1)(iii) of this section, January through December are coverage months for M, and January through August are coverage months for L. Because, under paragraphs (d) and (f)(1) of this section, the premium assistance amount for a coverage month is computed based on the applicable benchmark plan for that coverage month, L's applicable benchmark plan for January through August is the second lowest-cost option covering L and M. Under paragraph (f)(1)(i)(C) of this section, L's applicable benchmark plan for September through December is the second lowest-cost silver plan providing self-only coverage for M.

Example 8. Family member eligible for minimum essential coverage for the taxable year. The facts are the same as in *Example 7,* except that L is not eligible for government-sponsored minimum essential coverage for any months and M is eligible for government sponsored minimum essential coverage for the entire year. Under paragraph (f)(1)(i)(C) of this section, L's applicable benchmark plan is the second lowest-cost silver plan providing self-only coverage for L.

Example 9. Benchmark plan premium for a coverage family with family members who reside in different locations. (i) Taxpayer N's coverage family consists of N and her three dependents O, P, and Q. N, O, and P reside together but Q resides in a different location. The monthly applicable benchmark plan premium for N, O, and P is $1,000 and the monthly applicable benchmark plan premium for Q is $220.

(ii) Under paragraph (f)(4) of this section, because the members of N's coverage family reside in different locations, the monthly premium for N's applicable benchmark plan is the sum of $1,000, the monthly premiums for the applicable benchmark plan for N, O, and P, who reside together, and $220, the monthly applicable benchmark plan premium for Q, who resides in a different location than N, O, and P. Consequently, the premium for N's applicable benchmark plan is $1,220.

Example 10. Aggregation of silver-level policies for plans not covering a family under a single policy. (i) Taxpayers R and S are married and live with S's mother, T, whom they claim as a dependent. The Exchange for their rating area offers self-only and family coverage at the silver level through Issuers A, B, and C, which each offer only one silver-level plan. The silver-level plans offered by Issuers A and B do not cover R, S, and T under a single policy. The silver-level plan offered by Issuer A costs the following monthly amounts for self-only coverage of R, S, and T, respectively: $400, $450, and $600. The silver-level plan offered by Issuer B costs the following monthly amounts for self-only coverage of R, S, and T, respectively: $250, $300, and $450. The silver-level plan offered by Issuer C provides coverage for R, S, and T under one policy for a $1,200 monthly premium.

(ii) Under paragraph (f)(5) of this section, Issuer C's silver-level plan that covers R, S, and T under one policy ($1,200 monthly premium) and Issuer A's and Issuer B's silver-level plans that do not cover R, S and T under one policy are considered in determining R's and S's applicable benchmark plan. In addition, under paragraph (f)(5)(ii) of this section, in determining R's and S's applicable benchmark plan, the premium taken into account for Issuer A's plan is $1,450 (the aggregate premiums for self-only policies covering R ($400), S ($450), and T ($600) and the premium taken into account for Issuer B's plan is $1,000 (the aggregate premiums for self-only policies covering R ($250), S ($300), and T ($450). Consequently, R's and S's applicable benchmark plan is the Issuer C silver-level plan covering R's and S's coverage family and the premium for their applicable benchmark plan is $1,200.

Example 11. Benchmark plan premium for a taxpayer with family members who cannot enroll in one policy and who reside in different locations. (i) Taxpayer U's coverage family consists of U, U's mother, V, and U's two daughters, W and X. U and V reside together in Location 1 and W and X reside together in Location 2. The Exchange in the rating area in which U and V reside does not offer a silver-level plan that covers U and V under a single policy, whereas all the silver-level plans offered through the Exchange in the

rating area in which W and X reside cover W and X under a single policy. Both Exchanges offer only silver-level plans that provide pediatric dental benefits. The silver plan offered by the Exchange for the rating area in which U and V reside that would cover U and V under self-only policies with the second-lowest aggregate premium costs $400 a month for self-only coverage for U and $600 a month for self-only coverage for V. The monthly premium for the second-lowest cost silver plan covering W and X that is offered by the Exchange for the rating area in which W and X reside is $500.

