

- (iv) Dental care; or
- (v) Vision care.

(4) *Plan notice.* If the alternative method is used, the plan is required to—

(i) State prominently that the plan is using the alternative method of counting creditable coverage in disclosure statements concerning the plan, and state this to each enrollee at the time of enrollment under the plan; and

(ii) Include in these statements a description of the effect of using the alternative method, including an identification of the categories used.

(5) *Disclosure of information on previous benefits.* See § 2590.701-5(b) for special rules concerning disclosure of coverage to a plan, or issuer, using the alternative method of counting creditable coverage under this paragraph (c).

(6) *Counting creditable coverage—(i) In general.* Under the alternative method, the group health plan or issuer counts creditable coverage within a category if any level of benefits is provided within the category. Coverage under a reimbursement account or arrangement, such as a flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code), does not constitute coverage within any category.

(ii) *Special rules.* In counting an individual's creditable coverage under the alternative method, the group health plan, or issuer, first determines the amount of the individual's creditable coverage that may be counted under paragraph (b) of this section, up to a total of 365 days of the most recent creditable coverage (546 days for a late enrollee). The period over which this creditable coverage is determined is referred to as the determination period. Then, for the category specified under the alternative method, the plan or issuer counts within the category all days of coverage that occurred during the determination period (whether or not a significant break in coverage for that category occurs), and reduces the individual's preexisting condition exclusion period for that category by that number of days. The plan or issuer may determine the amount of creditable coverage in any other reasonable

manner, uniformly applied, that is at least as favorable to the individual.

(iii) *Example.* The rules of this paragraph (c)(6) are illustrated by the following example:

Example. (i) *Facts.* Individual *D* enrolls in Employer *V*'s plan on January 1, 2001. Coverage under the plan includes prescription drug benefits. On April 1, 2001, the plan ceases providing prescription drug benefits. *D*'s employment with Employer *V* ends on January 1, 2002, after *D* was covered under Employer *V*'s group health plan for 365 days. *D* enrolls in Employer *Y*'s plan on February 1, 2002 (*D*'s enrollment date). Employer *Y*'s plan uses the alternative method of counting creditable coverage and imposes a 12-month preexisting condition exclusion on prescription drug benefits.

(ii) *Conclusion.* In this *Example*, Employer *Y*'s plan may impose a 275-day preexisting condition exclusion with respect to *D* for prescription drug benefits because *D* had 90 days of creditable coverage relating to prescription drug benefits within *D*'s determination period.

[69 FR 78763, Dec. 30, 2004]

§ 2590.701-5 Evidence of creditable coverage.

(a) *Certificate of creditable coverage—*

(1) *Entities required to provide certificate—(i) In general.* A group health plan, and each health insurance issuer offering group health insurance coverage under a group health plan, is required to furnish certificates of creditable coverage in accordance with this paragraph (a).

(ii) *Duplicate certificates not required.* An entity required to provide a certificate under this paragraph (a) with respect to an individual satisfies that requirement if another party provides the certificate, but only to the extent that the certificate contains the information required in paragraph (a)(3) of this section. For example, in the case of a group health plan funded through an insurance policy, the issuer satisfies the certification requirement with respect to an individual if the plan actually provides a certificate that includes all the information required under paragraph (a)(3) of this section with respect to the individual.

(iii) *Special rule for group health plans.* To the extent coverage under a plan

consists of group health insurance coverage, the plan satisfies the certification requirements under this paragraph (a) if any issuer offering the coverage is required to provide the certificates pursuant to an agreement between the plan and the issuer. For example, if there is an agreement between an issuer and a plan sponsor under which the issuer agrees to provide certificates for individuals covered under the plan, and the issuer fails to provide a certificate to an individual when the plan would have been required to provide one under this paragraph (a), then the issuer, but not the plan, violates the certification requirements of this paragraph (a).

(iv) *Special rules for issuers—(A)(1) Responsibility of issuer for coverage period.* An issuer is not required to provide information regarding coverage provided to an individual by another party.

