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Department of Labor

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29 CFR Part 2590

Department of Health and Human Services

Centers for Medicare & Medicaid Services

45 CFR Parts 144 and 146

Final Regulations for Health Coverage Portability; Final Rule

Notice of Proposed Rulemaking for Health Coverage Portability and Request for Information on Benefit-Specific Waiting Periods Under HIPAA Titles I & IV; Proposed Rules

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Parts 54 and 602

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

45 CFR Parts 144 and 146

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Final Regulations for Health Coverage Portability for Group Health Plans and Group Health Insurance Issuers Under HIPAA Titles I & IV

AGENCIES: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services.

ACTION: Final regulation.

SUMMARY: This document contains final regulations governing portability requirements for group health plans and issuers of health insurance coverage offered in connection with a group health plan. The rules contained in this document implement changes made to the Internal Revenue Code, the Employee Retirement Income Security Act, and the Public Health Service Act enacted as part of the Health Insurance Portability and Accountability Act of 1996.

DATES: *Effective date.* These final regulations are effective February 28, 2005.

Applicability date. These final regulations apply for plan years beginning on or after July 1, 2005.

FOR FURTHER INFORMATION CONTACT: Dave Mlawsky, Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services, at 1–877–267–2323 ext. 61565; Amy Turner, Employee Benefits Security Administration, Department of Labor, at (202) 693–8335; or Russ Weinheimer, Internal Revenue Service, Department of the Treasury, at (202) 622–6080.

SUPPLEMENTARY INFORMATION:

Customer Service Information

To assist consumers and the regulated community, the Departments have issued questions and answers concerning HIPAA. Individuals interested in obtaining copies of Department of Labor publications concerning changes in health care law may call a toll free number, 1–866–444–EBSA (3272), or access the publications on-line at *www.dol.gov/ebsa,* the Department of Labor's Web site. These regulations as well as other information on the new health care laws are also available on the Department of Labor's interactive web pages, Health *E*laws. In addition, CMS's publication entitled ''Protecting Your Health Insurance Coverage'' is available by calling 1–800–633–4227 or on the Department of Health and Human Services' Web site (*www.cms.hhs.gov/hipaa1*), which includes the interactive webpages, HIPAA Online. Copies of the HIPAA regulations, as well as notices and press releases related to HIPAA and other health care laws, are also available at the above-referenced Web sites.

A. Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104–191, was enacted on August 21, 1996. HIPAA amended the Internal Revenue Code of 1986 (Code), the Employee Retirement Income Security Act of 1974 (ERISA), and the Public Health Service Act (PHS Act) to provide for, among other things, improved portability and continuity of health coverage. Interim final regulations implementing the HIPAA provisions were first made available to the public on April 1, 1997 (published in the **Federal Register** on April 8, 1997, 62 FR 16894) (April 1997 interim rules). On December 29, 1997, the Departments published in the **Federal Register** (62 FR 67688) a clarification of the April 1997 interim rules as they relate to excepted benefits. On October 25, 1999, the Departments published a notice in the **Federal Register** (64 FR 57520) soliciting additional comments on the portability requirements based on the experience of plans and issuers operating under the April 1997 interim rules.

After consideration of all the comments received on the portability provisions, the Departments are publishing these final regulations. These final regulations do not significantly modify the framework established in the April 1997 interim rules. Instead, these final regulations implement changes to improve the portability of health coverage while seeking to minimize burdens on group health plans and group health insurance issuers. These final regulations become applicable to plans and issuers on the first day of the plan year beginning on or after July 1, 2005. Each plan or issuer must continue to comply with the April 1997 interim rules until these final regulations become applicable to that plan or issuer. In addition, the Departments are publishing proposed regulations elsewhere in this issue of the **Federal Register** to address additional and discrete issues.

B. Overview of the Final Regulations

1. Definitions—26 CFR 54.9801–2, 29 CFR 2590–701–2, 45 CFR 144.103

This section of the final regulations provides most of the definitions used in the regulations implementing HIPAA. In addition to some minor restructuring of the April 1997 interim rules (*i.e.*, some definitions have been moved into other sections of the regulations), some additional terms have been added. Among the new terms is the definition of the term *dependent. Dependent* is defined as any individual who is or may become eligible for coverage under the terms of a group health plan because of a relationship to a participant. This is intended to clarify that for purposes of HIPAA the terms of the group health plan determine which individuals are eligible for coverage as a dependent under the plan. Thus, for example, the plan terms control the age (if any) at which and conditions under which a child of a participant ceases to be eligible for coverage as a dependent. Moreover, whether an individual is eligible for special enrollment as a dependent is determined in part based on the plan's definition of dependent.

2. Limitations on Preexisting Condition Exclusions—26 CFR 54.9801–3, 29 CFR 2590.701–3, 45 CFR 146.111

This section of the final regulations addresses HIPAA's limitations on a plan's or issuer's ability to impose a preexisting condition exclusion. Comments addressing this topic generally approved of the approach taken in the Departments' April 1997 interim rules. Accordingly, these final regulations do not modify significantly the April 1997 interim rules but instead add several clarifications to the general framework already established. Also, some comments reflect a misunderstanding of the notice requirements for plans and issuers that impose a preexisting condition exclusion. Thus, these final regulations are restructured to clarify these notice

obligations. In addition, an example in the regulations contains language that plans and issuers can use to satisfy the notice requirements.

Definition of a Preexisting Condition Exclusion

In these final regulations, a preexisting condition exclusion continues to be defined broadly. A preexisting condition exclusion is any limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. This definition has been moved to this section on limitations on preexisting condition exclusions to emphasize the difference between the broadness of the definition and the narrowness of permissible preexisting condition exclusions. The definition has also been modified slightly from the previous definition and clarifications of its application have been added.

If a plan exclusion satisfies the definition of a preexisting condition exclusion, it is subject to the rules of this section for preexisting condition exclusions. Under the April 1997 interim rules, whether an exclusion is a preexisting condition exclusion is determined by whether the plan provision restricts benefits for a condition because it was present before the ''first day of coverage.'' These final regulations have replaced the term *first day of coverage* with *effective date of coverage under a group health plan or health insurance coverage.* In the case of a plan that changes health insurance issuers, ''first day of coverage'' can be read to mean only the first day of coverage under the plan and not the first day of coverage under the new issuer's policy or contract (because ''first day of coverage'' is thus defined for purposes of determining the enrollment date). This reading would mean that an exclusion of benefits based on the fact that a condition existed before the effective date of coverage in the health insurance of the succeeding issuer would not be a preexisting condition (because it would not apply based on the fact that a condition existed before the first day of coverage under the plan). The phrase ''effective date of coverage under a group health plan or health insurance coverage'' under the final regulations thus applies to coverage either under a plan or health insurance coverage. Therefore, a provision used by a succeeding issuer to deny benefits for a condition because it arose before the effective date of coverage under the new policy would also fit the definition of a preexisting condition exclusion.

Since the April 1997 interim rules were published, several situations have repeatedly arisen in which a plan exclusion is not designated as a preexisting condition exclusion but nevertheless satisfies the definition of a preexisting condition exclusion. Examples have been added to illustrate some of these common plan provisions. These situations include a plan provision that provides coverage for accidental injury only if the injury occurred while covered under the plan, a plan provision that counts against a lifetime limit benefits received under prior health coverage, and a plan provision that denies benefits for pregnancy until 12 months after an individual generally becomes eligible for benefits under the plan.[1] The regulations also include a series of examples relating to exclusions for congenital conditions. These examples illustrate that a plan that generally provides benefits for a condition cannot exclude benefits for the condition in instances where it arises congenitally without complying with these limitations on preexisting condition exclusions. However, these limitations would not apply if a plan excludes benefits for all instances of a condition, even if all instances are likely to be congenital. Plans and policies that contain these types of preexisting condition exclusions that are not designated as such should be modified to comply with HIPAA's requirements for preexisting condition exclusions, or the exclusions should be deleted. In addition, because a preexisting condition exclusion discriminates against individuals based on one or more health factors, unless a preexisting condition exclusion complies with HIPAA's limitations on preexisting condition exclusions, the plan provision will also violate the HIPAA nondiscrimination provisions.[2]

General Rules Governing Preexisting Condition Exclusions

In addition to modifying the definition of a preexisting condition exclusion, these final regulations set forth HIPAA's limitations on preexisting condition exclusions, as follows:

Six-Month Look-Back Rule

The final regulations retain the 6-month look-back rule set forth in the April 1997 interim rules. In addition, these regulations clarify that a plan or issuer can use a period shorter than 6 months for purposes of applying the 6-month look-back rule. Examples in these final regulations also clarify that if a doctor's recommendation for treatment occurs before the 6-month look-back period, an individual can be subject to a preexisting condition exclusion only if the individual receives the recommended treatment within the 6-month look-back period.