(ii) Under paragraph (f)(5)(ii) of this section, because multiple policies are required to cover U and V, the members of U's coverage family who reside together in Location 1, the premium taken into account in determining U's benchmark plan is $1,000, the sum of the premiums for the second-lowest aggregate cost of self-only policies covering U ($400) and V ($600) offered by the Exchange to U and V for the rating area in which U and V reside. Under paragraph (f)(5)(i) of this section, because all silver-level plans offered by the Exchange in which W and X reside cover W and X under a single policy, the premium for W and X's coverage that is taken into account in determining U's benchmark plan is $500, the second-lowest cost silver policy covering W and X that is offered by the Exchange for the rating area in which W and X reside. Under paragraph (f)(4) of this section, because the members of U's coverage family reside in different locations, U's monthly benchmark plan premium is $1,500, the sum of the premiums for the applicable benchmark plans for each group of family members residing in different locations ($1,000 for U and V, who reside in Location 1, plus $500 for W and X, who reside in Location 2).

Example 12. Qualified health plan closed to enrollment. Taxpayer Y has two dependents, Z and AA. Y, Z, and AA enroll in a qualified health plan through the Exchange for the rating area where the family resides. The Exchange, which offers only qualified health plans that include pediatric dental benefits, offers silver-level plans J, K, L, and M, which are, respectively, the first, second, third, and fourth lowest cost silver plans covering Y's family. When Y's family enrolls, Plan J is closed to enrollment. Under paragraph (f)(6) of this section, Plan J is disregarded in determining Y's applicable benchmark plan, and Plan L is used in determining Y's applicable benchmark plan.

Example 13. Benchmark plan closes to new enrollees during the year. (i) Taxpayers BB, CC, and DD each have coverage families consisting of two adults. In that rating area, Plan 2 is the second lowest cost silver plan and Plan 3 is the third lowest cost silver plan covering the two adults in each coverage family offered through the Exchange. The BB and CC families each enroll in a qualified health plan that is not the applicable benchmark plan (Plan 4) in November during the annual open enrollment period. Plan 2 closes to new enrollees the following June. Thus, on July 1, Plan 3 is the second lowest cost silver plan available to new enrollees through the Exchange. The DD family enrolls in a qualified health plan in July.

(ii) Under paragraphs (f)(1), (f)(2), (f)(3), and (f)(7) of this section, the silver-level plan that BB and CC use to determine their applicable benchmark plan for all coverage months during the year is Plan 2. The applicable benchmark plan that DD uses to determine DD's applicable benchmark plan is Plan 3, because Plan 2 is not open to enrollment through the Exchange when the DD family enrolls.

Example 14. Benchmark plan terminates for all enrollees during the year. The facts are the same as in *Example 13,* except that Plan 2 terminates for all enrollees on June 30. Under paragraphs (f)(1), (f)(2), (f)(3), and (f)(7) of this section, Plan 2 is the silver-level plan that BB and CC use to determine their applicable benchmark plan for all coverage months during the year, and Plan 3 is the applicable benchmark plan that DD uses.

Example 15. Exchange offers only one silver-level plan. Taxpayer EE's coverage family consists of EE, his spouse FF, and their two dependent children GG and HH, who all reside together. The Exchange for the rating area in which they reside offers only one silver-level plan that EE's family may enroll in and the plan does not provide pediatric dental benefits. The Exchange also offers one stand-alone dental plan in which the family may enroll. Under paragraph (f)(8) of this section, the silver-level plan and the stand-alone dental plan offered by the Exchange are used for purposes of determining EE's applicable benchmark plan under paragraph (f)(3) of this section. Moreover, the lone silver-level plan and the lone stand-alone dental plan offered by the Exchange are used for purposes of determining EE's applicable benchmark plan regardless of whether these plans cover EE's family under a single policy or multiples policies.

