the individual market (defined in § 54.9801–2).

[T.D. 9166, 69 FR 78746, Dec. 30, 2004, as amended by T.D. 9299, 71 FR 75056, Dec. 13, 2006; T.D. 9427, 73 FR 62419, Oct. 20, 2008; T.D. 9464, 74 FR 51678, Oct. 7, 2009]

EFFECTIVE DATE NOTE: At 79 FR 10303, Feb. 24, 2014, § 54.9801–1 was amended by revising paragraph (b), effective Apr. 25, 2014. For the convenience of the user, the revised text is set forth as follows:

§ 54.9801–1 Basis and scope.

* * * * *

(b) *Scope.* A group health plan or health insurance issuer offering group health insurance coverage may provide greater rights to participants and beneficiaries than those set forth in the portability and market reform sections of this part 54. This part 54 sets forth minimum requirements for group health plans and group health insurance issuers offering group health insurance coverage concerning certain consumer protections of the Health Insurance Portability and Accountability Act (HIPAA), including special enrollment periods and the prohibition against discrimination based on a health factor, as amended by the Patient Protection and Affordable Care Act (Affordable Care Act). Other consumer protection provisions, including other protections provided by the Affordable Care Act and the Mental Health Parity and Addiction Equity Act, are set forth in this part 54.

* * * * *

§ 54.9801–2 Definitions.

Unless otherwise provided, the definitions in this section govern in applying the provisions of § 54.9801–1, this section, §§ 54.9801–3 through 54.9801–6, 54.9802–1, 54.9802–2, 54.9802–3T, 54.9811–1, 54.9812–1T, 54.9831–1, and 54.9833–1.

Affiliation period means a period of time that must expire before health insurance coverage provided by an HMO becomes effective, and during which the HMO is not required to provide benefits.

COBRA definitions:

(1) *COBRA* means title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(2) *COBRA continuation coverage* means coverage, under a group health plan, that satisfies an applicable COBRA continuation provision.

(3) *COBRA continuation provision* means section 4980B (other than paragraph (f)(1) of section 4980B insofar as it relates to pediatric vaccines), sections 601–608 of ERISA, or title XXII of the PHS Act.

(4) *Exhaustion of COBRA continuation coverage* means that an individual's COBRA continuation coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). An individual is considered to have exhausted COBRA continuation coverage if such coverage ceases—

(i) Due to the failure of the employer or other responsible entity to remit premiums on a timely basis;

(ii) When the individual no longer resides, lives, or works in the service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other COBRA continuation coverage available to the individual; or

(iii) When the individual incurs a claim that would meet or exceed a lifetime limit on all benefits and there is no other COBRA continuation coverage available to the individual.

Condition means a *medical condition*.

Creditable coverage means *creditable coverage* within the meaning of § 54.9801–4(a).

Dependent means any individual who is or may become eligible for coverage under the terms of a group health plan because of a relationship to a participant.

Employee Retirement Income Security Act of 1974 (ERISA) means the Employee Retirement Income Security Act of 1974, as amended (29 U.S.C. 1001 *et seq.*).

Enroll means to become covered for benefits under a group health plan (that is, when coverage becomes effective), without regard to when the individual may have completed or filed any forms that are required in order to become covered under the plan. For this purpose, an individual who has health coverage under a group health plan is enrolled in the plan regardless of whether the individual elects coverage,

the individual is a dependent who becomes covered as a result of an election by a participant, or the individual becomes covered without an election.

Enrollment date definitions (*enrollment date*, *first day of coverage*, and *waiting period*) are set forth in § 54.9801–3(a)(3)(i), (ii), and (iii).

Excepted benefits means the benefits described as excepted in § 54.9831(c).

Genetic information has the meaning given the term in § 54.9802–3T(a)(3).

Group health insurance coverage means health insurance coverage offered in connection with a group health plan.

Group health plan or *plan* means a *group health plan* within the meaning of § 54.9831–1(a).

Group market means the market for health insurance coverage offered in connection with a group health plan. (However, certain very small plans may be treated as being in the *individual market*, rather than the group market; see the definition of individual market in this section.)