Maximum Length of Preexisting Condition Exclusion

The final regulations retain the rule set forth in the April 1997 interim rules that a preexisting condition exclusion is not permitted to extend for more than 12 months (18 months in the case of a late enrollee) after the enrollment date.

Reducing a Preexisting Condition Exclusion Period by Creditable Coverage

The final regulations retain the rule set forth in the April 1997 interim rules. Accordingly, under these final regulations, the period of any preexisting condition exclusion that would otherwise apply to an individual under a group health plan is reduced by the number of days of creditable coverage[3] the individual has as of the enrollment date (not including any days before a significant break in coverage). Some comments asked how this rule applies to individuals who currently have coverage under another plan (that is, the coverage has not yet ended). An example clarifies that a plan or issuer must count all days of creditable coverage prior to an individual's enrollment date, even if that coverage is still in effect.

Other Standards

The final regulations retain the statement that other legal standards may apply to group health coverage preexisting condition exclusions. In this connection, the Department of Labor's Veterans' Employment and Training Service (VETS) has commented that the Uniformed Services Employment and Reemployment Rights Act (USERRA) provides reemployment rights for persons who leave civilian employment to perform service in the uniformed

[1] Several comments (including those of several State insurance commissioner's offices) have asked the Departments to clarify that a preexisting condition exclusion would also include any waiting period or other temporary benefit exclusion (other than a waiting period on all benefits). The Departments are publishing separately in this issue of the **Federal Register** a Request for Information, which invites further comments on this issue of benefit-specific waiting periods.

[2] See 26 CFR 54.9802–1T(b)(3), 29 CFR 2590.702(b)(3), and 45 CFR 146.121(b)(3), published on January 8, 2001 at 66 FR 1378.

[3] For purposes of these regulations, the phrase ''days of creditable coverage'' has the same meaning as the phrase ''aggregate of the periods of creditable coverage'' as such phrase is used in the statute.

services and prohibits employer discrimination against any person on the basis of the person's military service, obligations, intent to join or certain other protected activities. In general, USERRA reemployment rights apply to persons who leave civilian employment to serve a single enlistment period in the active military or to employees who are members of the National Guard or Reserve and are required to perform intermittent military service or training. USERRA provides rights regarding both continuation of group health plan coverage by an employee who is absent to perform service in the uniformed services and reinstatement of group health plan coverage upon reemployment if the coverage was interrupted by the service. In response to this comment, the final regulations include a statement that USERRA can affect the application of a preexisting condition exclusion to certain individuals who are reinstated in a group health plan following active military service. For more information, a VETS directory and additional USERRA information is available at *www.dol.gov/vets.*

Enrollment Definitions

Both the 6-month look-back period and the maximum length of preexisting condition exclusion are measured with respect to an individual's enrollment date. The final regulations generally retain the enrollment definitions that were set forth in the April 1997 interim rules (including definitions of enrollment date, waiting period, and late enrollee). Under HIPAA, the April 1997 interim rules, and these final regulations, the enrollment date is the first day of coverage under the plan or, if there is a waiting period, the first day of the waiting period. These final regulations clarify that if an individual receiving benefits under a group health plan changes benefit package options, or if the plan changes group health insurance issuers, the individual's enrollment date remains the same.

The Departments received several comments reflecting confusion about the relationship between the preexisting condition exclusion rules and the definitions of enrollment date and waiting period. Accordingly, guidance concerning waiting periods previously located in the definitions section has been moved to this section of the regulations and expanded. In addition, the definition of waiting period has been modified with respect to individuals seeking individual market coverage. Specifically, these final rules clarify that if an individual seeks coverage in the individual market, a waiting period begins on the date the individual submits a substantially complete application for coverage and ends on either the date coverage begins (if the application results in coverage), or the date on which the application is denied by the issuer or the date on which the offer of coverage lapses (if the application does not result in coverage). Under the statute, the April 1997 interim rules, and these final regulations, the effect of considering this period a waiting period is that the period is not counted when determining the length of any break in coverage. This rule modifies the rule contained in the April 1997 interim rules (which provided a waiting period only if the individual actually obtained coverage). The modification addresses situations where some individuals have been denied individual market policies or individuals declined coverage because, for example, the policies had an exorbitant premium.

Additional examples illustrate the interaction between a waiting period and the 6-month look-back period, the application of the 6-month look-back and maximum preexisting condition exclusion period rules to plans with more than one benefit package option at open season, and the interaction between these rules and other eligibility criteria under the plan.

Individuals and Conditions That Cannot Be Subject to a Preexisting Condition Exclusion

Under HIPAA, the April 1997 interim rules, and these final rules, a preexisting condition exclusion cannot be applied to pregnancy. Nor can a preexisting condition exclusion be applied to a newborn, adopted child, or child placed for adoption if the child is covered under a group health plan (or other creditable coverage) within 30 days after birth, adoption, or placement for adoption.

One comment noted that the rule for newborns in the April 1997 interim rules is expressed inconsistently. Some of those expressions are inconsistent with the rule for adopted children. Specifically, the rule for adopted children and one expression of the rule for newborns refers to eligibility being conditioned on being covered under any creditable coverage as of the last day of the 30-day period after birth, adoption, or placement for adoption. However, in other expressions of the rule for newborns, a reference is made to being covered under creditable coverage within 30 days after birth. These final regulations use one term consistently, referring to coverage within 30 days after birth, adoption, or placement for adoption. This accords with the conference report. H.R. Conf. Rep. No. 736, 104th Cong. 2d Session 184–185 (1996). Consequently, if, for example, a child is covered within 30 days of birth, the child cannot be subject to a preexisting condition exclusion even if the child is no longer covered under the plan on the 30th day after birth (unless the child has a significant break in coverage).

Several comments noted that State laws applicable to health insurance issuers sometimes require that a mother's health coverage must provide benefits for health care expenses incurred for the child for a specified period following birth and cannot be recouped even if the child never enrolls in the plan under which the mother is covered. A new example clarifies that, in this situation, the child has creditable coverage within 30 days after birth and, therefore, no preexisting condition exclusion may be imposed on the child unless the child has a subsequent significant break in coverage.

Finally, HIPAA, the April 1997 interim rules, and these final regulations provide that a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose a preexisting condition exclusion relating to a condition based solely on genetic information. Comments expressed concern that the definition of genetic information in the April 1997 interim rules was too broad and would prevent the application of a preexisting condition exclusion to conditions that would be otherwise permitted independent of any genetic information. Although these regulations have not changed the definition of genetic information, the regulations clarify that if an individual is diagnosed with a condition, even if the condition relates to genetic information, the plan may impose a preexisting condition exclusion with respect to the condition, subject to the other limitations of this section. This rule was located in the definition of medical condition in the April 1997 interim rules. Some comments indicated this rule was difficult to locate. Thus, it has been moved to this section, and an example illustrating the rule has been added.

First Notice of Preexisting Condition Exclusion—General Notice

Under these final regulations, as with the April 1997 interim rules, a group health plan imposing a preexisting condition exclusion, and a health insurance issuer offering group health insurance coverage under a plan imposing a preexisting condition

exclusion, must provide a written general notice of preexisting condition exclusion before it can impose a preexisting condition exclusion.

After publication of the April 1997 interim rules, the Departments received questions about the operation of this requirement. The April 1997 interim rules provided that a plan or issuer could not impose a preexisting condition exclusion with respect to a participant or dependent before providing the general notice to the participant. Several comments asked whether plans and issuers could delay providing the general notice until a large claim was filed and then pend the claim until the general notice was sent. Other comments expressed concern that if plans do not notify individuals upon enrollment about the benefit exclusions that apply to their coverage, individuals will not be able to make informed decisions about their health care choices.

