(1) A description of the number of covered lives under the plan (or coverage) involved at the time of the notification, and as applicable, at the time of any prior election of the cost exemption under this paragraph (g) by such plan (or coverage);

(2) For both the plan year upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical/surgical benefits and mental health and substance use disorder benefits; and

(3) For both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage with respect to mental health and substance use disorder benefits under the plan.

(B) Reporting. A group health plan, and any health insurance coverage offered in connection with a group health plan, must provide notice to the Department of Labor. This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (g)(6)(ii)(A) of this section identifying the benefit package to which the exemption applies.

(iii) Confidentiality. A notification to the Secretary under this paragraph (g)(6) shall be confidential. The Secretary shall make available, upon request and not more than on an annual basis, an anonymous itemization of each notification that includes—

(A) A breakdown of States by the size and type of employers submitting such notification; and

(B) A summary of the data received under paragraph (g)(6)(ii) of this section.

(iv) Audits. The Secretary may audit the books and records of a group health plan or a health insurance issuer relating to an exemption, including any actuarial reports, during the 6 year period following notification of such exemption under paragraph (g)(6) of this section. A State agency receiving a notification under paragraph (g)(6) of this section may also conduct such an audit with respect to an exemption covered by such notification.

(b) Sale of nonparity health insurance coverage. A health insurance issuer may not sell a policy, certificate, or contract of insurance that fails to comply with paragraph (b) or (c) of this section, except to a plan for a year for which the plan is exempt from the requirements of this section because the plan meets the requirements of paragraph (f) or (g) of this section.

(i) Applicability dates—(1) In general. Except as provided in paragraph (i)(2) of this section, this section applies to group health plans and health insurance issuers offering group health insurance coverage on the first day of the first plan year beginning on or after July 1, 2014. Until the applicability date, plans and issuers are required to continue to comply with the corresponding sections of 29 CFR 2590.712 contained in the 29 CFR, parts 1927 to end, edition revised as of July 1, 2013.

(2) Special effective date for certain collectively-bargained plans. For a group health plan maintained pursuant to one or more collective bargaining agreements ratified before October 3, 2008, the requirements of this section do not apply to the plan (or health insurance coverage offered in connection with the plan) for plan years beginning before the date on which the last of the collective bargaining agreements terminates (determined without regard to any extension agreed to after October 3, 2008).

[78 FR 68276, Nov. 13, 2013]

§ 2590.715–1251 Preservation of right to maintain existing coverage.

(a) Definition of grandfathered health plan coverage—(1) In general—(i) Grandfathered health plan coverage. Grandfathered health plan coverage means coverage provided by a group health plan, or a health insurance issuer, in which an individual was enrolled on March 23, 2010 (for as long as it maintains that status under the rules of this section). A group health plan or group health insurance coverage does not cease to be grandfathered health plan coverage merely because one or more (or even all) individuals enrolled on March 23, 2010 cease to be covered, provided that the plan has continuously covered someone since March 23, 2010 (not necessarily the same person, but at all times at least one person). In addition, subject to the limitation set forth in
paragraph (a)(1)(i) of this section, a group health plan (and any health insurance coverage offered in connection with the group health plan) does not cease to be a grandfathered health plan merely because the plan (or its sponsor) enters into a new policy, certificate, or contract of insurance after March 23, 2010 (for example, a plan enters into a contract with a new issuer or a new policy is issued with an existing issuer). For purposes of this section, a plan or health insurance coverage that provides grandfathered health plan coverage is referred to as a grandfathered health plan. The rules of this section apply separately to each benefit package made available under a group health plan or health insurance coverage.

(ii) Changes in group health insurance coverage. Subject to paragraphs (f) and (g)(2) of this section, if a group health plan (including a group health plan that was self-insured on March 23, 2010) or its sponsor enters into a new policy, certificate, or contract of insurance after March 23, 2010 that is effective before November 15, 2010, then the plan ceases to be a grandfathered health plan.

