SUBCHAPTER L—GROUP HEALTH PLANS

PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLANS

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SOURCE: 62 FR 16941, Apr. 8, 1997, unless otherwise noted.

Subpart A—Continuation Coverage, Qualified Medical Child Support Orders, Coverage for Adopted Children

§ 2590.606–1 General notice of continuation coverage.

(a) General. Pursuant to section 606(a)(1) of the Employee Retirement Income Security Act of 1974, as amended (the Act), the administrator of a group health plan subject to the continuation coverage requirements of part 6 of title I of the Act shall provide, in accordance with this section, written notice to each covered employee and spouse of the covered employee (if any) of the right to continuation coverage provided under the plan.

(b) Timing of notice. (1) The notice required by paragraph (a) of this section shall be furnished to each employee...
and each employee’s spouse, not later than the earlier of:

(i) The date that is 90 days after the date on which such individual’s coverage under the plan commences, or, if later, the date that is 90 days after the date on which the plan first becomes subject to the continuation coverage requirements; or

(ii) The first date on which the administrator is required, pursuant to §2590.606–4(b), to furnish the covered employee, spouse, or dependent child of such employee notice of a qualified beneficiary’s right to elect continuation coverage.

(2) A notice that is furnished in accordance with paragraph (b)(1) of this section shall, for purposes of section 606(a)(1) of the Act, be deemed to be provided at the time of commencement of coverage under the plan.

(3) In any case in which an administrator is required to furnish a notice to a covered employee or spouse pursuant to paragraph (b)(1)(ii) of this section, the furnishing of a notice to such individual in accordance with §2590.606–4(b) shall be deemed to satisfy the requirements of this section.

(c) Content of notice. The notice required by paragraph (a) of this section shall be written in a manner calculated to be understood by the average plan participant and shall contain the following information:

(1) The name of the plan under which continuation coverage is available, and the name, address and telephone number of a party or parties from whom additional information about the plan and continuation coverage can be obtained;

(2) A general description of the continuation coverage under the plan, including identification of the classes of individuals who may become qualified beneficiaries, the types of qualifying events that may give rise to the right to continuation coverage, the obligation of the employer to notify the plan administrator of the occurrence of certain qualifying events, the maximum period for which continuation coverage may be available, when and under what circumstances continuation coverage may be extended beyond the applicable maximum period, and the plan’s requirements applicable to the payment of premiums for continuation coverage;

(3) An explanation of the plan’s requirements regarding the responsibility of a qualified beneficiary to notify the administrator of a qualifying event that is a divorce, legal separation, or a child’s ceasing to be a dependent under the terms of the plan, and a description of the plan’s procedures for providing such notice;

(4) An explanation of the plan’s requirements regarding the responsibility of qualified beneficiaries who are receiving continuation coverage to provide notice to the administrator of a determination by the Social Security Administration, under title II or XVI of the Social Security Act (42 U.S.C. 401 et seq. or 1381 et seq.), that a qualified beneficiary is disabled, and a description of the plan’s procedures for providing such notice;

(5) An explanation of the importance of keeping the administrator informed of the current addresses of all participants or beneficiaries under the plan who are or may become qualified beneficiaries; and

(6) A statement that the notice does not fully describe continuation coverage or other rights under the plan and that more complete information regarding such rights is available from the plan administrator and in the plan’s SPD.

(d) Single notice rule. A plan administrator may satisfy the requirement to provide notice in accordance with this section to a covered employee and the covered employee’s spouse by furnishing a single notice addressed to both the covered employee and the covered employee’s spouse, if, on the basis of the most recent information available to the plan, the covered employee’s spouse resides at the same location as the covered employee, and the spouse’s coverage under the plan commences on or after the date on which the covered employee’s coverage commences, but not later than the date on which the notice required by this section is required to be provided to the covered employee. Nothing in this section shall be construed to create a requirement to provide a separate notice to dependent children who share a residence with a covered employee or a
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covered employee’s spouse to whom notice is provided in accordance with this section.

(e) Notice in summary plan description. A plan administrator may satisfy the requirement to provide notice in accordance with this section by including the information described in paragraphs (c)(1), (2), (3), (4), and (5) of this section in a summary plan description meeting the requirements of § 2520.102-3 of this chapter furnished in accordance with paragraph (b) of this section.