The Departments had contemplated under the April 1997 interim rules that individuals should be provided the information required in the general notice before they incurred claims that could be denied under a preexisting condition exclusion. These final regulations clarify the procedural requirements for the general notice of preexisting condition exclusion. Specifically, under the final regulations, the general notice of preexisting condition exclusion must be provided as part of any written application materials distributed by the plan or issuer for enrollment. If the plan or issuer does not distribute such materials, the notice must be provided by the earliest date following a request for enrollment that the plan or issuer, acting in a reasonable and prompt fashion, can provide the notice. Moreover, regarding the content of this general notice, the final regulations clarify precisely what is required when disclosing the existence and terms of the plan's preexisting condition exclusion. In addition, these final regulations require the notice to include the person to contact (including an address or telephone number) for obtaining additional information or assistance regarding the preexisting condition exclusion. An example in these final regulations sets forth sample language that plans and issuers can use when developing the general notice for their coverages.

Issuers that sell different policies to different plans should also be aware that when describing the existence and terms of the maximum preexisting condition exclusion period, the issuer must describe to individuals the actual maximum exclusion period under their policy. Therefore, if an issuer sells two policies, one with a 6-month and one with a 12-month maximum preexisting condition exclusion, the issuer could not send one notice to individuals under both policies indicating that the maximum preexisting condition exclusion is 12 months. Instead, the issuer is required to send one notice to participants under the policy with the 6-month preexisting condition exclusion (indicating that the maximum exclusion period is 6 months) and a different notice to participants under the policy with the 12-month preexisting condition exclusion (indicating that the maximum exclusion period is 12 months).

Determination of Creditable Coverage

These final regulations require a plan or issuer that imposes a preexisting condition exclusion to make a determination of creditable coverage within a reasonable time after receiving information regarding prior health coverage. This rule was included in the section of the April 1997 interim rules addressing certification and disclosure of previous coverage, and it has been moved to this section on preexisting condition exclusions unchanged. These final regulations clarify that a plan or issuer may not impose any limit on the amount of time that an individual has to present a certificate or other evidence of creditable coverage.[4]

Second Notice of Preexisting Condition Exclusion—Individual Notice

These final regulations retain the requirement to provide an individual a written notice of the length of preexisting condition exclusion that remains after offsetting for prior creditable coverage. These final regulations clarify that this individual notice is not required to identify any medical conditions specific to the individual that could be subject to the exclusion. Also, a plan or issuer is not required to provide this notice if the plan or issuer does not impose any preexisting condition exclusion on the individual or if the plan's preexisting condition exclusion is completely offset by the individual's prior creditable coverage. These final regulations add a new example that illustrates how the notice works and includes sample language that may be helpful to plans and issuers in developing this type of notice with respect to their coverage.

Reconsideration

Consistent with the April 1997 interim rules, these final regulations do not prevent a plan or issuer from modifying an initial determination of creditable coverage if it determines that the individual did not have the claimed creditable coverage and if certain procedural requirements are met. The final regulations have been slightly reorganized and modified to make clearer that a plan or issuer is permitted to modify its initial determination if a notice of the new determination (that meets the requirements of the second, individual notice of preexisting condition exclusion, described above) is provided and, until the notice of the new determination is provided, the plan or issuer acts in a manner consistent with the initial determination for purposes of approving access to medical services (such as pre-surgery authorization).

3. Rules Relating to Creditable Coverage—26 CFR 54.9801–4, 29 CFR 2590.701–4, 45 CFR 146.113

This section of the final regulations describes the varieties of health coverage that constitute creditable coverage and sets forth rules for how to count creditable coverage for purposes of the rule requiring plans and issuers to offset the maximum length of a preexisting condition exclusion by prior creditable coverage.

Creditable Coverage

The rules in the final regulations describing the varieties of health coverage that constitute creditable coverage generally follow the April 1997 interim rules, with two modifications. The April 1997 interim rules contain ten categories of creditable coverage. After publication of the April 1997 interim rules, Congress created the State Children's Health Insurance Program (S–CHIP), which allows states to provide health coverage to eligible children through Medicaid expansion or private market mechanisms. This coverage meets the definition of creditable coverage as either Medicaid coverage, group health plan coverage, or health insurance coverage. In addition, Congress specifically provides[5] that S–CHIP coverage is creditable coverage under HIPAA. Therefore, these final regulations have added coverage under S–CHIP as an eleventh category of creditable coverage.

The second modification is to the definition of public health plan. This

[4] Of course, after a claim has been denied under a preexisting condition exclusion, other laws, such as section 503 of ERISA, may set forth timing rules for an individual to appeal a denied claim.

[5] Section 2109 of the Social Security Act, enacted by section 4901 of the Balanced Budget Act of 1997, Pub. L. 105–33, 111 Stat. 567.

definition has been changed in two ways. The first change relates to the type of health coverage provided by a public health plan. The statute does not define the term. The April 1997 interim rules limit the definition of public health plans to certain plans provided through health *insurance* coverage. Some comments suggested it was unnecessary to restrict the definition to insured coverage and argued that the term public health plan should be expanded. These final regulations delete the word ''insurance'' from that requirement so that any health coverage provided by a governmental entity, regardless of whether it has the risk-shifting or risk-distributing effects of insurance, is a public health plan.

The second change to the definition of public health plan relates to the type of governmental entity that can establish or maintain a public health plan. Under the April 1997 interim rules, only health coverage provided under a plan established or maintained by a State, a county, or another political subdivision of a State can be a public health plan. This definition does not include a plan established or maintained by a foreign government or the U.S. government. The preamble to the April 1997 interim rules specifically solicited comments on whether public health systems of foreign countries should be considered public health plans.

Many comments addressed this issue, arguing both for and against including public health systems of foreign governments in the definition of public health plan. The comments in favor of inclusion argued that generally the health coverage provided through public health systems in foreign countries is more comprehensive than that received in this country. Some comments argued that the exclusion of foreign public health systems from the definition of public health plan arbitrarily penalizes individuals who maintain continuous health coverage through a foreign public health system. The comments against inclusion focused on the difficulty for a plan or issuer to verify whether someone had the coverage they claimed under a foreign public health system.

Under these final regulations, the definition of a public health plan includes health coverage provided under a plan established or maintained by a foreign country or a political subdivision. While this result can inconvenience plans and issuers, verifying this type of coverage may be no more inconvenient than verifying certain other types of coverage, such as group health coverage provided through foreign employers. In addition, this result is much less inequitable than denying an individual coverage for a preexisting condition in a case in which the individual can provide reliable evidence of having coverage under the public health system of a foreign government. Under the rules for establishing creditable coverage in the absence of a certificate of creditable coverage, an individual is required to present at a minimum some corroborating evidence of the claimed creditable coverage and is required to cooperate with a plan's or issuer's efforts to verify coverage. Thus, in the case of an individual claiming coverage under the public health system of a foreign country, a plan or issuer could require some evidence of residency in the foreign country (or evidence that some other eligibility standard had been met) and the individual would have to cooperate with the plan's or issuer's efforts to verify that the individual had coverage under that country's health system.

Under the revised definition in these final regulations, health coverage provided under a plan established or maintained by the U.S. Government is also a public health plan.

Counting Creditable Coverage

The rules in the final regulations for how to count creditable coverage are adopted with stylistic and conforming changes from the April 1997 interim rules. In addition, a technical modification was added, as required by a statutory change made by the Trade Act of 2002 (''the Trade Act'', Public Law 107–210, enacted on August 6, 2002). Under the Trade Act, workers whose employment is adversely affected by international trade may become entitled to receive trade adjustment assistance (TAA) and a 65% health coverage tax credit (HCTC). The Trade Act also amended COBRA continuation coverage provisions in ERISA, the Public Health Service Act, and the Internal Revenue Code, to provide a second opportunity to elect COBRA for individuals who are eventually determined to qualify for TAA, but who did not elect COBRA after their original loss of health coverage. Because this could result in a ''significant break in coverage'' for purposes of HIPAA, the Trade Act specifies that the period beginning with the loss of coverage, and ending on the first day of the second election period, for individuals who elect COBRA during this second election period, should be disregarded for purposes of the HIPAA pre-existing condition provisions. Accordingly, as required by the Trade Act, under these final rules the days between the date an individual lost group health plan coverage and the first day of the second COBRA election period are not taken into account in determining whether a significant break in coverage has occurred. For more information on TAA, contact the Department of Labor's Employment and Training Administration at 877–US2–JOBS or at *www.doleta.gov/tradeact.* For more information on the HCTC, contact the IRS toll-free at 866–628–4282.