(2) *Example.* The rule of this paragraph (a)(1)(iv)(A) is illustrated by the following example:

Example. (i) Facts. A plan offers coverage with an HMO option from one issuer and an indemnity option from a different issuer. The HMO has not entered into an agreement with the plan to provide certificates as permitted under paragraph (a)(1)(iii) of this section.

(ii) *Conclusion.* In this *Example*, if an employee switches from the indemnity option to the HMO option and later ceases to be covered under the plan, any certificate provided by the HMO is not required to provide information regarding the employee's coverage under the indemnity option.

(B)(1) *Cessation of issuer coverage prior to cessation of coverage under a plan.* If an individual's coverage under an issuer's policy or contract ceases before the individual's coverage under the plan ceases, the issuer is required to provide sufficient information to the plan (or to another party designated by the plan) to enable the plan (or other party), after cessation of the individual's coverage under the plan, to provide a certificate that reflects the period of coverage under the policy or contract. By providing that information to the plan, the issuer satisfies its obligation to provide an automatic certificate for that period of creditable coverage with respect to the individual under paragraph (a)(2)(ii) of this section. The issuer, however, must still

provide a certificate upon request as required under paragraph (a)(2)(iii) of this section. In addition, the issuer is required to cooperate with the plan in responding to any request made under paragraph (b)(2) of this section (relating to the alternative method of counting creditable coverage). Moreover, if the individual's coverage under the plan ceases at the time the individual's coverage under the issuer's policy or contract ceases, the issuer must still provide an automatic certificate under paragraph (a)(2)(ii) of this section. If an individual's coverage under an issuer's policy or contract ceases on the effective date for changing enrollment options under the plan, the issuer may presume (absent information to the contrary) that the individual's coverage under the plan continues. Therefore, the issuer is required to provide information to the plan in accordance with this paragraph (a)(1)(iv)(B)(1) (and is not required to provide an automatic certificate under paragraph (a)(2)(ii) of this section).

(2) *Example.* The rule of this paragraph (a)(1)(iv)(B) is illustrated by the following example:

Example. (i) Facts. A group health plan provides coverage under an HMO option and an indemnity option through different issuers, and only allows employees to switch on each January 1. Neither the HMO nor the indemnity issuer has entered into an agreement with the plan to provide certificates as permitted under paragraph (a)(1)(iii) of this section.

(ii) *Conclusion.* In this *Example*, if an employee switches from the indemnity option to the HMO option on January 1, the indemnity issuer must provide the plan (or a person designated by the plan) with appropriate information with respect to the individual's coverage with the indemnity issuer. However, if the individual's coverage with the indemnity issuer ceases at a date other than January 1, the issuer is instead required to provide the individual with an automatic certificate.

(2) *Individuals for whom certificate must be provided; timing of issuance—(i) Individuals.* A certificate must be provided, without charge, for participants or dependents who are or were covered under a group health plan upon the occurrence of any of the events described in paragraph (a)(2)(ii) or (iii) of this section.

(ii) *Issuance of automatic certificates.* The certificates described in this paragraph (a)(2)(ii) are referred to as automatic certificates.

(A) *Qualified beneficiaries upon a qualifying event.* In the case of an individual who is a qualified beneficiary (as defined in section 607(3) of the Act) entitled to elect COBRA continuation coverage, an automatic certificate is required to be provided at the time the individual would lose coverage under the plan in the absence of COBRA continuation coverage or alternative coverage elected instead of COBRA continuation coverage. A plan or issuer satisfies this requirement if it provides the automatic certificate no later than the time a notice is required to be furnished for a qualifying event under section 606 of the Act (relating to notices required under COBRA).

(B) *Other individuals when coverage ceases.* In the case of an individual who is not a qualified beneficiary entitled to elect COBRA continuation coverage, an automatic certificate must be provided at the time the individual ceases to be covered under the plan. A plan or issuer satisfies the requirement to provide an automatic certificate at the time the individual ceases to be covered if it provides the automatic certificate within a reasonable time after coverage ceases (or after the expiration of any grace period for nonpayment of premiums).