(f) Delivery of notice. The notice required by this section shall be furnished in a manner consistent with the requirements of § 2520.104b-1 of this chapter, including paragraph (c) of that section relating to the use of electronic media.

(g) Model notice. The appendix to this section contains a model notice that is intended to assist administrators in discharging the notice obligations of this section. Use of the model notice is not mandatory. The model notice reflects the requirements of this section as they would apply to single-employer group health plans and must be modified if used to provide notice with respect to other types of group health plans, such as multiemployer plans or plans established and maintained by employee organizations for their members. In order to use the model notice, administrators must appropriately add relevant information where indicated in the model notice, select among alternative language, and supplement the model notice to reflect applicable plan provisions. Items of information that are not applicable to a particular plan may be deleted. Use of the model notice, appropriately modified and supplemented, will be deemed to satisfy the notice content requirements of paragraph (c) of this section.

(h) Applicability. This section shall apply to any notice obligation described in this section that arises on or after the first day of the first plan year beginning on or after November 26, 2004.
APPENDIX TO § 2590.606-1

MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS
(For use by single-employer group health plans)

** CONTINUATION COVERAGE RIGHTS UNDER COBRA **

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan’s Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [choose and enter appropriate information: must pay or are not required to pay] for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.
§ 2590.606–1  29 CFR Ch. XXV (7–1–15 Edition)

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee’s employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a “dependent child.”

[If the Plan provides retiree health coverage, add the following paragraph:]

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [enter name of employer sponsoring the plan], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee’s spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, [add if Plan provides retiree health coverage: commencement of a proceeding in bankruptcy with respect to the employer,] or the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days [or enter longer period permitted under the terms of the Plan] after the qualifying event occurs. You must provide this notice to: [Enter name of appropriate party]. [Add description of any additional Plan procedures for this notice, including a description of any required information or documentation.]

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.
Employee Benefits Security Admin., Labor § 2590.606–1

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. [Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice].

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)
§ 2590.606–2 Notice requirement for employers.

(a) General. Pursuant to section 606(a)(2) of the Employee Retirement Income Security Act of 1974, as amended (the Act), except as otherwise provided herein, the employer of a covered employee under a group health plan subject to the continuation coverage requirements of part 6 of title I of the Act shall provide, in accordance with this section, notice to the administrator of the plan of the occurrence of a qualifying event that is the covered employee’s death, termination of employment (other than by reason of gross misconduct), reduction in hours of employment, Medicare entitlement, or a proceeding in a case under title 11, United States Code, with respect to the employer from whose employment the covered employee retired at any time.

(b) Timing of notice. The notice required by this section shall be furnished to the administrator of the plan—

(1) In the case of a plan that provides, with respect to a qualifying event, pursuant to section 607(5) of the Act, that continuation coverage and the applicable period for providing notice under section 606(a)(2) of the Act shall commence on the date of loss of coverage, not later than 30 days after the date on which a qualified beneficiary loses coverage under the plan due to the qualifying event;

(2) In the case of a multiemployer plan that provides, pursuant to section 606(a)(2) of the Act, for a longer period of time within which employers may provide notice of a qualifying event, not later than the end of the period provided pursuant to the plan’s terms for such notice; and

(3) In all other cases, not later than 30 days after the date on which the qualifying event occurred.

(c) Content of notice. The notice required by this section shall include sufficient information to enable the administrator to determine the plan, the covered employee, the qualifying event, and the date of the qualifying event.

(d) Multiemployer plan special rules. This section shall not apply to any employer that maintains a multiemployer plan, with respect to qualifying events affecting coverage under such plan, if the plan provides, pursuant to section 606(b) of the Act, that the administrator shall determine whether such a qualifying event has occurred.

(e) Applicability. This section shall apply to any notice obligation described in this section that arises on or after the first day of the first plan year beginning on or after November 26, 2004.

§ 2590.606–3 Notice requirements for covered employees and qualified beneficiaries.