The existing examples relating to the tolling of the period for determining a significant break in coverage in the case of individuals seeking coverage in the individual market have also been modified to conform to the change in the definition of waiting period, which under these final regulations includes the period beginning when an individual submits a substantially complete application for coverage in the individual market and ends when the application is denied or when the offer of coverage lapses. In addition, here, as throughout these final regulations, references in the April 1997 interim rules to ''plan or policy'' have been revised so that the reference includes health insurance coverage not offered through a policy of insurance, such as health insurance coverage offered through a contract of a health maintenance organization.

Published elsewhere in this issue of the **Federal Register** is a proposed rule that provides that the period that determines whether a significant break in coverage has occurred (generally 63 days) is tolled in cases in which a certificate of creditable coverage is not provided on or before the day coverage ceases. In those cases, the significant-break-in-coverage period would be tolled until a certificate is provided or, if earlier, until 44 days after the coverage ceases.

These final regulations retain the methods in the April 1997 interim rules for counting creditable coverage, that is, the standard method and the alternative method. Comments requested that the alternative method be expanded so that a plan or issuer could elect to have it apply to categories in addition to the five categories prescribed in the April 1997 interim rules (mental health; substance abuse treatment; prescription drugs; dental care; and vision care). The types of categories described in the comments were significant differences in deductibles, cost-sharing, or out-of-pocket maximums between plans. One comment suggested that any comparison between plans on the basis of difference in deductibles or cost sharing was unworkable.

It is the view of the Departments that a comparison between plans, and allowing one plan not to count creditable coverage (in whole or in part) under another plan, based solely on differences in deductibles or in some other cost-sharing mechanism or in all cost-sharing mechanisms, is an insufficient basis for determining the comparative value of benefits under the plans. A plan with a low deductible or low co-payments might also have an annual or per-incident limit on benefits so low as to make the plan with the higher deductible or higher cost sharing actually more valuable. Similarly, a plan with a higher deductible or coinsurance might also have a higher table of usual, customary, and reasonable costs, might be much more liberal in covering treatments considered experimental, and might provide a much broader base of benefits than the plan with the lower deductible or coinsurance. Because of the numerous ways that plans or issuers can limit the amount of benefits available under the plan, it is very complicated to compare the value of one plan or coverage with another. Singling out one or several of these features is insufficient for making a true comparison of the value of the benefits.

4. Evidence of Creditable Coverage—26 CFR 54.9801–5, 29 CFR 2590.701–5, 45 CFR 146.115

This section of the final regulations sets forth guidance regarding the certification requirements and other requirements for disclosure of information relating to prior creditable coverage. The provision of a certificate and certain other disclosures of information provided for in the statute, the April 1997 interim rules, and these final regulations are intended to enable an individual to establish prior creditable coverage for purposes of reducing or eliminating any preexisting condition exclusion imposed on the individual by any subsequent group health plan coverage. The Departments received generally favorable comments on the April 1997 interim rules from interested parties who submitted comments with regard to the certification requirements. For example, several comments praised the Departments' promulgation of a model certificate in the April 1997 interim rules as a vehicle that helped reduce compliance burdens associated with the statutory requirements under HIPAA.

Form of Certificate

These final regulations retain the requirement that the certificate must generally be provided in writing. The April 1997 interim rules clarified that for this purpose a writing included any form approved by the Secretaries as a writing. These final regulations modify that standard to include any other medium approved by the Secretary. As with the April 1997 interim rules, these final regulations provide that where an individual requests that the certificate be sent to another plan or issuer instead of the individual, and the other plan or issuer agrees, the certification information may be provided by other means, such as by telephone.

Information in Certificate

The information required to be provided in a certificate under these final regulations is the same as required under the April 1997 interim rules with one addition. In response to recommendations made by the U.S. General Accounting Office (GAO) [6] and several comments, the Departments have modified the April 1997 interim rules to require that an educational statement be provided as part of a certificate of creditable coverage in order to inform consumers of their HIPAA rights. Some comments stated that such educational language was not necessary, but indicated that if the Departments adopted such an approach they should provide language for compliance purposes. In response to the GAO recommendation, the Departments have amended the requirements for the certificate of creditable coverage in the final regulations to include the provision of an educational statement regarding certain HIPAA protections. Model educational language is provided in the model certificate (set forth below). This eliminates the burden on plans and issuers of developing language to satisfy this requirement.

Model Certificate

The first model certificate below has been authorized by the Secretary of each of the Departments. The model educational statement is set forth under the heading ''Statement of HIPAA Portability Rights.'' Use of the model certificate by group health plans and group health insurance issuers will satisfy the requirements of paragraph (a)(3)(ii) of the regulations. The second model certificate below has been authorized by the Secretary of Health and Human Services. State Medicaid programs may use this version. Once these final regulations are applicable, use of the previously-published model certificate (published in the preamble to the April 1997 interim rules) will no longer satisfy paragraph (a)(3)(ii) of the regulations.

In addition to these model certificates, the Departments are publishing a different model certificate for group health plans and group health insurance issuers in the preamble to the proposed rules published elsewhere in this issue of the **Federal Register**. That model certificate includes in its educational statement an additional paragraph regarding coordination with rules under the Family and Medical Leave Act (FMLA). The Secretaries of the Departments authorize plans and issuers to use either model certificate in fulfillment of their obligations under paragraph (a)(3)(ii) of this section in the final regulations. State Medicaid programs may use either the model certificate below that is designated for Medicaid programs, or the model certificate in the proposed rules that is so designated and includes an additional paragraph on FMLA.

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[6] In the report entitled ''PRIVATE HEALTH INSURANCE: Progress and Challenges in Implementing 1996 Federal Standards'' (GAO/HEHS–99–100, May 12, 1999) the GAO recommended that the Departments revise the model certificate of creditable health plan coverage to more explicitly inform consumers of their new rights under HIPAA. At a minimum, the GAO recommended that the certificate of creditable coverage should inform consumers about appropriate contacts for additional information about HIPAA and highlight key provisions and restrictions, including (1) the limits on preexisting condition exclusion periods and the guaranteed renewability of all health coverage; (2) the reduction or elimination of preexisting condition exclusion periods for employees changing jobs; (3) the prohibition against excluding an individual from an employer health plan on the basis of health status; and (4) the guarantee of access to insurance products for certain individuals losing group health coverage and the restrictions placed on that guarantee.

CERTIFICATE OF GROUP HEALTH PLAN COVERAGE

1. Date of this certificate: _____
2. Name of group health plan: _____
   _____
3. Name of participant: _____
4. Identification number of participant: _____
5 Name of individuals to whom this certificate applies: _____
   _____
6. Name, address, and telephone number of plan administrator or issuer responsible for providing this certificate: _____
   _____
7. For further information, call: _____
8. If the individual(s) identified in line 5 has (have) at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), check here and skip lines 9 and 10: ___
9. Date waiting period or affiliation period (if any) began:
   _____
10. Date coverage began: _____
11. Date coverage ended (or if coverage has not ended, enter "continuing"): _____

[Note: separate certificates will be furnished if information is not identical for the participant and each beneficiary.]

Statement of HIPAA Portability Rights

IMPORTANT — KEEP THIS CERTIFICATE. This certificate is evidence of your coverage under this plan. Under a federal law known as HIPAA, you may need evidence of your coverage to reduce a preexisting condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage even if you have health problems.

Preexisting condition exclusions. Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "preexisting condition exclusions." A preexisting condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a preexisting condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a preexisting condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a preexisting condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

➔ Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any preexisting condition exclusion if you enroll in another plan.

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

➔ Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Right to individual health coverage. Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a preexisting condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan (which can be shown by this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

➔ Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

State flexibility. This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

For more information. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at: http://www.dol.gov/ebsa, the DOL's interactive web pages - Health *E*laws, or http://www.cms.hhs.gov/hipaa1.