(2) Disclosure of grandfather status—(1) To maintain status as a grandfathered health plan, a plan or health insurance coverage must include a statement, in any plan materials provided to a participant or beneficiary describing the benefits provided under the plan or health insurance coverage, that the plan or coverage believes it is a grandfathered health plan within the meaning of section 1251 of the Patient Protection and Affordable Care Act and must provide contact information for questions and complaints.

(ii) The following model language can be used to satisfy this disclosure requirement:

This [group health plan or health insurance issuer] believes this [plan or coverage] is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information]. (For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans.) (For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.)

(3)(i) Documentation of plan or policy terms on March 23, 2010. To maintain status as a grandfathered health plan, a group health plan, or group health insurance coverage, must, for as long as the plan or health insurance coverage takes the position that it is a grandfathered health plan—

(i)(A) Maintain records documenting the terms of the plan or health insurance coverage in connection with the coverage in effect on March 23, 2010, and any other documents necessary to verify, explain, or clarify its status as a grandfathered health plan; and

(i)(B) Make such records available for examination upon request.

(ii) Change in group health insurance coverage. To maintain status as a grandfathered health plan, a group health plan that enters into a new policy, certificate, or contract of insurance must provide to the new health insurance issuer (and the new health insurance issuer must require) documentation of plan terms (including benefits, cost sharing, employer contributions, and annual limits) under the prior health coverage sufficient to determine whether a change causing a cessation of grandfathered health plan status under paragraph (g)(1) of this section has occurred.

(4) Family members enrolling after March 23, 2010. With respect to an individual who is enrolled in a group

870
health plan or health insurance coverage on March 23, 2010, grandfathered health plan coverage includes coverage of family members of the individual who enroll after March 23, 2010 in the grandfathered health plan coverage of the individual.

(b) Allowance for new employees to join current plan—(1) In general. Subject to paragraph (b)(2) of this section, a group health plan (including health insurance coverage provided in connection with the group health plan) that provided coverage on March 23, 2010 and has retained its status as a grandfathered health plan (consistent with the rules of this section, including paragraph (g) of this section) is grandfathered health plan coverage for new employees (whether newly hired or newly enrolled) and their families enrolling in the plan after March 23, 2010.

(2) Anti-abuse rules—(i) Mergers and acquisitions. If the principal purpose of a merger, acquisition, or similar business restructuring is to cover new individuals under a grandfathered health plan, the plan ceases to be a grandfathered health plan.

(ii) Change in plan eligibility. A group health plan or health insurance coverage (including a benefit package under a group health plan) ceases to be a grandfathered health plan if—

(A) Employees are transferred into the plan or health insurance coverage (the transferee plan) from a plan or health insurance coverage under which the employees were covered on March 23, 2010 (the transferor plan);

(B) Comparing the terms of the transferee plan with those of the transferor plan (as in effect on March 23, 2010) and treating the transferee plan as if it were an amendment of the transferor plan would cause a loss of grandfather status under the provisions of paragraph (g)(1) of this section; and

(C) There was no bona fide employment-based reason to transfer the employees into the transferee plan. For this purpose, changing the terms or cost of coverage is not a bona fide employment-based reason.

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

Example 1. (i) Facts. A group health plan offers two benefit packages on March 23, 2010, Options F and G. During a subsequent open enrollment period, some of the employees enrolled in Option F on March 23, 2010 switch to Option G.

(ii) Conclusion. In this Example 1, the group health coverage provided under Option G remains a grandfathered health plan under the rules of paragraph (b)(1) of this section because employees previously enrolled in Option F are allowed to enroll in Option G as new employees.

Example 2. (i) Facts. Same facts as Example 1, except that the plan sponsor eliminates Option F because of its high cost and transfers employees covered under Option F to Option G. If instead of transferring employees from Option F to Option G, Option F was amended to match the terms of Option G, then Option F would cease to be a grandfathered health plan.