(a) General. In accordance with the authority of sections 505 and 606(a)(3) of the Employee Retirement Income Security Act of 1974, as amended (the Act), this section sets forth requirements for group health plans subject to the continuation coverage requirements of part 6 of title I of the Act with respect to the responsibility of
covered employees and qualified beneficiaries to provide the following notices to administrators:

(1) Notice of the occurrence of a qualifying event that is a divorce or legal separation of a covered employee from his or her spouse;

(2) Notice of the occurrence of a qualifying event that is a beneficiary’s ceasing to be covered under a plan as a dependent child of a participant;

(3) Notice of the occurrence of a second qualifying event after a qualified beneficiary has become entitled to continuation coverage with a maximum duration of 18 (or 29) months;

(4) Notice that a qualified beneficiary entitled to receive continuation coverage with a maximum duration of 18 months has been determined by the Social Security Administration, under title II or XVI of the Social Security Act (42 U.S.C. 401 et seq. or 1381 et seq.) (SSA), to be disabled at any time during the first 60 days of continuation coverage; and

(5) Notice that a qualified beneficiary, with respect to whom a notice described in paragraph (a)(4) of this section has been provided, has subsequently been determined by the Social Security Administration, under title II or XVI of the SSA to no longer be disabled.

(b) Reasonable procedures. (1) A plan subject to the continuation coverage requirements shall establish reasonable procedures for the furnishing of the notices described in paragraph (a) of this section.

(2) For purposes of this section, a plan’s notice procedures shall be deemed reasonable only if such procedures:

(i) Are described in the plan’s summary plan description required by §2520.102-3 of this chapter;

(ii) Specify the individual or entity designated to receive such notices;

(iii) Specify the means by which notice may be given;

(iv) Describe the information concerning the qualifying event or determination of disability that the plan deems necessary in order to provide continuation coverage rights consistent with the requirements of the Act; and

(v) Comply with the requirements of paragraphs (c), (d), and (e) of this section.

(3) A plan’s procedures will not fail to be reasonable, pursuant to this section, solely because the procedures require a covered employee or qualified beneficiary to utilize a specific form to provide notice to the administrator, provided that any such form is easily available, without cost, to covered employees and qualified beneficiaries.

(4) If a plan has not established reasonable procedures for providing a notice required by this section, such notice shall be deemed to have been provided when a written or oral communication identifying a specific event is made in a manner reasonably calculated to bring the information to the attention of any of the following:

(i) In the case of a single-employer plan, the person or organizational unit that customarily handles employee benefits matters of the employer;

(ii) In the case of a plan to which more than one unaffiliated employer contributes, or which is established or maintained by an employee organization, either the joint board, association, committee, or other similar group (or any member of any such group) administering the plan, or the person or organizational unit to which claims for benefits under the plan customarily are referred; or

(iii) In the case of a plan the benefits of which are provided or administered by an insurance company, insurance service, or other similar organization subject to regulation under the insurance laws of one or more States, the person or organizational unit that customarily handles claims for benefits under the plan or any officer of the insurance company, insurance service, or other similar organization.

(c) Periods of time for providing notice. A plan may establish a reasonable period of time for furnishing any of the notices described in paragraph (a) of this section, provided that any time limit imposed by the plan with respect to a particular notice may not be shorter than the time limit described in this paragraph (c) with respect to that notice.
§2590.606–3

(1) Time limits for notices of qualifying events. The period of time for furnishing a notice described in paragraph (a)(1), (2), or (3) of this section may not end before the date that is 60 days after the latest of:

(i) The date on which the relevant qualifying event occurs;

(ii) The date on which the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event; or

(iii) The date on which the qualified beneficiary is informed, through the furnishing of the plan’s summary plan description or the notice described in §2590.606–1, of both the responsibility to provide the notice and the plan’s procedures for providing such notice to the administrator.

(2) Time limits for notice of disability determination. (i) Subject to paragraph (c)(2)(ii) of this section, the period of time for furnishing the notice described in paragraph (a)(4) of this section may not end before the date that is 60 days after the latest of:

(A) The date of the disability determination by the Social Security Administration;

(B) The date on which a qualifying event occurs;

(C) The date on which the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event; or

(D) The date on which the qualified beneficiary is informed, through the furnishing of the plan’s summary plan description or the notice described in §2590.606–1, of both the responsibility to provide the notice and the plan’s procedures for providing such notice to the administrator.