CERTIFICATE OF MEDICAID COVERAGE

1. Date of this certificate: _____
2. Name of state Medicaid program: _____
3. Name of recipient: _____
4. Identification number of recipient: _____
5. Name of individuals to whom this certificate applies: _____ _____
6. Name, address, and telephone number of state Medicaid agency responsible for providing this certificate: _____ _____
7. For further information call: _____
8. If the individual(s) identified in line 5 has (have) at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), check here and skip line 9. ____
9. Date coverage began: _____
10. Date coverage ended (or if coverage has not ended, enter "continuing"): _____

[Note: separate certificates will be furnished if information is not identical for the recipient and each dependent.]

Statement of HIPAA Portability Rights

IMPORTANT — KEEP THIS CERTIFICATE. This certificate is evidence of your coverage under this state Medicaid program. Under a federal law known as HIPAA, you may need evidence of your coverage to reduce a preexisting condition exclusion period under a group health plan, to help you get special enrollment in a group health plan, or to get certain types of individual health coverage even if you have health problems.

Preexisting condition exclusions. Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "preexisting condition exclusions." A preexisting condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a preexisting condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a preexisting condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a preexisting condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

➔ Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any preexisting condition exclusion if you enroll in a group health plan.

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

➔ Therefore, once your coverage in a group health plan ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Right to individual health coverage. Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a preexisting condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan;
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

➔ Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

State flexibility. This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

For more information. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at: http://www.dol.gov/ebsa or http://www.cms.hhs.gov/hipaa1.

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Procedure for Requesting Certificates

The April 1997 interim rules require plans and health insurance issuers to establish a procedure for individuals to request and receive certificates of creditable coverage. The Departments have received requests to clarify whether such procedures need to be in writing. These final regulations clarify that the procedures need to be in writing, helping to ensure that individuals are aware of their right to request a certificate and how to make the request.

In addition, the Departments have become aware that some plans and issuers believe they are not required to provide a certificate to individuals who request one while their coverage is still in effect. This requirement exists under the April 1997 interim rules. However, due to these questions being raised, the final regulations more explicitly state this requirement.

Dependent Coverage Information

Under HIPAA, plans and health insurance issuers are required to issue certificates of creditable coverage (automatically, and upon request) to dependents who are or were covered under a group health plan. In response to comments, and in order to allow entities responsible for issuing certificates adequate time to modify their data collection systems, the Departments established a transitional rule in the April 1997 interim rules for providing dependent coverage information. Under this transitional rule, a group health plan or health insurance issuer that, after having made reasonable efforts, could not provide a certificate of creditable coverage for a dependent could satisfy the requirements for providing a certificate to the dependent by providing the name of the participant covered by the group health plan or health insurance issuer and specifying that the type of coverage described in the certificate was for dependent coverage (for example, family coverage or employee-plus-spouse coverage). This transitional rule was effective through June 30, 1998.

Under these final regulations, the transitional rule is no longer in effect and dependents are entitled to receive individualized certificates of creditable coverage under the same circumstances as other individuals. As with the April 1997 interim rules, these final regulations permit a single certificate of creditable coverage to be provided with respect to both a participant and the participant's dependents if the information is identical for each individual. In addition, these final regulations retain the provisions of the April 1997 interim rules permitting the combining of information for families. As a result, in situations where coverage information is not identical for a participant and the participant's dependents, these final regulations allow certificates for all individuals to 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.

Special Rules for Certain Entities

Section 2791(a)(3) of the PHS Act provides that certain entities not otherwise subject to HIPAA's requirements are to comply with the statutory certification of coverage requirements that apply to group health plans, with respect to providing certificates of creditable coverage for Medicare, Medicaid, TRICARE, and medical care programs provided through the Indian Health Service or a tribal organization. These rules further establish that such entities are required to comply with the general statutory requirement to provide certificates. However, the Departments recognize that these programs operate in a different manner than do private employment-based group health plans, nonfederal governmental group health plans, and health insurance issuers. In addition, the populations served by these programs are unique. Therefore, it may be appropriate to allow these programs to implement the certification process in a manner that addresses these unique characteristics and better serves the individuals covered by these programs, including requiring different information elements (for example, see the above model certificate of creditable coverage for use by State Medicaid programs). HHS will coordinate with the appropriate entities responsible for issuing these certificates and will issue separate guidance to these entities on how they must comply with the certification requirements.

5. Special Enrollment Periods—26 CFR 54.9801–6, 29 CFR 2590.701–6, 45 CFR 146.117

Under HIPAA, the April 1997 interim rules, and these final regulations, a group health plan and a health insurance issuer offering group health insurance coverage are required to provide for special enrollment periods during which certain individuals are allowed to enroll (without having to wait until a late enrollment opportunity and regardless of whether the plan offers late enrollment). A special enrollment right can arise if a person with other health coverage loses eligibility for that coverage or employer contributions toward the other coverage cease, or if a person becomes a dependent through marriage, birth, adoption, or placement for adoption.

In order to qualify for special enrollment, an individual must be otherwise eligible for coverage under the plan. Being otherwise eligible for coverage means having met the plan's substantive eligibility requirements (such as satisfying any waiting period, being in an eligible job classification, or working full time), regardless of whether the individual previously satisfied the plan's procedural requirements for becoming enrolled (such as completing written application materials or providing them to the plan within a specified time frame) during any enrollment opportunity prior to special enrollment.

The special enrollment rules have been reorganized and clarified. As discussed below, the special enrollment rules have also been modified in response to comments.

Loss of Eligibility for Other Coverage

A special enrollment right resulting from loss of eligibility for other coverage is available to employees and their dependents who meet certain requirements. As under the April 1997 interim rules, the employee or dependent must otherwise be eligible for coverage under the terms of the plan. When coverage was previously declined, the employee or dependent must have been covered under another group health plan or must have had other health insurance coverage. The plan can require that, when coverage in the plan was previously declined, the employee must have declared in writing that the reason was other coverage, in which case the plan must at that time have provided notice of this requirement and the consequences of the employee's failure to provide the statement.

These regulations include an example that clarifies that the initial opportunity for enrollment (generally provided when employment begins) is not the only time when an individual with other health coverage may decline coverage for purposes of satisfying the prerequisites to special enrollment upon loss of other coverage. (Other examples discussed below also illustrate this principle.) An individual who initially did not enroll for coverage without having other health coverage might later be eligible for special enrollment. This could occur if, after subsequently enrolling in other coverage, the individual had an opportunity for late

enrollment or special enrollment under the plan, but again chose not to enroll.

These final regulations, like the April 1997 interim rules, contain a list of situations when an individual loses eligibility for other coverage. While the list is not exhaustive, it has nonetheless been expanded in these final regulations to address situations that have prompted frequent questions. Thus, these regulations clarify that a loss of eligibility for coverage occurs, in the case of individual coverage provided through an HMO, when an individual no longer resides, lives, or works in the service area of the HMO (whether or not within the choice of the individual) and the HMO does not provide coverage for that reason. In the case of group coverage provided through an HMO, the same rule applies, provided that there is no other coverage under the plan available to the individual. For purposes of this rule, the HMO service area is typically defined by State law. In addition, the regulations clarify that a loss of eligibility for coverage occurs due to the cessation of dependent status. For example, a child who ''ages out'' of dependent coverage—who attains an age in excess of the maximum age for coverage of a dependent child—incurs a loss of eligibility for coverage for purposes of special enrollment.

The regulations also clarify that a loss of eligibility for coverage occurs when a plan no longer offers any benefits to a class of similarly situated individuals. Thus, if a plan terminated health coverage for all part-time workers, the part-time workers incur a loss of eligibility for coverage, even if the plan continues to provide coverage to other employees. An example in the final regulations also illustrates how the loss of eligibility rule applies to a plan that terminates a benefit package option. Similarly, if an issuer providing one of the options ceases to operate in the group market, thus terminating one of the options offered by the plan, the individuals formerly in the terminated option would incur a loss of eligibility for coverage for purposes of special enrollment, unless the plan otherwise provided a current right to enroll in alternative health coverage. In addition, the final regulations clarify that an employee who is already enrolled in a benefit package may enroll in another benefit package under the plan if a dependent of that employee has a special enrollment right in the plan because the dependent lost eligibility for other coverage.

These regulations clarify that a loss of eligibility for coverage is still considered to exist even if there are subsequent coverage opportunities. As under the April 1997 interim rules, an individual does not have to elect COBRA continuation coverage or exercise similar continuation rights in order to preserve the right to special enrollment. Moreover, a special enrollment right exists even if an individual who lost coverage elects COBRA continuation coverage. In that case, if an individual declines special enrollment, and instead elects and exhausts COBRA continuation coverage, the individual has a second special enrollment right upon exhausting the COBRA continuation coverage.