(ii) Conclusion. In this Example 2, the plan did not have a bona fide employment-based reason to transfer employees from Option F to Option G. Therefore, Option G ceases to be a grandfathered health plan with respect to all employees. (However, any other benefit package maintained by the plan sponsor is analyzed separately under the rules of this section.)

Example 3. (i) Facts. A group health plan offers two benefit packages on March 23, 2010, Options H and I. On March 23, 2010, Option H provides coverage only for employees in one manufacturing plant. Subsequently, the plant is closed, and some employees in the closed plant are moved to another plant. The employer eliminates Option H and the employees that are moved are transferred to Option I. If instead of transferring employees from Option H to Option I, Option H was amended to match the terms of Option I, then Option H would cease to be a grandfathered health plan.

(ii) Conclusion. In this Example 3, the plan has a bona fide employment-based reason to transfer employees from Option H to Option I. Therefore, Option I does not cease to be a grandfathered health plan.

(c) General grandfathering rule—(1) Except as provided in paragraphs (d) and (e) of this section, subtitles A and C of title I of the Patient Protection and Affordable Care Act (and the amendments made by those subtitles, and the incorporation of those amendments into ERISA section 715 and Internal Revenue Code section 9815) do not apply to grandfathered health plan coverage. Accordingly, the provisions of PHS Act sections 2701, 2702, 2703, 2705, 2706, 2707, 2709 (relating to coverage for individuals participating in
approved clinical trials, as added by section 10103 of the Patient Protection and Affordable Care Act, 2713, 2715A, 2716, 2717, 2719, and 2719A, as added or amended by the Patient Protection and Affordable Care Act, do not apply to grandfathered health plans. (In addition, see 45 CFR 147.140(c), which provides that the provisions of PHS Act section 2704, and PHS Act section 2711 insofar as it relates to annual limits, do not apply to grandfathered health plans that are individual health insurance coverage.)

(2) To the extent not inconsistent with the rules applicable to a grandfathered health plan, a grandfathered health plan must comply with the requirements of the PHS Act, ERISA, and the Internal Revenue Code applicable prior to the changes enacted by the Patient Protection and Affordable Care Act.

(d) Provisions applicable to all grandfathered health plans. The provisions of PHS Act section 2711 insofar as it relates to lifetime limits, and the provisions of PHS Act sections 2712, 2714, 2715, and 2718, apply to grandfathered health plans for plan years beginning on or after September 23, 2010. The provisions of PHS Act section 2708 apply to grandfathered health plans for plan years beginning on or after January 1, 2014.

(e) Applicability of PHS Act sections 2704, 2711, and 2714 to grandfathered group health plans and group health insurance coverage—(1) The provisions of PHS Act section 2704 as it applies with respect to enrollees who are under 19 years of age, and the provisions of PHS Act section 2711 insofar as it relates to annual limits, apply to grandfathered health plans that are group health plans (including group health insurance coverage) for plan years beginning on or after September 23, 2010. The provisions of PHS Act section 2704 apply generally to grandfathered health plans that are group health plans (including group health insurance coverage) for plan years beginning on or after January 1, 2014.

(2) For plan years beginning before January 1, 2014, the provisions of PHS Act section 2714 apply in the case of an adult child with respect to a grandfathered health plan that is a group health plan only if the adult child is not eligible to enroll in an eligible employer-sponsored health plan (as defined in section 5000A(f)(2) of the Internal Revenue Code) other than a grandfathered health plan of a parent. For plan years beginning on or after January 1, 2014, the provisions of PHS Act section 2714 apply with respect to a grandfathered health plan that is a group health plan without regard to whether an adult child is eligible to enroll in any other coverage.