(g) *Applicable percentage*—(1) *In general.* The applicable percentage multiplied by a taxpayer's household income determines the taxpayer's annual required share of premiums for the benchmark plan. The required share is divided by 12 and this monthly amount is subtracted from the adjusted monthly premium for the applicable benchmark plan when computing the premium assistance amount. The applicable percentage is computed by first determining the percentage that the taxpayer's household income bears to the

Federal poverty line for the taxpayer's family size. The resulting Federal poverty line percentage is then compared to the income categories described in the table in paragraph (g)(2) of this section. An applicable percentage within an income category increases on a sliding scale in a linear manner and is rounded to the nearest one-hundredth of one percent. For taxable years beginning after December 31, 2014, the applicable percentages in the table will be adjusted by the ratio of premium growth to income growth for the preceding calendar year and may be further adjusted to reflect changes to the data used to compute the ratio of premium growth to income growth for the 2014 calendar year or the data sources used to compute the ratio of premium growth to income growth. Premium growth and income growth will be determined in accordance with published guidance, see §601.601(d)(2) of this chapter. In addition, the applicable percentages in the table may be adjusted for taxable years beginning after December 31, 2018, to reflect rates of premium growth relative to growth in the consumer price index.

(2) *Applicable percentage table.*

Household income percentage of Federal poverty line	Initial percentage	Final percentage
Less than 133%	2.0	2.0
At least 133% but less than 150%	3.0	4.0
At least 150% but less than 200%	4.0	6.3
At least 200% but less than 250%	6.3	8.05
At least 250% but less than 300%	8.05	9.5
At least 300% but not more than 400%	9.5	9.5

(3) *Examples.* The following examples illustrate the rules of this paragraph (g):

Example 1. A's household income is 275 percent of the Federal Poverty line for A's family size for that taxable year. In the table in paragraph (g)(2) of this section, the initial percentage for a taxpayer with household income of 250 to 300 percent of the Federal poverty line is 8.05 and the final percentage is 9.5. A's Federal poverty line percentage of 275 percent is halfway between 250 percent and 300 percent. Thus, rounded to the nearest one-hundredth of one percent, A's applicable percentage is 8.78, which is halfway between the initial percentage of 8.05 and the final percentage of 9.5.

Example 2. (i) B's household income is 210 percent of the Federal poverty line for B's family size. In the table in paragraph (g)(2) of this section, the initial percentage for a taxpayer with household income of 200 to 250 percent of the Federal poverty line is 6.3 and the final percentage is 8.05. B's applicable percentage is 6.65, computed as follows.

(ii) Determine the excess of B's Federal poverty line percentage (210) over the initial household income percentage in B's range (200), which is 10. Determine the difference between the initial household income percentage in the taxpayer's range (200) and the ending household income percentage in the taxpayer's range (250), which is 50. Divide the first amount by the second amount:

$210 - 200 = 10$
$250 - 200 = 50$
$10 / 50 = .20$

(iii) Compute the difference between the initial premium percentage (6.3) and the second premium percentage (8.05) in the taxpayer's range; $8.05 - 6.3 = 1.75$.

(iv) Multiply the amount in the first calculation (.20) by the amount in the second calculation (1.75) and add the product (.35) to the initial premium percentage in B's range (6.3), resulting in B's applicable percentage of 6.65:

$.20 \times 1.75 = .35$
$6.3 + .35 = 6.65$.

(h) *Plan covering more than one family*—(1) *In general.* If a qualified health plan covers more than one family under a single policy, each applicable taxpayer covered by the plan may claim a premium tax credit, if otherwise allowable. Each taxpayer computes the credit using that taxpayer's applicable percentage, household income, and the benchmark plan that applies to the taxpayer under paragraph (f) of this section. In determining whether the amount computed under paragraph (d)(1)(i) of this section (the premiums for the qualified health plan in which the taxpayer enrolls) is less than the amount computed under paragraph (d)(1)(ii) of this section (the benchmark plan premium minus the product of household income and the applicable percentage), the premiums

paid are allocated to each taxpayer in proportion to the premiums for each taxpayer's applicable benchmark plan.