In addition, as under the statute and the April 1997 interim rules, even if there is no loss of eligibility for coverage, a special enrollment right can result when employer contributions towards other coverage terminate. This is the case even if an individual continues the other coverage by paying the amount previously paid by the employer.

Lifetime Benefit Limits

Comments asked how the special enrollment rules apply when an individual reaches a lifetime limit on all benefits under a plan. The regulations clarify that where an individual has a claim denied due to the operation of a lifetime limit on all benefits, there is a loss of eligibility for coverage for special enrollment purposes. In this regard, an individual has a special enrollment right when a claim that would exceed a lifetime limit on all benefits is incurred, and the right continues at least until 30 days after the earliest date that a claim is denied due to the operation of the lifetime limit. Accordingly, because individuals who are keeping track of claims in relation to a lifetime limit can request enrollment immediately (after the claim is incurred, but before it is denied by the plan), the period for requesting special enrollment can be longer than 30 days. (Timeframes for providing certificates of creditable coverage and determining when COBRA is exhausted for individuals who have reached a lifetime limit on all benefits are set forth elsewhere in these final regulations, under the certificate and the definition provisions, respectively.)

Tolling of the Special Enrollment Period

Proposed rules, published elsewhere in this issue of the **Federal Register**, would toll the beginning of the 30-day period for requesting special enrollment until a certificate of creditable coverage is provided to the person losing coverage, up to a maximum of 44 days of tolling. This tolling rule would be in the paragraph reserved for special enrollment procedures in these final regulations.

Dependent Special Enrollment

Comments asked for clarification of the interaction of coverage for children under a State Children's Health Insurance Program (S–CHIP) and special enrollment. In particular, it was asked whether a child would have a right to special enrollment in a group health plan if the child becomes eligible for benefits under S–CHIP and the child is otherwise eligible for dependent coverage under the plan. This situation would arise if a State creates a children's health program that provides payments to a parent to cover the increased cost of enrolling a dependent child in the parent's employer's group health. However, without a special enrollment right, the parent might not be able to take advantage of the program until the next late enrollment opportunity, if the plan allows late enrollment at all. The statutory language of HIPAA, however, only provides special enrollment if there is loss of eligibility for other coverage, loss of employer contributions, or addition of a new dependent to the employee's family. Becoming eligible under a health program such as S–CHIP does not fall under any of these categories.[7]

Under these final regulations, as under the April 1997 interim rules, the special enrollment of dependents is subject to the plan's general eligibility requirements. For example, a plan may require an employee to remain enrolled, or to special enroll, in order to special enroll the employee's dependent. However, a plan's general eligibility requirements cannot prevent the application of a special enrollment right. For example, a plan may not deny special enrollment to an otherwise eligible dependent merely because the individual became a dependent of the participant after the participant's first day of coverage under the plan.

Modification of Special Enrollment Procedures

Under proposed rules, published elsewhere in this issue of the **Federal Register**, more detailed procedures are described for how plans and issuers would have to enroll individuals requesting special enrollment.

[7] Nonetheless, in addition to the dependent special enrollment rights under HIPAA, for plans subject to ERISA, section 609 of ERISA imposes additional requirements on group health plans to provide benefits to certain children, including in cases where a qualified medical child support order applies, as well as in cases of adoption. HIPAA does not prevent States from imposing similar requirements on nonfederal governmental plans.

When Coverage Begins Under Special Enrollment

Where the special enrollment right results from marriage or a loss of eligibility, coverage generally begins no later than the first day of the first calendar month after the date the plan or issuer receives the request for special enrollment. Where the special enrollment right results from a birth, coverage must begin on the date of birth. In the case of adoption or placement for adoption, coverage must begin no later than the date of such adoption or placement for adoption.

Clarification of Special Enrollment During a Late Enrollment Opportunity

The April 1997 interim rules provided a definition of the term *special enrollment date.* The purpose of the definition and accompanying examples was to illustrate that if an individual who qualified for special enrollment enrolled during a coinciding late enrollment opportunity, the individual could not be treated as a late enrollee. The final regulations eliminate the term *special enrollment date* and clarify this issue by providing that if an individual requests enrollment while the individual is entitled to special enrollment, the individual is a special enrollee, even if the request coincides with a late enrollment opportunity under the plan. Thus, the individual cannot be treated as a late enrollee.

Notice of Special Enrollment

The preamble to the April 1997 interim rules stated that a plan must provide a description of the special enrollment rights to anyone who declines coverage. However, the text of the April 1997 interim rules required the notice to be provided to all eligible employees. Even employees who enroll may need to avail themselves of their special enrollment rights in the future, either for a spouse or other dependent, or if they lose the present coverage. Thus, these regulations reiterate the requirement in the April 1997 interim rules that a plan must provide all employees (those who enroll as well as those who decline enrollment) with a notice of special enrollment at or before the time the employee is initially offered the opportunity to enroll in the plan. The regulation also provides model language that plans can use to satisfy this requirement.

Treatment of Special Enrollees

HIPAA provides that a late enrollee does not include an individual who enrolls when first eligible or who enrolls during a special enrollment period. These regulations further clarify that individuals who enroll during a special enrollment period must generally be treated the same as individuals who enroll when first eligible. That is, relative to similarly situated individuals who enroll when first eligible, special enrollees must be offered all the same benefit packages, cannot be required to pay more for coverage, and cannot be subject to a longer preexisting condition exclusion.

6. HMO Affiliation Period as an Alternative to a Preexisting Condition Exclusion—29 CFR 2590.701–7, 45 CFR 146.119

Under HIPAA, the April 1997 interim rules, and these final regulations, a group health plan that offers health insurance coverage through an HMO, or an HMO that offers health insurance coverage in connection with a group health plan, may impose an affiliation period under certain conditions. An affiliation period is a period of time that must expire before health insurance coverage provided by an HMO becomes effective and during which time the HMO is not required to provide benefits. Under these final regulations an affiliation period can be imposed if each of the following requirements is satisfied:

(1) No preexisting condition exclusion is imposed with respect to any coverage offered by the HMO in connection with the particular group health plan.

(2) No premium is charged to a participant or beneficiary for the affiliation period.

(3) The affiliation period for the HMO coverage is imposed consistent with the requirements of the HIPAA nondiscrimination provisions.

(4) The affiliation period does not exceed 2 months (or 3 months for a late enrollee).

(5) The affiliation period begins on the enrollment date (or, in the case of a late enrollee, the affiliation period begins on the day that would be the first day of coverage, but for the affiliation period).

(6) The affiliation period for enrollment in the HMO under a plan runs concurrently with any waiting period.

The requirements related to HMO affiliation periods contained in these final regulations clarify that a group health plan offering health insurance through an HMO or an HMO that offers health insurance coverage in connection with a group health plan may impose different affiliation periods, so long as the affiliation period complies with the requirements of the HIPAA nondiscrimination provisions. To illustrate this clarification, these final regulations contain an example where a group health plan that provides benefits through an HMO imposes an affiliation period with respect to salaried employees but does not impose an affiliation period with respect to hourly employees. This example illustrates that it is permissible to impose an affiliation period on salaried employees but not hourly employees, so long as treating these two groups differently complies with the requirements of the HIPAA nondiscrimination provisions.

The April 1997 interim rules and these final regulations specify that the affiliation period begins on the enrollment date (which is the first day of coverage under the plan, or if there is a waiting period for coverage under the plan, the first day of the waiting period), not when coverage under a particular benefit package option begins. Accordingly, an example in these final regulations illustrates that if a group health plan offers multiple benefit package options simultaneously, the HMO cannot impose an affiliation period on a plan participant who later switches to the HMO benefit package option, assuming the period of time that has elapsed since the enrollment date (during which the participant was covered under the first benefit package option) exceeds the duration of the HMO affiliation period. Moreover, these regulations clarify that, in the case of a late enrollee, the affiliation period begins on the day that would be the first day of coverage, but for the affiliation period.

The April 1997 interim rules and these final regulations allow an HMO to use alternative methods in lieu of an affiliation period to address adverse selection, as approved by the State insurance commissioner or other official designated to regulate HMOs. Because an affiliation period may be imposed only if no preexisting condition exclusion is imposed, an alternative to an affiliation period may not encompass an arrangement that is in the nature of a preexisting condition exclusion.