(f) Effect on collectively bargained plans—In general. In the case of health insurance coverage maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers that was ratified before March 23, 2010, the coverage is grandfathered health plan coverage at least until the date on which the last of the collective bargaining agreements relating to the coverage that was in effect on March 23, 2010 terminates. Any coverage amendment made pursuant to a collective bargaining agreement relating to the coverage that amends the coverage solely to conform to any requirement added by subtitles A and C of title I of the Patient Protection and Affordable Care Act (and the amendments made by those subtitles, and the incorporation of those amendments into ERISA section 715 and Internal Revenue Code section 9815) is not treated as a termination of the collective bargaining agreement. After the date on which the last of the collective bargaining agreements relating to the coverage that was in effect on March 23, 2010 terminates, the determination of whether health insurance coverage maintained pursuant to a collective bargaining agreement is grandfathered health plan coverage is made under the rules of this section other than this paragraph (f) (comparing the terms of the health insurance coverage after the date the last collective bargaining agreement terminates with the terms of the health insurance coverage that were in effect on March 23, 2010).
this paragraph (g)(1) describe situations in which a group health plan or health insurance coverage ceases to be a grandfathered health plan.

(i) Elimination of benefits. The elimination of all or substantially all benefits to diagnose or treat a particular condition causes a group health plan or health insurance coverage to cease to be a grandfathered health plan. For this purpose, the elimination of benefits for any necessary element to diagnose or treat a condition is considered the elimination of all or substantially all benefits to diagnose or treat a particular condition.

(ii) Increase in percentage cost-sharing requirement. Any increase, measured from March 23, 2010, in a percentage cost-sharing requirement (such as an individual's coinsurance requirement) causes a group health plan or health insurance coverage to cease to be a grandfathered health plan.

(iii) Increase in a fixed-amount cost-sharing requirement other than a copayment. Any increase in a fixed-amount cost-sharing requirement other than a copayment (for example, deductible or out-of-pocket limit), determined as of the effective date of the increase, causes a group health plan or health insurance coverage to cease to be a grandfathered health plan.

(iv) Increase in a fixed-amount copayment. Any increase in a fixed-amount copayment, determined as of the effective date of the increase, causes a group health plan or health insurance coverage to cease to be a grandfathered health plan, if the total percentage increase in the cost-sharing requirement measured from March 23, 2010 exceeds the maximum percentage increase (as defined in paragraph (g)(3)(ii) of this section).

(v) Decrease in contribution rate by employers and employee organizations—(A) Contribution rate based on cost of coverage. A group health plan or group health insurance coverage ceases to be a grandfathered health plan if the employer or employee organization decreases its contribution rate based on cost of coverage (as defined in paragraph (g)(3)(iii)(A) of this section) towards the cost of any tier of coverage for any class of similarly situated individuals (as described in §2590.702(d) of this part) by more than 5 percentage points below the contribution rate for the coverage period that includes March 23, 2010.

(B) Contribution rate based on a formula. A group health plan or group health insurance coverage ceases to be a grandfathered health plan if the employer or employee organization decreases its contribution rate based on a formula (as defined in paragraph (g)(3)(iii)(B) of this section) towards the cost of any tier of coverage for any class of similarly situated individuals (as described in section 2590.702(d) of this part) by more than 5 percent below the contribution rate for the coverage period that includes March 23, 2010.

(vi) Changes in annual limits—(A) Addition of an annual limit. A group health plan, or group health insurance coverage, that, on March 23, 2010, did not impose an overall annual or lifetime limit on the dollar value of all benefits ceases to be a grandfathered health plan if the plan or health insurance coverage imposes an overall annual limit on the dollar value of benefits.

(B) Decrease in limit for a plan or coverage with only a lifetime limit. A group health plan, or group health insurance coverage, that, on March 23, 2010, imposed an overall lifetime limit on the dollar value of all benefits but no overall annual limit on the dollar value of all benefits ceases to be a grandfathered health plan if the plan or health insurance coverage imposes an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit on March 23, 2010.