(1) The cessation of temporary continuation coverage (TCC) under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefit Program) is a cessation of coverage upon which an automatic certificate must be provided.

(2) In the case of an individual who is entitled to elect to continue coverage under a State program similar to COBRA and who receives the automatic certificate not later than the time a notice is required to be furnished under the State program, the certificate is deemed to be provided within a reasonable time after coverage ceases under the plan.

(3) If an individual's coverage ceases due to the operation of a lifetime limit on all benefits, coverage is considered to cease for purposes of this paragraph (a)(2)(ii)(B) on the earliest date that a

claim is denied due to the operation of the lifetime limit.

(C) *Qualified beneficiaries when COBRA ceases.* In the case of an individual who is a qualified beneficiary and has elected COBRA continuation coverage (or whose coverage has continued after the individual became entitled to elect COBRA continuation coverage), an automatic certificate is to be provided at the time the individual's coverage under the plan ceases. A plan, or issuer, satisfies this requirement if it provides the automatic certificate within a reasonable time after coverage ceases (or after the expiration of any grace period for nonpayment of premiums). An automatic certificate is required to be provided to such an individual regardless of whether the individual has previously received an automatic certificate under paragraph (a)(2)(ii)(A) of this section.

(iii) *Any individual upon request.* A certificate must be provided in response to a request made by, or on behalf of, an individual at any time while the individual is covered under a plan and up to 24 months after coverage ceases. Thus, for example, a plan in which an individual enrolls may, if authorized by the individual, request a certificate of the individual's creditable coverage on behalf of the individual from a plan in which the individual was formerly enrolled. After the request is received, a plan or issuer is required to provide the certificate by the earliest date that the plan or issuer, acting in a reasonable and prompt fashion, can provide the certificate. A certificate is required to be provided under this paragraph (a)(2)(iii) even if the individual has previously received a certificate under this paragraph (a)(2)(iii) or an automatic certificate under paragraph (a)(2)(ii) of this section.

(iv) *Examples.* The rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual A terminates employment with Employer Q. A is a qualified beneficiary entitled to elect COBRA continuation coverage under Employer Q's group health plan. A notice of the rights provided under COBRA is typically furnished to qualified beneficiaries under the plan within 10 days after a covered employee terminates employment.

(ii) *Conclusion.* In this *Example 1*, the automatic certificate may be provided at the same time that *A* is provided the COBRA notice.

Example 2. (i) *Facts.* Same facts as *Example 1*, except that the automatic certificate for *A* is not completed by the time the COBRA notice is furnished to *A*.

(ii) *Conclusion.* In this *Example 2*, the automatic certificate may be provided after the COBRA notice but must be provided within the period permitted by law for the delivery of notices under COBRA.

Example 3. (i) *Facts.* Employer *R* maintains an insured group health plan. *R* has never had 20 employees and thus *R*'s plan is not subject to the COBRA continuation provisions. However, *R* is in a State that has a State program similar to COBRA. *B* terminates employment with *R* and loses coverage under *R*'s plan.

(ii) *Conclusion.* In this *Example 3*, the automatic certificate must be provided not later than the time a notice is required to be furnished under the State program.

Example 4. (i) *Facts.* Individual *C* terminates employment with Employer *S* and receives both a notice of *C*'s rights under COBRA and an automatic certificate. *C* elects COBRA continuation coverage under Employer *S*'s group health plan. After four months of COBRA continuation coverage and the expiration of a 30-day grace period, *S*'s group health plan determines that *C*'s COBRA continuation coverage has ceased due to a failure to make a timely payment for continuation coverage.

(ii) *Conclusion.* In this *Example 4*, the plan must provide an updated automatic certificate to *C* within a reasonable time after the end of the grace period.