7. Interaction With the Family and Medical Leave Act—26 CFR 54.9801–7, 29 CFR 701–8, 45 CFR 146.120

This section has been reserved. For proposed rules on the interaction with the Family and Medical Leave Act, see the Departments' notice of proposed rulemaking, published elsewhere in this issue of the **Federal Register**.

8. Special Rules; Excepted Plans and Excepted Benefits—26 CFR 54.9831–1, 29 2590.732, 45 CFR 146.145

This section of the final regulations contains special rules that apply for

Chapter 100 of the Code, Part 7 of Subtitle B of Title I of ERISA (Part 7 of ERISA), and Title XXVII of the PHS Act. For ease in applying these rules, the definition of *group health plan* has been moved from the definitions section to this section (and the reference to employees in that definition has been modified to clarify that the term includes both current and former employees). New rules have been added for defining limited scope dental and vision benefits and for determining the extent to which benefits provided under a health flexible spending arrangement are excepted benefits. Special rules for partnerships have also been clarified.

Determination of the Number of Plans

A paragraph has been reserved in the final regulation for determining the number of plans an employer or employee organization maintains. For proposed rules on this topic, see the Departments' notice of proposed rulemaking, published elsewhere in this issue of the **Federal Register**.

Coverage Provided by an Employer Through Two or More Individual Policies

If an employer provides coverage to its employees through two or more individual policies, the coverage may be considered coverage offered in connection with a group health plan and, therefore, subject to the group market provisions under HIPAA. A determination of whether there is a group health plan depends on the particular facts and circumstances surrounding the extent of the employer's involvement. For example, one significant factor in establishing whether there is a group health plan is the extent to which the employer makes contributions to health insurance premiums. The fact that health insurance coverage is provided through a contract regulated under State law as individual health insurance coverage does not necessarily prevent the coverage from being treated for HIPAA purposes as coverage sold in the group market. Similarly, the policy that provides the coverage does not have to be considered a ''group'' policy under State law in order for the group market requirements to apply. Further, the mere fact that an employer forwards employee payroll deductions to a health insurance issuer will not, alone, cause the coverage to become group health plan coverage. However, the employer need not be a party to the insurance policy, or arrange or pay for it directly, in order for its coverage to be considered group health plan coverage. For example, if an employer's actions appear to endorse one or more policies offered by a health insurance issuer (or issuers), the coverage might be considered group health plan coverage.

General Exception for Certain Small Group Health Plans

Under HIPAA, the April 1997 interim rules, and these final regulations, the group market requirements do not apply to a group health plan or to group health insurance coverage offered in connection with a group health plan for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees. As noted in the preamble to the April 1997 interim rules, a State may apply some or all of the group market provisions in the PHS Act to health insurance issuers in connection with group health plans with fewer than two participants who are current employees on the first day of the plan year. In this case, to the extent the State applies its group market provisions to such insurance, the insurance would not be subject to the individual market requirements.

In the event a group health plan has two or more participants who are current employees on the first day of the plan year but the number of participants who are current employees drops below two during the plan year, under these final regulations the group market requirements continue to apply to the group health plan for the duration of the plan year.

To the extent a health insurance issuer offers group health insurance that is subject to HIPAA's group health insurance requirements, HIPAA generally prohibits the issuer from terminating or failing to offer to renew the insurance (*see* 45 CFR 146.152). With respect to very small employers, whether group health insurance is subject to the requirements of 45 CFR 146.152 is generally determined by whether the group health plan has two or more participants who are current employees on the first day of the plan year. If so, the issuer generally must provide such coverage throughout the plan year, and is prohibited from terminating coverage in the midst of that plan year merely because the number of current-employee participants drops below two.[8] However, an issuer is permitted to terminate an employer's coverage in the midst of a plan year if the employer fails to satisfy any valid plan participation requirements in the midst of that plan year (*see* 45 CFR 146.152(a)(3)), including instances where such failure causes the number of current-employee participants to drop below two.

Excepted Benefits

Under HIPAA, the April 1997 interim rules, and these final regulations, certain benefits are excepted from HIPAA in all circumstances, including coverage only for accident (including accidental death and dismemberment); disability income coverage; liability insurance, including general liability insurance and automotive liability insurance; coverage issued as a supplement to liability insurance; workers' compensation or similar coverage; automobile medical payment insurance; credit-only insurance (for example, mortgage insurance); and coverage for on-site medical clinics.

Limited Excepted Benefits

Under HIPAA, the April 1997 interim rules, and these final regulations, limited scope dental benefits, limited scope vision benefits, and long-term care benefits[9] are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a plan that is subject to these regulations. Benefits are not an integral part of such a plan if participants have the right not to elect coverage for the benefits, and if participants who elect such coverage must pay an additional premium or contribution for it. These regulations clarify that whether limited scope dental benefits, limited scope vision benefits, or long-term care benefits are provided through a plan that is subject to these regulations, or through a separate plan, is irrelevant to determining whether such benefits are an integral part of a plan that is subject to these regulations. Thus, if participants can decline coverage for the limited-scope benefits, and those electing such coverage must pay an additional premium or contribution, the limited scope benefits could be considered not to be an integral part of a plan that is subject to these regulations, even if such benefits are not provided through that plan.

Limited Scope Vision and Dental Benefits

These regulations define *limited scope dental benefits* as benefits

[8] See CMS Program Memorandum No. 99–03, *Group Size Issues Under Title XXVII of the Public Health Service Act,* September 1999.

[9] Long term care benefits are defined as benefits that are either subject to State long-term care insurance laws; that meet the qualifications of section 7702B(c)(1) or 7702B0(b) of the Internal Revenue Code; or are based on cognitive impairment or loss of functional capacity that is expected to be chronic.

substantially all of which are for treatment of the mouth (including any organ or structure within the mouth). These regulations also define *limited scope vision benefits* as benefits substantially all of which are for treatment of the eye. Thus, if benefits meet the definition of limited scope dental benefits or limited scope vision benefits, they will be excepted benefits if they satisfy the requirements set forth in these regulations.

These definitions were added in response to questions raised in comments about the prior guidance. The April 1997 interim rules did not define these terms. The preamble to the April 1997 interim rules suggested that the term *limited scope dental benefits* typically does not include medical services, such as those procedures associated with oral cancer or with a mouth injury that results in broken, displaced, or lost teeth. Similarly, the preamble to the April 1997 interim rules suggested that the term *limited scope vision benefits* does not include benefits for such ophthalmological services as treatment of an eye disease (such as glaucoma or a bacterial eye infection) or an eye injury. Comments indicated that typically most independent dental and vision coverages include benefits for these types of medical services. Accordingly, these regulations include definitions of limited scope dental benefits and limited scope vision benefits that reflect this market reality.

Health FSAs

Some comments asked about the extent to which health flexible spending arrangements (FSAs) are subject to these regulations. A health FSA generally is a benefit program that provides employees with coverage under which specified, incurred expenses may be reimbursed (subject to reimbursement maximums and any other reasonable conditions) and under which the maximum amount of reimbursement that is reasonably available to a participant for a period of coverage is not substantially in excess of the total premium (including both employee-paid and employer-paid portions of the premium) for the participant's coverage. Coverage and reimbursements provided to an individual under a group health plan that is a health FSA and that conforms to the generally applicable rules for accident or health plans qualify for the same tax-favored treatment that generally is extended to coverage and reimbursements under employer-provided accident or health plans. Health FSA reimbursements typically provide coverage for medical care expenses not otherwise covered by the employer's primary group health plan. A health FSA is permitted to operate under a cafeteria plan described in section 125 of the Code. Pursuant to the rules of section 125, an employee can elect to reduce the employee's salary in order to pay for health FSA coverage without the employee having to include that portion of the salary in gross income. Commonly, the maximum benefit payable under a health FSA for any year is equal to the amount of the employee's salary reduction election for the year, plus any additional employer contribution for the year.