(C) Decrease in limit for a plan or coverage with an annual limit. A group health plan, or group health insurance coverage, that, on March 23, 2010, imposed an overall annual limit on the
§ 2590.715–1251

The dollar value of all benefits ceases to be a grandfathered health plan if the plan or health insurance coverage decreases the dollar value of the annual limit (regardless of whether the plan or health insurance coverage also imposed an overall lifetime limit on March 23, 2010 on the dollar value of all benefits).

(2) Transitional rules—(i) Changes made prior to March 23, 2010. If a group health plan or health insurance issuer makes the following changes to the terms of the plan or health insurance coverage, the changes are considered part of the terms of the plan or health insurance coverage on March 23, 2010 even though they were not effective at that time and such changes do not cause a plan or health insurance coverage to cease to be a grandfathered health plan:

(A) Changes effective after March 23, 2010 pursuant to a legally binding contract entered into on or before March 23, 2010; or

(B) Changes effective after March 23, 2010 pursuant to a filing on or before March 23, 2010 with a State insurance department; or

(C) Changes effective after March 23, 2010 pursuant to written amendments to a plan that were adopted on or before March 23, 2010.

(ii) Changes made after March 23, 2010 and adopted prior to issuance of regulations. If, after March 23, 2010, a group health plan or health insurance issuer makes changes to the terms of the plan or health insurance coverage and the changes are adopted prior to June 14, 2010, the changes will not cause the plan or health insurance coverage to cease to be a grandfathered health plan if the changes are revoked or modified effective as of the first day of the first plan year (in the individual market, policy year) beginning on or after September 23, 2010, and the terms of the plan or health insurance coverage on that date, as modified, would not cause the plan or coverage to cease to be a grandfathered health plan under the rules of this section, including paragraph (g)(1) of this section. For this purpose, changes will be considered to have been adopted prior to June 14, 2010 if:

(A) The changes are effective on or after that date pursuant to a legally binding contract entered into before that date; or

(B) The changes are effective on or after that date pursuant to a filing before that date with a State insurance department; or

(C) The changes are effective on or after that date pursuant to written amendments to a plan that were adopted before that date.

(iii) Contribution rate defined. For purposes of paragraph (g)(1)(v) of this section:

(A) Contribution rate based on cost of coverage. The term contribution rate based on cost of coverage means the amount of contributions made by an employer or employee organization compared to the total cost of coverage, expressed as a percentage. The total cost of coverage is determined in the same manner as the applicable premium is calculated under the COBRA continuation provisions of section 604 of ERISA, section 4980B(f)(4) of the Internal Revenue Code, and section 2204 of the PHS Act. In the case of a self-insured plan, contributions by an employer or employee organization are equal to the total cost of coverage
minus the employee contributions towards the total cost of coverage.

(b) Contribution rate based on a formula. The term contribution rate based on a formula means, for plans that, on March 23, 2010, made contributions based on a formula (such as hours worked or tons of coal mined), the formula.

(4) Examples. The rules of this paragraph (g) are illustrated by the following examples:

Example 1. (i) Facts. On March 23, 2010, a grandfathered health plan has a coinsurance requirement of 20% for inpatient surgery. The plan is subsequently amended to increase the coinsurance requirement to 25%.

(ii) Conclusion. In this Example 1, the increase in the coinsurance requirement from 20% to 25% causes the plan to cease to be a grandfathered health plan.

Example 2. (i) Facts. Before March 23, 2010, the terms of a group health plan provide benefits for a particular mental health condition, the treatment for which is a combination of counseling and prescription drugs. Subsequently, the plan eliminates benefits for counseling.

(ii) Conclusion. In this Example 2, the plan ceases to be a grandfathered health plan because counseling is an element that is necessary to treat the condition. Thus the plan is considered to have eliminated substantially all benefits for the treatment of the condition.

Example 3. (i) Facts. On March 23, 2010, a grandfathered health plan has a copayment requirement of $30 per office visit for primary care providers. The plan is subsequently amended to increase the copayment requirement to $40.