(ii) Notwithstanding paragraph (c)(2)(i) of this section, a plan may require the notice described in paragraph (a)(4) of this section to be furnished before the end of the first 18 months of continuation coverage.

(3) Time limits for notice of change in disability status. The period of time for furnishing the notice described in paragraph (a)(5) of this section may not end before the date that is 30 days after the later of:

(i) The date of the final determination by the Social Security Administration, under title II or XVI of the SSA, that the qualified beneficiary is no longer disabled; or

(ii) The date on which the qualified beneficiary is informed, through the furnishing of the plan’s summary plan description or the notice described in §2590.606–1, of both the responsibility to provide the notice and the plan’s procedures for providing such notice to the administrator.

(d) Required contents of notice. (1) A plan may establish reasonable requirements for the content of any notice described in this section, provided that a plan may not deem a notice to have been provided untimely if such notice, although not containing all of the information required by the plan, is provided within the time limit established under the plan in conformity with paragraph (c) of this section, and the administrator is able to determine from such notice the plan, the covered employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event (if any) occurred.

(2) An administrator may require a notice that does not contain all of the information required by the plan to be supplemented with the additional information necessary to meet the plan’s reasonable content requirements for such notice in order for the notice to be deemed to have been provided in accordance with this section.

(e) Who may provide notice. With respect to each of the notice requirements of this section, any individual who is either the covered employee, a qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the covered employee or qualified beneficiary may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries with respect to the qualifying event.

(f) Plan provisions. To the extent that a plan provides a covered employee or qualified beneficiary a period of time longer than that specified in this section to continue coverage, the terms of the plan shall govern the time frame for such notice.

(g) Additional rights to continuation coverage. Nothing in this section shall...
be construed to preclude a plan from providing, in accordance with its terms, continuation coverage to a qualified beneficiary although a notice requirement of this section was not satisfied.

(b) Applicability. This section shall apply to any notice obligation described in this section that arises on or after the first day of the first plan year beginning on or after November 26, 2004.

§ 2590.606–4 Notice requirements for plan administrators.

(a) General. Pursuant to section 606(a)(4) of the Employee Retirement Income Security Act of 1974, as amended (the Act), the administrator of a group health plan subject to the continuation coverage requirements of Part 6 of title I of the Act shall provide, in accordance with this section, notice to each qualified beneficiary of the qualified beneficiary’s rights to continuation coverage under the plan.

(b) Notice of right to elect continuation coverage. (1) Except as provided in paragraph (b)(2) or (3) of this section, upon receipt of a notice of qualifying event furnished in accordance with § 2590.606–2 or § 2590.606–3, the administrator shall furnish to each qualified beneficiary, not later than 14 days after receipt of the notice of qualifying event, a notice meeting the requirements of paragraph (b)(4) of this section.

(2) In the case of a plan with respect to which an employer of a covered employee is also the administrator of the plan, except as provided in paragraph (b)(3) of this section, if the employer is otherwise required to furnish a notice of a qualifying event to an administrator pursuant to § 2590.606–2, the administrator shall furnish to each qualified beneficiary, not later than 14 days after receipt of the notice of qualifying event, a notice meeting the requirements of paragraph (b)(4) of this section.

(3) In the case of a plan that is a multiemployer plan, a notice meeting the requirements of paragraph (b)(4) of this section shall be furnished not later than the later of:

(i) The end of the time period provided in paragraph (b)(1) of this section; or

(ii) The end of the time period provided in the terms of the plan for such purpose.

(4) The notice required by this paragraph (b) shall be written in a manner calculated to be understood by the average plan participant and shall contain the following information:

(i) The name of the plan under which continuation coverage is available; and the name, address and telephone number of the party responsible under the plan for the administration of continuation coverage benefits;

(ii) Identification of the qualifying event;

(iii) Identification, by status or name, of the qualified beneficiaries who are recognized by the plan as being entitled to elect continuation coverage with respect to the qualifying event, and the date on which coverage under the plan will terminate (or has terminated) unless continuation coverage is elected;

(iv) A statement that each individual who is a qualified beneficiary with respect to the qualifying event has an independent right to elect continuation coverage, that a covered employee or a qualified beneficiary who is the spouse of the covered employee (or was the spouse of the covered employee on the day before the qualifying event occurred) may elect continuation coverage on behalf of a minor child; and