Example 5. (i) *Facts.* Individual *D* is currently covered under the group health plan of Employer *T*. *D* requests a certificate, as permitted under paragraph (a)(2)(iii) of this section. Under the procedure for *T*'s plan, certificates are mailed (by first class mail) 7 business days following receipt of the request. This date reflects the earliest date that the plan, acting in a reasonable and prompt fashion, can provide certificates.

(ii) *Conclusion.* In this *Example 5*, the plan's procedure satisfies paragraph (a)(2)(iii) of this section.

(3) *Form and content of certificate—(i) Written certificate—(A) In general.* Except as provided in paragraph (a)(3)(i)(B) of this section, the certificate must be provided in writing (or any other medium approved by the Secretary).

(B) *Other permissible forms.* No written certificate is required to be provided under this paragraph (a) with respect to a particular event described in para-

graph (a)(2)(ii) or (iii) of this section, if—

(1) An individual who is entitled to receive the certificate requests that the certificate be sent to another plan or issuer instead of to the individual;

(2) The plan or issuer that would otherwise receive the certificate agrees to accept the information in this paragraph (a)(3) through means other than a written certificate (such as by telephone); and

(3) The receiving plan or issuer receives the information from the sending plan or issuer through such means within the time required under paragraph (a)(2) of this section.

(ii) *Required information.* The certificate must include the following—

(A) The date the certificate is issued;

(B) The name of the group health plan that provided the coverage described in the certificate;

(C) The name of the participant or dependent with respect to whom the certificate applies, and any other information necessary for the plan providing the coverage specified in the certificate to identify the individual, such as the individual's identification number under the plan and the name of the participant if the certificate is for (or includes) a dependent;

(D) The name, address, and telephone number of the plan administrator or issuer required to provide the certificate;

(E) The telephone number to call for further information regarding the certificate (if different from paragraph (a)(3)(ii)(D) of this section);

(F) Either—

(1) A statement that an individual has at least 18 months (for this purpose, 546 days is deemed to be 18 months) of creditable coverage, disregarding days of creditable coverage before a significant break in coverage, or

(2) The date any waiting period (and affiliation period, if applicable) began and the date creditable coverage began;

(G) The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing as of the date of the certificate; and

(H) An educational statement regarding HIPAA, which explains:

(1) The restrictions on the ability of a plan or issuer to impose a preexisting condition exclusion (including an individual's ability to reduce a preexisting condition exclusion by creditable coverage);

(2) Special enrollment rights;

(3) The prohibitions against discrimination based on any health factor;

(4) The right to individual health coverage;

(5) The fact that state law may require issuers to provide additional protections to individuals in that State; and

(6) Where to get more information.

(iii) *Periods of coverage under the certificate.* If an automatic certificate is provided pursuant to paragraph (a)(2)(ii) of this section, the period that must be included on the certificate is the last period of continuous coverage ending on the date coverage ceased. If an individual requests a certificate pursuant to paragraph (a)(2)(iii) of this section, the certificate provided must include each period of continuous coverage ending within the 24-month period ending on the date of the request (or continuing on the date of the request). A separate certificate may be provided for each such period of continuous coverage.

(iv) *Combining information for families.* A certificate may provide information with respect to both a participant and the participant's dependents if the information is identical for each individual. If the information is not identical, certificates may be provided on one form if the form provides all the required information for each individual and separately states the information that is not identical.

(v) *Model certificate.* The requirements of paragraph (a)(3)(ii) of this section are satisfied if the plan or issuer provides a certificate in accordance with a model certificate authorized by the Secretary.

(vi) *Excepted benefits; categories of benefits.* No certificate is required to be furnished with respect to excepted benefits described in § 2590.732(c). In addition, the information in the certificate regarding coverage is not required to specify categories of benefits described in § 2590.701-4(c) (relating to the alternative method of counting creditable

coverage). However, if excepted benefits are provided concurrently with other creditable coverage (so that the coverage does not consist solely of excepted benefits), information concerning the benefits may be required to be disclosed under paragraph (b) of this section.

