end for the alternate recipient(s) when similarly situated dependents are no longer eligible for coverage under the terms of the plan, or upon the occurrence of certain specified events.

(d) (1) Under ERISA section 609(a)(4), a qualified medical child support order may not require a plan to provide any type or form of benefit, or any option, not otherwise provided under the plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in section 1908 of the Social Security Act, 42 U.S.C. 1396g–1.

(2) The Notice satisfies the conditions of ERISA section 609(a)(4) because it requires the plan to provide to an alternate recipient only those benefits that the plan provides to any dependent of a participant who is enrolled in the plan, and any other benefits that are necessary to meet the requirements of a State law described in such section 1908.

(e) For the purposes of this section, an “Issuing Agency” is a State agency that administers the child support enforcement program under Part D of Title IV of the Social Security Act.

[65 FR 82142, Dec. 27, 2000]

Subpart B—Health Coverage Portability, Nondiscrimination, and Renewability


§ 2590.701–1 Basis and scope.

(a) Statutory basis. This Subpart B implements Part 7 of Subtitle B of Title I of the Employee Retirement Income Security Act of 1974, as amended (hereinafter ERISA or the Act).

(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 this Subpart B. This Subpart B sets forth minimum requirements for group health plans and health insurance issuers offering group health insurance coverage concerning:

(1) Limitations on a preexisting condition exclusion period.

(2) Certificates and disclosure of previous coverage.

(3) Rules relating to counting creditable coverage.

(4) Special enrollment periods.

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

(6) Additional requirements prohibiting discrimination based on genetic information.

(7) Use of an affiliation period by an HMO as an alternative to a preexisting condition exclusion.


§ 2590.701–2 Definitions.

Unless otherwise provided, the definitions in this section govern in applying the provisions of §§2590.701 through 2590.734.

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 sections 601–608 of the Act, section 4980B of the Internal Revenue Code (other than paragraph (f)(1) of such section 4980B insofar as it relates to pediatric vaccines), 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 avail-
able to the individual; or
(iii) When the individual incurs a
claim that would meet or exceed a life-
time 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
§ 2590.701–4(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 partici-
pant.

Enroll means to become covered for
benefits under a group health plan
(that is, when coverage becomes effec-
tive), without regard to when the indi-
vidual may have completed or filed any
forms that are required in order to be-
come 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 be-
comes covered as a result of an election
by a participant, or the individual be-
comes covered without an election.

Enrollment date definitions (enrollment
data, first day of coverage, and waiting
period) are set forth in § 2590.701–3(a)(3)(i), (ii), and (iii).

Excepted benefits means the benefits
described as excepted in § 2590.732(c).

Genetic information has the meaning
given the term in § 2590.702–1(a)(3) of
this Part.

Group health insurance coverage
means health insurance coverage of-
ered in connection with a group health plan.

Group health plan or plan means a
group health plan within the meaning of
§ 2590.732(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 indi-
vidual market, rather than the group
market; see the definition of individual
market in this section.)

Health insurance coverage means bene-
fits consisting of medical care (pro-
vided directly, through insurance or re-
imbursement, 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 In-
surance coverage includes group health
insurance coverage, individual health
insurance coverage, and short-term,
limited-duration insurance.

Health insurance issuer or issuer means
an insurance company, insurance serv-
ices, or insurance organization (includ-
ing an HMO) that is required to be li-
censed to engage in the business of in-
surance in a State and that is subject
to State law that regulates insurance
(within the meaning of section 514(b)(2)
of the Act). Such term does not include
a group health plan.

Health maintenance organization or
HMO means—
(1) A federally qualified health main-
tenance organization (as defined in sec-
tion 1301(a) of the PHS Act);
(2) An organization recognized under
State law as a health maintenance or-
ganization; 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 organiza-
tion.

Individual health insurance coverage
means health insurance coverage of-
ered to individuals in the individual
market, but does not include short-
term, limited-duration insurance. Indi-
vidual 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 employ-
ees on the first day of the plan year.

Internal Revenue Code means the In-
ternal Revenue Code of 1986, as amend-
ed (Title 26, United States Code).

Issuer means a health insurance issuer.
Late enrollment definitions (late enrollee and late enrollment) are set forth in §2590.701-3(a)(3)(v) and (vi).

Medical care means amounts paid for—
(1) The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;
(2) Transportation primarily for and essential to medical care referred to in paragraph (1) of this definition; and
(3) Insurance covering medical care referred to in paragraphs (1) and (2) of this definition.

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 the Act.

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 preexisting condition exclusion within the meaning of §2590.701-3(a)(1).

Public health plan means public health plan within the meaning of §2590.701-4(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 §2590.701-4(b)(2)(iii).

Special enrollment means enrollment in a group health plan or group health insurance coverage under the rights described in §2590.701-6.

State means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

State health benefits risk pool means a State health benefits risk pool within the meaning of §2590.701-4(a)(1)(vii).

Waiting period means waiting period within the meaning of §2590.701-3(a)(3)(iii).


EFFECTIVE DATE NOTE: At 75 FR 37229, June 28, 2010, §2590.701-2 was amended by revising the definition of preexisting condition exclusion, effective Aug. 27, 2010. For the convenience of the user, the revised text is set forth as follows:

§2590.701-2 Definitions.

* * * * *

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.

* * * * *

§ 2590.701-3 Limitations on preexisting condition exclusion period.

(a) Preexisting condition exclusion—

(1) Defined—

(i) A preexisting condition exclusion means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage under a group health plan or group health insurance coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day.

(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 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