Within the 12-month period before the $40 copayment takes effect, the greatest value of the overall medical care component of the CPI-U (unadjusted) is 415.

(ii) Conclusion. In this Example 3, the increase in the copayment from $30 to $40, expressed as a percentage, is 33.33% (40 – 30 = 10; 10 ÷ 30 = 0.3333; 0.3333 = 33.33%). Medical inflation (as defined in paragraph (g)(3)(i) of this section) from March 2010 to March 2010 is 0.0720 (415.0 – 387.142 = 27.858; 27.858 ÷ 387.142 = 0.0720). The increase that would cause a plan to cease to be a grandfathered health plan under paragraph (g)(1)(iv) of this section is the greater of the maximum percentage increase of 40.27% (0.2527 = 25.27%; 25.27% + 15% = 40.27%), or $6.26 ($5 × 0.2527 = $1.26; $1.26 + $5 = $6.26). Because 50% exceeds 40.27% and $15 exceeds $6.26, the change in the copayment requirement at that time causes the plan to cease to be a grandfathered health plan.

Example 4. (i) Facts. Same facts as Example 3, except on March 23, 2010, the grandfathered health plan has a copayment of $10 per office visit for primary care providers. The plan is subsequently amended to increase the copayment requirement to $15.

Within the 12-month period before the $15 copayment takes effect, the greatest value of the overall medical care component of the CPI-U (unadjusted) is 485.

(ii) Conclusion. In this Example 4, the increase in the copayment from $10 (the copayment that was in effect on March 23, 2010) to $15, expressed as a percentage, is 50% (15 – 10 = 5; 5 ÷ 10 = 0.5; 0.5 = 50%). Medical inflation (as defined in paragraph (g)(3)(i) of this section) from March 2010 to March 2010 is 0.2527 (485 – 387.142 = 97.858; 97.858 ÷ 387.142 = 0.2527). The increase that would cause a plan to cease to be a grandfathered health plan under paragraph (g)(1)(iv) of this section is the greater of the maximum percentage increase of 40.27% (0.2527 = 25.27%; 25.27% + 15% = 40.27%), or $6.26 ($5 × 0.2527 = $1.26; $1.26 + $5 = $6.26). Because 50% exceeds 40.27% and $15 exceeds $6.26, the change in the copayment requirement at that time causes the plan to cease to be a grandfathered health plan.

Example 5. (i) Facts. On March 23, 2010, a grandfathered health plan has a copayment of $10 per office visit for primary care providers. The plan is subsequently amended to increase the copayment requirement to $15.

Within the 12-month period before the $15 copayment takes effect, the greatest value of the overall medical care component of the CPI-U (unadjusted) is 415.

(ii) Conclusion. In this Example 5, the increase in the copayment, expressed as a percentage, is 50% (15 – 10 = 5; 5 ÷ 10 = 0.5; 0.5 = 50%). Medical inflation (as defined in paragraph (g)(3) of this section) from March 2010 to March 2010 is 0.0720 (415.0 – 387.142 = 27.858; 27.858 ÷ 387.142 = 0.0720). The increase that would cause a plan to cease to be a grandfathered health plan under paragraph (g)(1)(iv) of this section is the greater of the maximum percentage increase of 22.20% (0.0720 = 7.20%; 7.20% + 15% = 22.20%), or $5.36 ($5 × 0.0720 = $0.36; $0.36 + $5 = $5.36). The $5 increase in copayment in this Example 5 would not cause the plan to cease to be a grandfathered health plan pursuant to paragraph (g)(1)(iv) of this section, which would permit an increase in the copayment of up to $5.36.

Example 6. (i) Facts. The same facts as Example 3, except on March 23, 2010, the grandfathered health plan has no copayment ($0) for office visits for primary care providers. The plan is subsequently amended to increase the copayment requirement to $5 for office visits for primary care providers.