(4) *Procedures*—(i) *Method of delivery.* The certificate is required to be provided to each individual described in paragraph (a)(2) of this section or an entity requesting the certificate on behalf of the individual. The certificate may be provided by first-class mail. (See also § 2520.104b-1, which permits plans to make disclosures under the Act—including the furnishing of certificates—through electronic means if certain standards are met.) If the certificate or certificates are provided to the participant and the participant's spouse at the participant's last known address, then the requirements of this paragraph (a)(4) are satisfied with respect to all individuals residing at that address. If a dependent's last known address is different than the participant's last known address, a separate certificate is required to be provided to the dependent at the dependent's last known address. If separate certificates are being provided by mail to individuals who reside at the same address, separate mailings of each certificate are not required.

(ii) *Procedure for requesting certificates.* A plan or issuer must establish a written procedure for individuals to request and receive certificates pursuant to paragraph (a)(2)(iii) of this section. The written procedure must include all contact information necessary to request a certificate (such as name and phone number or address).

(iii) *Designated recipients.* If an automatic certificate is required to be provided under paragraph (a)(2)(ii) of this section, and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the plan or issuer responsible for providing the certificate is permitted to provide the certificate to the designated individual or entity. If a certificate is required to be provided upon request under paragraph

(a)(2)(iii) of this section and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the plan or issuer responsible for providing the certificate is required to provide the certificate to the designated individual or entity.

(5) *Special rules concerning dependent coverage—(i)(A) Reasonable efforts.* A plan or issuer is required to use reasonable efforts to determine any information needed for a certificate relating to dependent coverage. In any case in which an automatic certificate is required to be furnished with respect to a dependent under paragraph (a)(2)(ii) of this section, no individual certificate is required to be furnished until the plan or issuer knows (or making reasonable efforts should know) of the dependent's cessation of coverage under the plan.

(B) *Example.* The rules of this paragraph (a)(5)(i) are illustrated by the following example:

Example. (i) *Facts.* A group health plan covers employees and their dependents. The plan annually requests all employees to provide updated information regarding dependents, including the specific date on which an employee has a new dependent or on which a person ceases to be a dependent of the employee.

(ii) *Conclusion.* In this *Example*, the plan has satisfied the standard in this paragraph (a)(5)(i) of this section that it make reasonable efforts to determine the cessation of dependents' coverage and the related dependent coverage information.

(ii) *Special rules for demonstrating coverage.* If a certificate furnished by a plan or issuer does not provide the name of any dependent covered by the certificate, the procedures described in paragraph (c)(5) of this section may be used to demonstrate dependent status. In addition, these procedures may be used to demonstrate that a child was covered under any creditable coverage within 30 days after birth, adoption, or placement for adoption. *See also* § 2590.701-3(b), under which such a child cannot be subject to a preexisting condition exclusion.

(6) *Special certification rules for entities not subject to Part 7 of Subtitle B of Title I of the Act—(i) Issuers.* For special rules requiring that issuers not subject to Part 7 of Subtitle B of Title I of the Act provide certificates consistent

with the rules in this section, including issuers offering coverage with respect to creditable coverage described in sections 701(c)(1)(G), (I), and (J) of the Act (coverage under a State health benefits risk pool, a public health plan, and a health benefit plan under section 5(e) of the Peace Corps Act), see sections 2743 and 2721(b)(1)(B) of the PHS Act (requiring certificates by issuers in the individual market, and issuers offering health insurance coverage in connection with a group health plan, including a church plan or a governmental plan (such as the Federal Employees Health Benefits Program (FEHBP)). (However, this section does not require a certificate to be provided with respect to short-term, limited-duration insurance, as described in the definition of *individual health insurance coverage* in § 2590.701-2, that is not provided by a group health plan or issuer offering health insurance coverage in connection with a group health plan.)