(v) An explanation of the consequences of failing to elect or waiving
continuation coverage, including an explanation that a qualified beneficiary’s decision whether to elect continuation coverage will affect the future rights of qualified beneficiaries to portability of group health coverage, guaranteed access to individual health coverage, and special enrollment under part 7 of title I of the Act, with a reference to where a qualified beneficiary may obtain additional information about such rights; and a description of the plan’s procedures for revoking a waiver of the right to continuation coverage before the date by which the election must be made;

(vii) A description of the continuation coverage that will be made available under the plan, if elected, including the date on which such coverage will commence, either by providing a description of the coverage or by reference to the plan’s summary plan description;

(viii) An explanation of the maximum period for which continuation coverage will be available under the plan, if elected; an explanation of the continuation coverage termination date; and an explanation of any events that might cause continuation coverage to be terminated earlier than the end of the maximum period;

(ix) A description of the circumstances (if any) under which the maximum period of continuation coverage may be extended due either to the occurrence of a second qualifying event or a determination by the Social Security Administration, under title II or XVI of the Social Security Act (42 U.S.C. 401 et seq. or 1381 et seq.) (SSA), that the qualified beneficiary is disabled, and the length of any such extension;

(x) In the case of a notice that offers continuation coverage with a maximum duration of less than 36 months, a description of the plan’s requirements regarding the responsibility of qualified beneficiaries to provide notice of a second qualifying event and notice of a disability determination under the SSA, along with a description of the plan’s procedures for providing such notices, including the times within which such notices must be provided and the consequences of failing to provide such notices. The notice shall also explain the responsibility of qualified beneficiaries to provide notice that a disabled qualified beneficiary has subsequently been determined to no longer be disabled;

(xi) A description of the amount, if any, that each qualified beneficiary will be required to pay for continuation coverage;

(xii) A description of the due dates for payments, the qualified beneficiaries’ right to pay on a monthly basis, the grace periods for payment, the address to which payments should be sent, and the consequences of delayed payment and non-payment;

(xiii) An explanation of the importance of keeping the administrator informed of the current addresses of all participants or beneficiaries under the plan who are or may become qualified beneficiaries; and

(xiv) A statement that the notice does not fully describe continuation coverage or other rights under the plan, and that more complete information regarding such rights is available in the plan’s summary plan description or from the plan administrator.

(c) Notice of unavailability of continuation coverage. (1) In the event that an administrator receives a notice furnished in accordance with §2590.606–3 relating to a qualifying event, second qualifying event, or determination of disability by the Social Security Administration regarding a covered employee, qualified beneficiary, or other individual and determines that the individual is not entitled to continuation coverage under part 6 of title I of the Act, the administrator shall provide to such individual an explanation as to why the individual is not entitled to continuation coverage.

(2) The notice required by this paragraph (c) shall be written in a manner calculated to be understood by the average plan participant and shall be furnished by the administrator in accordance with the time frame set out in paragraph (b) of this section that would apply if the administrator received a notice of qualifying event and determined that the individual was entitled to continuation coverage.

(d) Notice of termination of continuation coverage. (1) The administrator of a plan that is providing continuation
coverage to one or more qualified beneficiaries with respect to a qualifying event shall provide, in accordance with this paragraph (d), notice to each such qualified beneficiary of any termination of continuation coverage that takes effect earlier than the end of the maximum period of continuation coverage applicable to such qualifying event.

(2) The notice required by this paragraph (d) shall be written in a manner calculated to be understood by the average plan participant and shall contain the following information:

(i) The reason that continuation coverage has terminated earlier than the end of the maximum period of continuation coverage applicable to such qualifying event;

(ii) The date of termination of continuation coverage; and

(iii) Any rights the qualified beneficiary may have under the plan or under applicable law to elect an alternative group or individual coverage, such as a conversion right.

(3) The notice required by this paragraph (d) shall be furnished by the administrator as soon as practicable following the administrator’s determination that continuation coverage shall terminate.

