§ 147.145

(1) Facts. On March 23, 2010, a self-insured 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 employer reduces the contribution to 50% for family coverage, but keeps the same contribution rate for self-only coverage.

(i) 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-insured 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 $1500 for self-only coverage and $4000 for family coverage. Thus, the contribution rate based on cost of coverage for 2010 is 80% ((5000 – 1000)/5000) for self-only coverage and 67% ((4000 – 4000)/4000) for family coverage. For a subsequent plan year, the COBRA premium is $6000 for self-only coverage and $15,000 for family coverage. The employee contributions for that plan year are $3200 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 three benefit packages on March 23, 2010. Option F is a self-insured option. Options G and H are insured options. Beginning July 1, 2013, the plan increases coinsurance under Option H from 10% to 15%.

(ii) Conclusion. In this Example 9, the coverage under Option H is not grandfathered health plan coverage as of July 1, 2013, consistent with the rule in paragraph (g)(1)(ii) of this section. Whether the coverage under Options F and G is grandfathered health plan coverage is determined separately under the rules of this paragraph (g).

(75 FR 34566, June 17, 2010, as amended at 75 FR 70121, Nov. 15, 2010)
education (as defined in the Higher Education Act of 1965) and a health insurance issuer, and provided to students enrolled in that institution of higher education and their dependents, that meets the following conditions:

1. Does not make health insurance coverage available other than in connection with enrollment as a student (or as a dependent of a student) in the institution of higher education.

2. Does not condition eligibility for the health insurance coverage on any health status-related factor (as defined in §146.121(a) of this subchapter) relating to a student (or a dependent of a student).

3. Meets any additional requirement that may be imposed under State law.

(b) Exemptions from the Public Health Service Act.

1. Guaranteed availability and guaranteed renewability. For purposes of sections 2741(e)(1) and 2742(b)(5) of the Public Health Service Act, student health insurance coverage is deemed to be available only through a bona fide association.

2. Annual limits. (i) Notwithstanding the annual dollar limits requirements of §147.126, for policy years beginning before September 23, 2012, a health insurance issuer offering student health insurance coverage may not establish an annual dollar limit on essential health benefits that is lower than $100,000.

(ii) Notwithstanding the annual dollar limits requirements of §147.126, for policy years beginning on or after September 23, 2012, but before January 1, 2014, a health insurance issuer offering student health insurance coverage may not establish an annual dollar limit on essential health benefits that is lower than $500,000.

(iii) For policy years beginning on or after January 1, 2014, a health insurance issuer offering student health insurance coverage may not establish an annual dollar limit on essential health benefits that is lower than $1,000,000.

(c) Student administrative health fees.

1. Definition. A student administrative health fee is a fee charged by the institution of higher education on a periodic basis to students of the institution of higher education to offset the cost of providing health care through health clinics regardless of whether the students utilize the health clinics or enroll in student health insurance coverage.

2. Preventive services. Notwithstanding the requirements under section 2713 of the Public Health Service Act and its implementing regulations, student administrative health fees as defined in paragraph (c)(1) of this section are not considered cost-sharing requirements with respect to specified recommended preventive services.

(d) Notice. (1) Requirements. (i) A health insurance issuer that provides student health insurance coverage, and does not meet the annual dollar limits requirements under section 2711 of the Public Health Service Act, must provide a notice informing students that the policy does not meet the minimum annual limits requirements under section 2711 of the Public Health Service Act. The notice must include the dollar amount of the annual limit along with a description of the plan benefits to which the limit applies for the student health insurance coverage.

(ii) The notice must state that the student may be eligible for coverage as a dependent in a group health plan of a parent’s employer or under the parent’s individual market coverage if the student is under the age of 26.

(iii) The notice must be prominently displayed in clear, conspicuous 14-point bold type on the front of the insurance policy or certificate and in any other plan materials summarizing the terms of the coverage (such as a summary description document).

(iv) The notice must be provided for policy years beginning before January 1, 2014.

2. Model language. The following model language, or substantially similar language, can be used to satisfy the notice requirement of this paragraph (d): “Your student health insurance coverage, offered by [name of health insurance issuer], may not meet the minimum standards required by the health care reform law for the restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are
§ 147.200 Summary of benefits and coverage and uniform glossary.

(a) Summary of benefits and coverage—
(1) In general. A group health plan (and its administrator as defined in section 3(16)(A) of ERISA), and a health insurance issuer offering group or individual health insurance coverage, is required to provide a written summary of benefits and coverage (SBC) for each benefit package without charge to entities and individuals described in this paragraph (a)(1) in accordance with the rules of this section.

(i) SBC provided by a group health insurance issuer to a group health plan—
(A) Upon application. A health insurance issuer offering group health insurance coverage must provide the SBC to a group health plan (or its sponsor) upon application for health coverage, as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application.

(B) By first day of coverage (if there are changes). If there is any change in the information required to be in the SBC that was provided upon application and before the first day of coverage, the issuer must update and provide a current SBC to the plan (or its sponsor) no later than the first day of coverage.

(C) Upon renewal. If the issuer renews or reissues the policy, certificate, or contract of insurance (for example, for a succeeding policy year), the issuer must provide a new SBC as follows:
(I) If written application is required (in either paper or electronic form) for renewal or reissuance, the SBC must be provided no later than the date the written application materials are distributed.

(ii) If renewal or reissuance is automatic, the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year; however, with respect to an insured plan, if the policy, certificate, or contract of insurance has not been issued or renewed before such 30-day period, the SBC must be provided as soon as practicable but in no event later than seven business days after issuance of the new policy, certificate, or contract of insurance, or the receipt of written confirmation of intent to renew, whichever is earlier.

(ii) Upon request. If a group health plan (or its sponsor) requests an SBC or summary information about a health insurance product from a health insurance issuer offering group health insurance coverage, an SBC must be provided as soon as practicable, but in no event later than seven business days following receipt of the request.

(ii) SBC provided by a group health insurance issuer and a group health plan to participants and beneficiaries—
(A) In general. A group health plan (including its administrator, as defined under section 3(16) of ERISA), and a health insurance issuer offering group health insurance coverage, an SBC must be provided as soon as practicable but in no event later than seven business days following issuance of the new policy, certificate, or contract of insurance, or the receipt of written confirmation of intent to renew, whichever is earlier.

Be advised that you may be eligible for coverage under a group health plan of a parent’s employer or under a parent’s individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent’s employer plan or the parent’s individual health insurance issuer for more information.”

(e) Applicability. The provisions of this section apply for policy years beginning on or after July 1, 2012.

[77 FR 16468, Mar. 21, 2012]