Health insurance coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance. However, benefits described in § 54.9831(c)(2) are not treated as benefits consisting of medical care.

Health insurance issuer or *issuer* means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance (within the meaning of section 514(b)(2) of ERISA). Such term does not include a group health plan.

Health maintenance organization or *HMO* means—

(1) A federally qualified health maintenance organization (as defined in section 1301(a) of the PHS Act);

(2) An organization recognized under State law as a health maintenance organization; or

(3) A similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

Individual health insurance coverage means health insurance coverage offered to individuals in the individual market, but does not include short-term, limited-duration insurance. Individual health insurance coverage can include dependent coverage.

Individual market means the market for health insurance coverage offered to individuals other than in connection with a group health plan. Unless a State elects otherwise in accordance with section 2791(e)(1)(B)(ii) of the PHS Act, such term also includes coverage offered in connection with a group health plan that has fewer than two participants who are current employees on the first day of the plan year.

Issuer means a *health insurance issuer*.

Late enrollment definitions (*late enrollee* and *late enrollment*) are set forth in § 54.9801–3(a)(3)(v) and (vi) .

Medical care has the meaning given such term by section 213(d), determined without regard to section 213(d)(1)(C) and so much of section 213(d)(1)(D) as relates to qualified long-term care insurance.

Medical condition or *condition* means any condition, whether physical or mental, including, but not limited to, any condition resulting from illness, injury (whether or not the injury is accidental), pregnancy, or congenital malformation. However, genetic information is not a condition.

Participant means *participant* within the meaning of section 3(7) of ERISA.

Placement, or being placed, for adoption means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person ends upon the termination of such legal obligation.

Plan year means the year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not

designate a plan year or if there is no plan document, the plan year is—

(1) The deductible or limit year used under the plan;

(2) If the plan does not impose deductibles or limits on a yearly basis, then the plan year is the policy year;

(3) If the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, then the plan year is the employer's taxable year; or

(4) In any other case, the plan year is the calendar year.

Preexisting condition exclusion means a limitation or exclusion of benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan or group or individual health insurance coverage (or other coverage provided to federally eligible individuals pursuant to 45 CFR part 148), whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any limitation or exclusion of benefits (including a denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan, or group or individual health insurance coverage (or other coverage provided to Federally eligible individuals pursuant to 45 CFR part 148), such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

Public health plan means *public health plan* within the meaning of §54.9801–4(a)(1)(ix).

Public Health Service Act (PHS Act) means the Public Health Service Act (42 U.S.C. 201, *et seq.*).

Short-term, limited-duration insurance means health insurance coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is less than 12 months after the original effective date of the contract.

Significant break in coverage means a *significant break in coverage* within the meaning of §54.9801–4(b)(2)(iii).

Special enrollment means enrollment in a group health plan under the rights described in §54.9801–6 or in group health insurance coverage under the rights described in 29 CFR 2590.701–6 or 45 CFR 146.117.

State health benefits risk pool means a *State health benefits risk pool* within the meaning of §54.9801–4(a)(1)(vii).

Waiting period means *waiting period* within the meaning of §54.9801–3(a)(3)(iii).

[T.D. 9166, 69 FR 78746, Dec. 30, 2004, as amended by T.D. 9299, 71 FR 75056, Dec. 13, 2006; T.D. 9427, 73 FR 62420, Oct. 20, 2008; T.D. 9464, 74 FR 51678, Oct. 7, 2009; T.D. 9491, 75 FR 37222, June 28, 2010]

EFFECTIVE DATE NOTE: At 79 FR 10304, Feb. 24, 2014, §54.9801–2 was amended by revising the definitions of ''*enrollment date*'', ''*late enrollment*'', and ''*waiting period*'', and by adding definitions of ''*first day of coverage*'' and ''*late enrollee*'' in alphabetical order, effective Apr. 25, 2014. For the convenience of the user, the revised and added text is set forth as follows:

§54.9801–2 Definitions.

* * * * *

Enrollment date means the first day of coverage or, if there is a waiting period, the first day of the waiting period. If an individual receiving benefits under a group health plan changes benefit packages, or if the plan changes group health insurance issuers, the individual's enrollment date does not change.