(e) Special notice rules. The notices required by paragraphs (b), (c), and (d) of this section shall be furnished to each qualified beneficiary or individual, except that:

(1) An administrator may provide notice to a covered employee and the covered employee’s spouse by furnishing a single notice addressed to both the covered employee and the covered employee’s spouse, if, on the basis of the most recent information available to the plan, the covered employee’s spouse resides at the same location as the covered employee; and

(2) An administrator may provide notice to each qualified beneficiary who is the dependent child of a covered employee by furnishing a single notice to the covered employee or the covered employee’s spouse, if, on the basis of the most recent information available to the plan, the dependent child resides at the same location as the individual to whom such notice is provided.

(f) Delivery of notice. The notices required by this section shall be furnished in any manner consistent with the requirements of §2520.104b–1 of this chapter, including paragraph (c) of that section relating to the use of electronic media.

(g) Model notice. The appendix to this section contains a model notice that is intended to assist administrators in discharging the notice obligations of paragraph (b) of this section. Use of the model notice is not mandatory. The model notice reflects the requirements of this section as they would apply to single-employer group health plans and must be modified if used to provide notice with respect to other types of group health plans, such as multiemployer plans or plans established and maintained by employee organizations for their members. In order to use the model notice, administrators must appropriately add relevant information where indicated in the model notice, select among alternative language and supplement the model notice to reflect applicable plan provisions. Items of information that are not applicable to a particular plan may be deleted. Use of the model notice, appropriately modified and supplemented, will be deemed to satisfy the notice content requirements of paragraph (b)(4) of this section.

(h) Applicability. This section shall apply to any notice obligation described in this section that arises on or after the first day of the first plan year beginning on or after November 26, 2004.
APPENDIX TO § 2590.606-4

MODEL COBRA CONTINUATION COVERAGE ELECTION NOTICE
(For use by single-employer group health plans)

[Enter date of notice]

Dear: [Identify the qualified beneficiary(ies), by name or status]

This notice contains important information about your right to continue your health care coverage in the [enter name of group health plan] (the Plan). Please read the information contained in this notice very carefully.

To elect COBRA continuation coverage, follow the instructions on the next page to complete the enclosed Election Form and submit it to us.

If you do not elect COBRA continuation coverage, your coverage under the Plan will end on [enter date] due to [check appropriate box]:

☐ End of employment ☐ Reduction in hours of employment
☐ Death of employee ☐ Divorce or legal separation
☐ Entitlement to Medicare ☐ Loss of dependent child status

Each person (“qualified beneficiary”) in the category(ies) checked below is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Plan for up to ___ months [enter 18 or 36, as appropriate and check appropriate box or boxes; names may be added]:

☐ Employee or former employee
☐ Spouse or former spouse
☐ Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage
☐ Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

If elected, COBRA continuation coverage will begin on [enter date] and can last until [enter date]. [Add, if appropriate: You may elect any of the following options for COBRA continuation coverage: [list available coverage options].

COBRA continuation coverage will cost: [enter amount each qualified beneficiary will be required to pay for each option per month of coverage and any other permitted coverage periods.] You do not have to send any payment with the Election Form. Important additional information about payment for COBRA continuation coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to COBRA continuation coverage, you should contact [enter name of party responsible for COBRA administration for the Plan, with telephone number and address].
COBRA CONTINUATION COVERAGE ELECTION FORM

INSTRUCTIONS: To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you must have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan.

Send completed Election Form to: [Enter Name and Address]

This Election Form must be completed and returned by mail [or describe other means of submission and due date]. If mailed, it must be post-marked no later than [enter date].

If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.

Read the important information about your rights included in the pages after the Election Form.

I (We) elect COBRA continuation coverage in the [enter name of plan] (the Plan) as indicated below:

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>Relationship to Employee</th>
<th>SSN (or other identifier)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>[Add if appropriate: Coverage option elected: ___________________________]</td>
</tr>
<tr>
<td>b.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>[Add if appropriate: Coverage option elected: ___________________________]</td>
</tr>
<tr>
<td>c.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>[Add if appropriate: Coverage option elected: ___________________________]</td>
</tr>
</tbody>
</table>