(ii) *Other entities.* For special rules requiring that certain other entities not subject to Part 7 of Subtitle B of Title I of the Act provide certificates consistent with the rules in this section, see section 2791(a)(3) of the PHS Act applicable to entities described in sections 2701(c)(1)(C), (D), (E), and (F) of the PHS Act (relating to Medicare, Medicaid, TRICARE, and Indian Health Service), section 2721(b)(1)(A) of the PHS Act applicable to nonfederal governmental plans generally, section 2721(b)(2)(C)(ii) of the PHS Act applicable to nonfederal governmental plans that elect to be excluded from the requirements of Subparts 1 through 3 of Part A of Title XXVII of the PHS Act, and section 9832(a) of the Internal Revenue Code applicable to group health plans, which includes church plans (as defined in section 414(e) of the Internal Revenue Code).

(b) *Disclosure of coverage to a plan or issuer using the alternative method of counting creditable coverage—(1) In general.* After an individual provides a certificate of creditable coverage to a plan or issuer using the alternative method under § 2590.701-4(c), that plan or issuer (requesting entity) must request that the entity that issued the certificate (prior entity) disclose the information

set forth in paragraph (b)(2) of this section. The prior entity is required to disclose this information promptly.

(2) *Information to be disclosed.* The prior entity is required to identify to the requesting entity the categories of benefits with respect to which the requesting entity is using the alternative method of counting creditable coverage, and the requesting entity may identify specific information that the requesting entity reasonably needs in order to determine the individual's creditable coverage with respect to any such category.

(3) *Charge for providing information.* The prior entity may charge the requesting entity for the reasonable cost of disclosing such information.

(c) *Ability of an individual to demonstrate creditable coverage and waiting period information—(1) Purpose.* The rules in this paragraph (c) implement section 701(c)(4) of the Act, which permits individuals to demonstrate the duration of creditable coverage through means other than certificates, and section 701(e)(3) of the Act, which requires the Secretary to establish rules designed to prevent an individual's subsequent coverage under a group health plan or health insurance coverage from being adversely affected by an entity's failure to provide a certificate with respect to that individual.

(2) *In general.* If the accuracy of a certificate is contested or a certificate is unavailable when needed by an individual, the individual has the right to demonstrate creditable coverage (and waiting or affiliation periods) through the presentation of documents or other means. For example, the individual may make such a demonstration when—

(i) An entity has failed to provide a certificate within the required time;

(ii) The individual has creditable coverage provided by an entity that is not required to provide a certificate of the coverage pursuant to paragraph (a) of this section;

(iii) The individual has an urgent medical condition that necessitates a determination before the individual can deliver a certificate to the plan; or

(iv) The individual lost a certificate that the individual had previously re-

ceived and is unable to obtain another certificate.

(3) *Evidence of creditable coverage—(i) Consideration of evidence—(A)* A plan or issuer is required to take into account all information that it obtains or that is presented on behalf of an individual to make a determination, based on the relevant facts and circumstances, whether an individual has creditable coverage. A plan or issuer shall treat the individual as having furnished a certificate under paragraph (a) of this section if—

(1) The individual attests to the period of creditable coverage;

(2) The individual also presents relevant corroborating evidence of some creditable coverage during the period; and

(3) The individual cooperates with the plan's or issuer's efforts to verify the individual's coverage.

(B) For purposes of this paragraph (c)(3)(i), cooperation includes providing (upon the plan's or issuer's request) a written authorization for the plan or issuer to request a certificate on behalf of the individual, and cooperating in efforts to determine the validity of the corroborating evidence and the dates of creditable coverage. While a plan or issuer may refuse to credit coverage where the individual fails to cooperate with the plan's or issuer's efforts to verify coverage, the plan or issuer may not consider an individual's inability to obtain a certificate to be evidence of the absence of creditable coverage.

(ii) *Documents.* Documents that corroborate creditable coverage (and waiting or affiliation periods) include explanations of benefits (EOBs) or other correspondence from a plan or issuer indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, a certificate of coverage under a group health policy, records from medical care providers indicating health coverage, third party statements verifying periods of coverage, and any other relevant documents that evidence periods of health coverage.