* * * * *

First day of coverage means, in the case of an individual covered for benefits under a group health plan, the first day of coverage under the plan and, in the case of an individual covered by health insurance coverage in the individual market, the first day of coverage under the policy or contract.

* * * * *

Late enrollee means an individual whose enrollment in a plan is a late enrollment.

Late enrollment means enrollment of an individual under a group health plan other than on the earliest date on which coverage

can become effective for the individual under the terms of the plan; or through special enrollment. (For rules relating to special enrollment, see § 54.9801–6.) If an individual ceases to be eligible for coverage under a plan, and then subsequently becomes eligible for coverage under the plan, only the individual's most recent period of eligibility is taken into account in determining whether the individual is a late enrollee under the plan with respect to the most recent period of coverage. Similar rules apply if an individual again becomes eligible for coverage following a suspension of coverage that applied generally under the plan.

* * * * *

Waiting period means *waiting period* within the meaning of § 54.9815–2708(b).

* * * * *

§ 54.9801–3 Limitations on preexisting condition exclusion period.

(a) *Preexisting condition exclusion*—(1) *Defined*—(i) A *preexisting condition exclusion* means a *preexisting condition exclusion* within the meaning set forth in § 54.9801–2.

(ii) *Examples.* The rules of this paragraph (a)(1) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan provides benefits solely through an insurance policy offered by Issuer *S*. At the expiration of the policy, the plan switches coverage to a policy offered by Issuer *T*. Issuer *T*'s policy excludes benefits for any prosthesis if the body part was lost before the effective date of coverage under the policy.

(ii) *Conclusion.* In this *Example 1*, the exclusion of benefits for any prosthesis if the body part was lost before the effective date of coverage is a preexisting condition exclusion because it operates to exclude benefits for a condition based on the fact that the condition was present before the effective date of coverage under the policy. (Therefore, the exclusion of benefits is required to comply with the limitations on preexisting condition exclusions in this section. For an example illustrating the application of these limitations to a succeeding insurance policy, see *Example 3* of paragraph (a)(3)(iv) of this section.)

Example 2. (i) *Facts.* A group health plan provides coverage for cosmetic surgery in cases of accidental injury, but only if the injury occurred while the individual was covered under the plan.

(ii) *Conclusion.* In this *Example 2*, the plan provision excluding cosmetic surgery benefits for individuals injured before enrolling in the plan is a preexisting condition exclusion because it operates to exclude benefits relating to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 3. (i) *Facts.* A group health plan provides coverage for the treatment of diabetes, generally not subject to any lifetime dollar limit. However, if an individual was diagnosed with diabetes before the effective date of coverage under the plan, diabetes coverage is subject to a lifetime limit of $10,000.

(ii) *Conclusion.* In this *Example 3*, the $10,000 lifetime limit is a preexisting condition exclusion because it limits benefits for a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 4. (i) *Facts.* A group health plan provides coverage for the treatment of acne, subject to a lifetime limit of $2,000. The plan counts against this $2,000 lifetime limit on acne treatment benefits provided under prior health coverage.

(ii) *Conclusion.* In this *Example 4*, counting benefits for a specific condition provided under prior health coverage against a lifetime limit for that condition is a preexisting condition exclusion because it operates to limit benefits for a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 5. (i) *Facts.* When an individual's coverage begins under a group health plan, the individual generally becomes eligible for all benefits. However, benefits for pregnancy are not available until the individual has been covered under the plan for 12 months.

(ii) *Conclusion.* In this *Example 5*, the requirement to be covered under the plan for 12 months to be eligible for pregnancy benefits is a subterfuge for a preexisting condition exclusion because it is designed to exclude benefits for a condition (pregnancy) that arose before the effective date of coverage. Because a plan is prohibited under paragraph (b)(5) of this section from imposing any preexisting condition exclusion on pregnancy, the plan provision is prohibited. However, if the plan provision included an exception for women who were pregnant before the effective date of coverage under the plan (so that the provision applied only to women who became pregnant on or after the effective date of coverage) the plan provision would not be a preexisting condition exclusion (and would not be prohibited by paragraph (b)(5) of this section).