__________________________  __________________________
Signature                      Date

__________________________
Print Name

__________________________
Relationship to individual(s) listed above

__________________________
Print Address

__________________________
Telephone number
§2590.606–4  29 CFR Ch. XXV (7–1–15 Edition)

IMPORTANT INFORMATION
ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

What is continuation coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a “qualifying event” that would result in a loss of coverage under an employer’s plan. Depending on the type of qualifying event, “qualified beneficiaries” can include the employee (or retired employee) covered under the group health plan, the covered employee’s spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including [add if applicable: open enrollment and] special enrollment rights.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee’s death, divorce or legal separation, the employee’s becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

[If the maximum period shown on page 1 of this notice is less than 36 months, add the following three paragraphs:]
How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify [enter name of party responsible for COBRA administration] of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. [Describe Plan provisions for requiring notice of disability determination, including time frames and procedures.] Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact within 30 days after SSA’s determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child’s ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee’s spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.
§ 2590.606–4

29 CFR Ch. XXV (7–1–15 Edition)

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse’s employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

**How much does COBRA continuation coverage cost?**

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

**If employees might be eligible for trade adjustment assistance, the following information may be added:** The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-628-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

**When and how must payment for COBRA continuation coverage be made?**

**First payment for continuation coverage**

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact
Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the [enter due day for each monthly payment] for that coverage period. [If Plan offers other payment schedules, enter with appropriate dates: You may instead make payments for continuation coverage for the following coverage periods, due on the following dates: ]. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan [select one: will or will not] send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period [or enter longer period permitted by Plan] to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. [If Plan suspends coverage during grace period for nonpayment, enter and modify as necessary: However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.]

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to:

[enter appropriate payment address]

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact [enter name of party responsible for COBRA administration for the Plan, with telephone number and address].
§ 2590.609–1

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.)

Keep Your Plan Informed of Address Changes

In order to protect your and your family’s rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

§ 2590.609–1 [Reserved]

§ 2590.609–2 National Medical Support Notice.

(a) This section promulgates the National Medical Support Notice (the Notice), as mandated by section 401(b) of the Child Support Performance and Incentive Act of 1998 (Pub. L. 105–200). If the Notice is appropriately completed and satisfies paragraphs (3) and (4) of section 609(a) of the Employee Retirement Income Security Act (ERISA), the Notice is deemed to be a qualified medical child support order (QMCSO) pursuant to ERISA section 609(a)(5)(C). Section 609(a) of ERISA delineates the rights and obligations of the alternate recipient (child), the participant, and the group health plan under a QMCSO. A copy of the Notice is available on the Internet at http://www.dol.gov/ebsa.

(b) For purposes of this section, a plan administrator shall find that a Notice is appropriately completed if it contains the name of an Issuing Agency, the name and mailing address (if any) of an employee who is a participant under the plan, the name and mailing address of one or more alternate recipient(s) (child(ren) of the participant) (or the name and address of a substituted official or agency which has been substituted for the mailing address of the alternate recipient(s)), and identifies an underlying child support order.

(c)(1) Under section 609(a)(3)(A) of ERISA, in order to be qualified, a medical child support order must clearly specify the name and the last known mailing address (if any) of the participant and the name and mailing address of each alternate recipient covered by the order, except that, to the extent provided in the order, the name and mailing address of an official of a State or a political subdivision thereof may be substituted for the mailing address of any such alternate recipient. Section 609(a)(3)(B) of ERISA requires a reasonable description of the type of coverage to be provided to each such alternate recipient, or the manner in which such type of coverage is to be determined. Section 609(a)(3)(C) of ERISA requires that the order specify the period to which such order applies.

(2) The Notice satisfies ERISA section 609(a)(3)(A) by including the necessary identifying information described in §2590.609–2(b).

(3) The Notice satisfies ERISA section 609(a)(3)(B) by having the Issuing Agency identify either the specific type of coverage or all available group health coverage. If an employer receives a Notice that does not designate either specific type(s) of coverage or all available coverage, the employer and plan administrator should assume that all are designated. The Notice further satisfies ERISA section 609(a)(3)(B) by instructing the plan administrator that if a group health plan has multiple options and the participant is not enrolled, the Issuing Agency will make a selection after the Notice is qualified, and, if the Issuing Agency does not respond within 20 days, the child will be enrolled under the plan’s default option (if any).

(4) Section 609(a)(3)(C) of ERISA is satisfied because the Notice specifies that the period of coverage may only
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 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 Subpart C of this part.


§ 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