

tax under chapter 43 of subtitle D of the Internal Revenue Code (relating to qualified pension, etc., plans), the transaction must be disclosed in the manner stated in such published guidance.

(b) *Effective date.* This section applies to transactions entered into on or after January 1, 2003.

[T.D. 9046, 68 FR 10170, Mar. 4, 2003]

**§ 54.9801-1 Basis and scope.**

(a) *Statutory basis.* Sections 54.9801-1 through 54.9801-6, 54.9802-1, 54.9802-1T, 54.9811-1T, 54.9812-1T, 54.9831-1, and 54.9833-1 (portability sections) implement Chapter 100 of Subtitle K of the Internal Revenue Code of 1986.

(b) *Scope.* A group health plan may provide greater rights to participants and beneficiaries than those set forth in these portability sections. These portability sections set forth minimum requirements for group health plans concerning:

(1) Limitations on a preexisting condition exclusion period.

(2) Certificates and disclosure of previous coverage.

(3) Rules relating to creditable coverage.

(4) Special enrollment periods.

(5) Prohibition against discrimination on the basis of health factors.

(c) *Similar requirements under the Employee Retirement Income Security Act and the Public Health Service Act.* Sections 701, 702, 703, 711, 712, 732, and 733 of the Employee Retirement Income Security Act of 1974 and sections 2701, 2702, 2704, 2705, 2721, and 2791 of the Public Health Service Act impose requirements similar to those imposed under Chapter 100 of Subtitle K with respect to health insurance issuers offering group health insurance coverage. See 29 CFR part 2590 and 45 CFR parts 144, 146, and 148. See also part B of Title XXVII of the Public Health Service Act and 45 CFR part 148 for other rules applicable to health insurance offered in the individual market (defined in § 54.9801-2).

[T.D. 9166, 69 FR 78746, Dec. 30, 2004]

**§ 54.9801-2 Definitions.**

Unless otherwise provided, the definitions in this section govern in applying

the provisions of §§ 54.9801-1 through 54.9801-6, 54.9802-1, 54.9802-1T, 54.9811-1T, 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.