(ii) Conclusion. In this Example 6, medical inflation (as defined in paragraph (g)(3)(i) of this section) from March 2010 to March 2010 is 0.0720 (415.0 – 387.142 = 27.858; 27.858 ÷ 387.142 = 0.0720). The increase that would cause a plan to cease to be a grandfathered health plan under paragraph (g)(1)(iv)(A) of this section is $5.36 ($5 × 0.0720 = $0.36; $0.36 + $5 = $5.36). The $5 increase in copayment in this Example 6 is less than the amount calculated pursuant to paragraph (g)(1)(iv)(A) of this section of $5.36. Thus, the $5 increase in copayment does not cause the plan to cease to be a grandfathered health plan.

Example 7. (i) Facts. On March 23, 2010, a self-insured group health plan provides two
§ 2590.715–2704

29 CFR Ch. XXV (7–1–14 Edition)

tiers of coverage—self-only and family. The employer contributes 80% of the total cost of coverage for self-only and 60% of the total cost of coverage for family. Subsequently, the employer reduces the contribution to 50% for family coverage, but keeps the same contribution rate for self-only coverage.

(ii) Conclusion. In this Example 7, the decrease of 10 percentage points for family coverage in the contribution rate based on cost of coverage causes the plan to cease to be a grandfathered health plan. The fact that the contribution rate for self-only coverage remains the same does not change the result.

Example 8. (i) Facts. On March 23, 2010, a self-only grandfathered health plan has a COBRA premium for the 2010 plan year of $5000 for self-only coverage and $12,000 for family coverage. The required employee contribution for the coverage is $1000 for self-only coverage and $4000 for family coverage. Thus, the contribution rate based on cost of coverage for family coverage is 80% ((5000—1000)/5000) for family coverage. Subsequently, the COBRA premium for the 2010 plan year of $6000 for self-only coverage and $15,000 for family coverage. The employee contributions for that plan year are $1200 for self-only coverage and $5000 for family coverage. Thus, the contribution rate based on cost of coverage is 80% ((6000—1200)/6000) for self-only coverage and 67% ((15,000—5000)/15,000) for family coverage.

(ii) Conclusion. In this Example 8, because there is no change in the contribution rate based on cost of coverage, the plan retains its status as a grandfathered health plan. The result would be the same if all or part of the employee contribution was made pre-tax through a cafeteria plan under section 125 of the Internal Revenue Code.

Example 9. (i) Facts. A group health plan not maintained pursuant to a collective bargaining agreement offers benefits through a cafeteria plan under section 125 of the Internal Revenue Code.

(ii) Conclusion. In this Example 9, the exclusion of benefits for oral surgery required as a result of a traumatic injury if the injury occurred before the effective date of coverage under the policy.

Example 2. (i) Facts. Individual C applies for individual health insurance coverage with Issuer M. M denies C’s application for coverage based on the fact that the condition was present before the effective date of coverage. C’s application for coverage is a preexisting condition exclusion because a pre-enrollment physical revealed that C has type 2 diabetes.

(ii) Conclusion. See Example 2 in 45 CFR 147.108(a)(2) for a conclusion that M’s denial of C’s application for coverage is a pre-existing condition exclusion because a denial of an application for coverage based on the fact that the condition was present before the effective date of denial is an exclusion of benefits for oral surgery required as a result of a traumatic injury if the injury occurred before the effective date of coverage under the policy.

(b) Applicability—(1) General applicability date. Except as provided in paragraph (b)(2) of this section, the rules of this section apply for plan years beginning on or after January 1, 2014.

(2) Early applicability date for children. The rules of this section apply with respect to enrollees, including applicants for enrollment, who are under 19 years of age for plan years beginning on or after September 23, 2010.

(3) Applicability to grandfathered health plans. See § 2590.715–1251 of this part for determining the applicability of this section to grandfathered health plans (providing that a grandfathered health plan that is a group health plan or group health insurance coverage must comply with the prohibition against preexisting condition exclusions).