(iii) *Other evidence.* Creditable coverage (and waiting or affiliation periods) may also be corroborated through means other than documentation, such as by a telephone call from the plan or

provider to a third party verifying creditable coverage.

(iv) *Example.* The rules of this paragraph (c)(3) are illustrated by the following example:

Example. (i) *Facts.* Individual *F* terminates employment with Employer *W* and, a month later, is hired by Employer *X*. *X*'s group health plan imposes a preexisting condition exclusion of 12 months on new enrollees under the plan and uses the standard method of determining creditable coverage. *F* fails to receive a certificate of prior coverage from the self-insured group health plan maintained by *F*'s prior employer, *W*, and requests a certificate. However, *F* (and *X*'s plan, on *F*'s behalf and with *F*'s cooperation) is unable to obtain a certificate from *W*'s plan. *F* attests that, to the best of *F*'s knowledge, *F* had at least 12 months of continuous coverage under *W*'s plan, and that the coverage ended no earlier than *F*'s termination of employment from *W*. In addition, *F* presents evidence of coverage, such as an explanation of benefits for a claim that was made during the relevant period.

(ii) *Conclusion.* In this *Example*, based solely on these facts, *F* has demonstrated creditable coverage for the 12 months of coverage under *W*'s plan in the same manner as if *F* had presented a written certificate of creditable coverage.

(4) *Demonstrating categories of creditable coverage.* Procedures similar to those described in this paragraph (c) apply in order to determine the duration of an individual's creditable coverage with respect to any category under paragraph (b) of this section (relating to determining creditable coverage under the alternative method).

(5) *Demonstrating dependent status.* If, in the course of providing evidence (including a certificate) of creditable coverage, an individual is required to demonstrate dependent status, the group health plan or issuer is required to treat the individual as having furnished a certificate showing the dependent status if the individual attests to such dependency and the period of such status and the individual cooperates with the plan's or issuer's efforts to verify the dependent status.

[69 FR 78763, Dec. 30, 2004]

§ 2590.701-6 Special enrollment periods.

(a) *Special enrollment for certain individuals who lose coverage—(1) In general.* A group health plan, and a health in-

surance issuer offering health insurance coverage in connection with a group health plan, is required to permit current employees and dependents (as defined in § 2590.701-2) who are described in paragraph (a)(2) of this section to enroll for coverage under the terms of the plan if the conditions in paragraph (a)(3) of this section are satisfied. The special enrollment rights under this paragraph (a) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan.

(2) *Individuals eligible for special enrollment—(i) When employee loses coverage.* A current employee and any dependents (including the employee's spouse) each are eligible for special enrollment in any benefit package under the plan (subject to plan eligibility rules conditioning dependent enrollment on enrollment of the employee) if—

(A) The employee and the dependents are otherwise eligible to enroll in the benefit package;

(B) When coverage under the plan was previously offered, the employee had coverage under any group health plan or health insurance coverage; and

(C) The employee satisfies the conditions of paragraph (a)(3)(i), (ii), or (iii) of this section and, if applicable, paragraph (a)(3)(iv) of this section.

(ii) *When dependent loses coverage—(A)* A dependent of a current employee (including the employee's spouse) and the employee each are eligible for special enrollment in any benefit package under the plan (subject to plan eligibility rules conditioning dependent enrollment on enrollment of the employee) if—

(1) The dependent and the employee are otherwise eligible to enroll in the benefit package;

(2) When coverage under the plan was previously offered, the dependent had coverage under any group health plan or health insurance coverage; and

(3) The dependent satisfies the conditions of paragraph (a)(3)(i), (ii), or (iii) of this section and, if applicable, paragraph (a)(3)(iv) of this section.

(B) However, the plan or issuer is not required to enroll any other dependent unless that dependent satisfies the criteria of this paragraph (a)(2)(ii), or the