(2) *Example.* The following example illustrates the rules of this paragraph (h):

Example. (i) Taxpayers A and B enroll in a single policy under a qualified health plan. B is A's 25-year old child who is not A's dependent. B has no dependents. The plan covers A, B, and A's two additional children who are A's dependents. The premium for the plan in which A and B enroll is $15,000. The premium for the second lowest cost silver family plan covering only A and A's dependents is $12,000 and the premium for the second lowest cost silver plan providing self-only coverage to B is $6,000. A and B are applicable taxpayers and otherwise eligible to claim the premium tax credit.

(ii) Under paragraph (h)(1) of this section, both A and B may claim premium tax credits. A computes her credit using her household income, a family size of three, and a benchmark plan premium of $12,000. B computes his credit using his household income, a family size of one, and a benchmark plan premium of $6,000.

(iii) In determining whether the amount in paragraph (d)(1)(i) of this section (the premiums for the qualified health plan A and B purchase) is less than the amount in paragraph (d)(1)(ii) of this section (the benchmark plan premium minus the product of household income and the applicable percentage), the $15,000 premiums paid are allocated to A and B in proportion to the premiums for their applicable benchmark plans. Thus, the portion of the premium allocated to A is $10,000 ($15,000 × $12,000/$18,000) and the portion allocated to B is $5,000 ($15,000 × $6,000/$18,000).

(i) [Reserved]

(j) *Additional benefits*—(1) *In general.* If a qualified health plan offers benefits in addition to the essential health benefits a qualified health plan must provide under section 1302 of the Affordable Care Act (42 U.S.C. 18022), or a State requires a qualified health plan to cover benefits in addition to these essential health benefits, the portion of the premium for the plan properly allocable to the additional benefits is excluded from the monthly premiums under paragraph (d)(1)(i) or (ii) of this section. Premiums are allocated to additional benefits before determining the applicable benchmark plan under paragraph (f) of this section.

(2) *Method of allocation.* The portion of the premium properly allocable to additional benefits is determined under guidance issued by the Secretary of Health and Human Services. See section 36B(b)(3)(D).

(3) *Examples.* The following examples illustrate the rules of this paragraph (j):

Example 1. (i) Taxpayer B enrolls in a qualified health plan that provides benefits in addition to essential health benefits (additional benefits). The monthly premiums for the plan in which B enrolls are $370, of which $35 is allocable to additional benefits. B's benchmark plan premium (determined after allocating premiums to additional benefits for all silver level plans) is $440, of which $40 is allocable to additional benefits. B's monthly contribution amount, which is the product of B's household income and the applicable percentage, is $60.

(ii) Under this paragraph (j), B's enrollment premiums and the benchmark plan premium are reduced by the portion of the premium that is allocable to the additional benefits provided under that plan. Therefore, B's monthly enrollment premiums are reduced to $335 ($370 − $35) and B's benchmark plan premium is reduced to $400 ($440 − $40). B's premium assistance amount for a coverage month is $335, the lesser of $335 (B's enrollment premiums, reduced by the portion of the premium allocable to additional benefits) and $340 (B's benchmark plan premium, reduced by the portion of the premium allocable to additional benefits ($400), minus B's $60 contribution amount).

Example 2. The facts are the same as in *Example 1* of this paragraph (j)(3), except that the plan in which B enrolls provides no benefits in addition to the essential health benefits required to be provided by the plan. Thus, under paragraph (j) of this section, B's benchmark plan premium ($440) is reduced by the portion of the premium allocable to additional benefits provided under that plan ($40). B's enrollment premiums ($370) are not reduced under this paragraph (j). B's premium assistance amount for a coverage month is $340, the lesser of $370 (B's enrollment premiums) and $340 (B's benchmark plan premium, reduced by the portion of the premium allocable to additional benefits ($400), minus B's $60 contribution amount).

(k) *Pediatric dental coverage*—(1) *In general.* For purposes of determining the amount of the monthly premium a taxpayer pays for coverage under paragraph (d)(1)(i) of this section, if an individual enrolls in both a qualified health plan and a plan described in section 1311(d)(2)(B)(ii) of the Affordable Care Act (42 U.S.C. 13031(d)(2)(B)(ii)) (a stand-alone dental plan), the portion of

the premium for the stand-alone dental plan that is properly allocable to pediatric dental benefits that are essential benefits required to be provided by a qualified health plan is treated as a premium payable for the individual's qualified health plan.

(2) *Method of allocation.* The portion of the premium for a stand-alone dental plan properly allocable to pediatric dental benefits is determined under guidance issued by the Secretary of Health and Human Services.

(3) *Example.* The following example illustrates the rules of this paragraph (k):

Example. (i) Taxpayer C and C's dependent, R, enroll in a qualified health plan. The premium for the plan in which C and R enroll is $7,200 ($600/month) (Amount 1). The plan does not provide dental coverage. C also enrolls in a stand-alone dental plan covering C and R. The portion of the premium for the dental plan allocable to pediatric dental benefits that are essential health benefits is $240 ($20 per month). The excess of the premium for C's applicable benchmark plan over C's contribution amount (the product of C's household income and the applicable percentage) is $7,260 ($605/month) (Amount 2).

(ii) Under this paragraph (k), the amount C pays for premiums (Amount 1) for purposes of computing the premium assistance amount is increased by the portion of the premium for the stand-alone dental plan allocable to pediatric dental benefits that are essential health benefits. Thus, the amount of the premiums for the plan in which C enrolls is treated as $620 for purposes of computing the amount of the premium tax credit. C's premium assistance amount for each coverage month is $605 (Amount 2), the lesser of Amount 1 (increased by the premiums allocable to pediatric dental benefits) and Amount 2.

(l) *Families including individuals not lawfully present*—(1) *In general.* If one or more individuals for whom a taxpayer is allowed a deduction under section 151 are not lawfully present (within the meaning of § 1.36B–1(g)), the percentage a taxpayer's household income bears to the Federal poverty line for the taxpayer's family size for purposes of determining the applicable percentage under paragraph (g) of this section is determined by excluding individuals who are not lawfully present from family size and by determining household income in accordance with paragraph (l)(2) of this section.

(2) *Revised household income computation*—(i) *Statutory method.* For purposes of paragraph (l)(1) of this section, household income is equal to the product of the taxpayer's household income (determined without regard to this paragraph (l)(2)) and a fraction—

(A) The numerator of which is the Federal poverty line for the taxpayer's family size determined by excluding individuals who are not lawfully present; and

(B) The denominator of which is the Federal poverty line for the taxpayer's family size determined by including individuals who are not lawfully present.

(ii) *Comparable method.* The Commissioner may describe a comparable method in additional published guidance, see § 601.601(d)(2) of this chapter.

(m) *Applicability date.* Paragraph (g)(1) of this section applies to taxable years beginning after December 31, 2013.

(n) *Effective/applicability date.* (1) Except as provided in paragraphs (n)(2) and (3) of this section, this section applies to taxable years ending after December 31, 2013.

(2) Paragraphs (c)(4), (d)(1) and (d)(2) of this section apply to taxable years beginning after December 31, 2016. Paragraph (f) of this section applies to taxable years beginning after December 31, 2018. Paragraphs (d)(1) and (d)(2) of § 1.36B–3, as contained in 26 CFR part I edition revised as of April 1, 2016, applies to taxable years ending after December 31, 2013, and beginning before January 1, 2017. Paragraph (f) of § 1.36B–3, as contained in 26 CFR part I edition revised as of April 1, 2016, applies to taxable years ending after December 31, 2013, and beginning before January 1, 2019.

(3) Paragraph (d)(1)(i) of this section applies to taxable years beginning after December 31, 2022.

[T.D. 9590, 77 FR 30385, May 23, 2012; 77 FR 41048, July 12, 2012; T.D. 9683, 79 FR 43627, July 28, 2014; T.D. 9745, 80 FR 78975, Dec. 18, 2015; 81 FR 2088, Jan. 15, 2016; T.D. 9804, 81 FR 91765, Dec. 19, 2016; T.D. 9822, 82 FR 34606, July 26, 2017; T.D. 9968, 87 FR 62002, Oct. 13, 2022]