The April 1997 interim rules did not address the extent to which health FSAs qualify as excepted benefits. On December 29, 1997, a clarification to the April 1997 interim rules was published that specified the circumstances under which a health FSA qualifies as excepted benefits. (62 FR 67688) That clarification stated that benefits under a health FSA are treated as excepted benefits if the FSA meets certain requirements. Specifically, FSA benefits are treated as excepted benefits if the maximum benefit payable for the employee under the FSA for the year does not exceed two times the employee's salary reduction election under the FSA for the year (or, if greater, the amount of the employee's salary reduction election under the FSA for the year, plus $500). In addition, the employee must have other coverage available under a group health plan of the employer for the year, and that other coverage cannot be limited to benefits that are excepted benefits.

Based on section 9832(c)(2)(C) of the Code, section 733(c)(2)(C) of ERISA, and section 2791(c)(2)(C) of the PHS Act, these regulations adopt the December 29, 1997 guidance with some additional clarifications. Specifically, these regulations clarify that to be considered excepted benefits, a health FSA must meet the definition of a health FSA in section 106(c)(2) of the Code. Also, these regulations clarify that other group health plan coverage not limited to excepted benefits must be made available for the year to the class of participants by reason of their employment. Similarly, the maximum amount payable to any participant in the class for the year is the amount to consider when determining whether the maximum amount payable under the FSA for the year complies with the limit specified in the previous paragraph. Additionally, these regulations clarify that an employer credit under a health FSA that an employee can elect to receive as taxable income is considered an employee salary reduction election. However, if the employee cannot receive the employer credit as taxable income (that is, the credit is lost unless the employee uses the amount for nontaxable benefits under a cafeteria plan), then the amount is not considered an employee salary reduction election.

Application to HSAs and HDHPs

Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108–173, added section 223 to the Internal Revenue Code to permit individuals to establish Health Savings Accounts (HSAs). HSAs are established to receive tax-favored contributions and amounts in an HSA may be used to pay or reimburse qualified medical expenses. Questions have arisen concerning the application of HIPAA to HSAs.

In order to establish and contribute to an HSA, an individual must be covered by a High Deductible Health Plan (HDHP). An HDHP is a health plan that satisfies certain requirements with respect to deductibles and out-of-pocket expenses. An HDHP may be a group health plan sponsored by an employer or individual health insurance coverage purchased in the individual market. There is no provision in the HIPAA rules that excludes an HDHP, by virtue of qualifying as an HDHP, from the respective HIPAA requirements for group health plans or individual health insurance coverage. Generally, employer-sponsored HDHPs are employee welfare benefit plans. See Department of Labor Field Assistance Bulletin 2004–01 (FAB 2004–01), issued on April 7, 2004. Because an employer-sponsored HDHP provides medical care, it is generally subject to the portability requirements of HIPAA and the applicable regulations.

FAB 2004–01 concluded that HSAs, in contrast to HDHPs, generally will not constitute employee welfare benefit plans. See Department of Labor Field Assistance Bulletin 2004–01 (FAB 2004–01), issued on April 7, 2004. Because HSAs are generally not employee welfare benefit plans, the HIPAA portability requirements under ERISA or the PHS Act generally will not apply.

Moreover, the HIPAA portability requirements generally are not relevant for purposes of HSAs. Due to the rules imposed by the Internal Revenue Code with respect to HSAs, employers or HSA trustees do not have discretion with respect to the coverage provided by an HSA, both with respect to what expenses qualify for reimbursement as well as which individuals' expenses are eligible. For example, expenses reimbursable by an HSA cannot

generally be restricted by the employer or HSA trustee. Under the statute and administrative guidance, any expense incurred after an HSA is established is eligible for reimbursement, without restriction by an employer contributing to the HSA or trustee of the HSA. Thus, as a practical matter, whether or not an expense relates to a preexisting condition cannot determine the reimbursement. As such HSAs by design cannot impose a preexisting condition exclusion. Similarly, due to comparability rules requiring uniform contributions to HSAs by employers, employers and trustees generally cannot use differing amounts of contributions to impose a preexisting condition exclusion.

The eligibility for tax-free reimbursement from an HSA is also determined by statute; namely, the qualified medical expenses of the HSA owner and the HSA owner's dependents incurred after the HSA is established may be reimbursed on a tax-free basis by the HSA. Special enrollment rules for dependent children or spouses are not relevant because once an HSA is established they are eligible for tax-free reimbursements immediately. With respect to special enrollment upon loss of coverage, the rules for employer contributions generally require that all employees who are eligible for HSA contributions and participating in the employer's HDHP receive comparable HSA contributions. Thus, the combination of the comparability rules and the application of the special enrollment rules to the HDHP will generally ensure compliance with respect to employer HSA contributions because once an employee is enrolled in an employer-provided HDHP due to the special enrollment rules, the employer must make comparable contributions to the employee's HSA.

Indemnity Insurance

Under HIPAA, the April 1997 interim rules, and these final regulations, hospital indemnity and other fixed-dollar indemnity insurance are excepted benefits if the benefits are provided under a separate policy, certificate, or contract of insurance; if there is no coordination of benefits between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and if the benefits are paid with respect to an event regardless of whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor. These regulations clarify that, for hospital indemnity or other fixed-dollar indemnity insurance to qualify as excepted benefits, such insurance must pay a fixed dollar amount per day (or other period), regardless of the amount of expenses incurred. An example clarifies that if a policy provides benefits only for hospital stays at a fixed percentage of hospital expenses up to a maximum amount per day, the benefits are not excepted benefits. This is the result even if, in practice, the policy pays the maximum for every day of hospitalization.

Supplemental Insurance

Under HIPAA, the April 1997 interim rules, and these final regulations, Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act); coverage supplemental to TRICARE; and similar coverage that is supplemental to a group health plan are excepted benefits if they are provided under a separate policy, certificate, or contract of insurance. These regulations clarify that, for coverage supplemental to a group health plan to qualify as excepted benefits, the coverage must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles. Coverage that becomes secondary or supplemental only under a coordination-of-benefits provision in the insurance contract or plan documents does not qualify as excepted supplemental benefits.

Treatment of Partnerships

Any plan, fund, or program that is established or maintained by a partnership and that provides medical care to present or former partners or their dependents, and that otherwise would not be an employee welfare benefit plan, is considered an employee welfare benefit plan that is a group health plan under Part 7 of ERISA and Title XXVII of the PHS Act.[10] As such, the partnership is considered the employer with respect to any partner. Participants in the plan include individuals who are partners of the partnership. Additionally, with respect to group health plans maintained by self-employed individuals (under which one or more employees are participants), the self-employed individual is considered a participant if this individual is or may become eligible to receive a benefit under the plan or if the individual's beneficiaries may be so eligible. These regulations clarify that, for purposes of Part 7 of ERISA and Title XXVII of PHS Act, a partner must be a bona fide partner in order to be considered an employee, and the partnership is considered the employer of a partner only if the partner is a bona fide partner. These final regulations also clarify that whether an individual is a bona fide partner is determined based on all the relevant facts and circumstances, including whether the individual performs services on behalf of the partnership.

Counting the Average Number of Employees

A paragraph has been reserved in the final rules for determining the average number of employees employed by an employer for a year. For proposed rules on this topic, see the Departments' notice of proposed rulemaking, published elsewhere in this issue of the **Federal Register**.

C. Economic Impact and Paperwork Burden

Summary—Department of Labor and Department of Health and Human Services

HIPAA's group market portability provisions, which include limitations on the scope and application of preexisting condition exclusions, and special enrollment rights, provide a minimum standard of protection designed to increase access to health coverage. The Departments crafted these final regulations to secure these protections, consistent with the intent of Congress, and to do so in a manner that is economically efficient.

The primary economic effects of HIPAA's portability provisions ensue directly from the statute. These regulations, by clarifying and securing HIPAA's statutory protections, will delineate and possibly expand HIPAA's effects at the margin.

Effects of the Statute

HIPAA's statutory group market portability provisions extend coverage to certain individuals and preexisting conditions not otherwise covered. This extension of coverage entails both benefits and costs. Individuals enjoying expanded coverage will realize benefits. In some instances these individuals will gain coverage for services they otherwise would have purchased out-of-pocket. In other instances the extension of coverage will induce individuals to consume more (or different) health care services, which in some cases may improve health outcomes. The dollar value of the extended coverage is estimated to be $515 million annually. Potential additional benefits from improved health outcomes are difficult

[10] Such a plan, fund, or program is also considered a group health plan under section 5000(b)(1) and Chapter 100 of the Code.

to quantify (and the Departments have not attempted to do so), but may be large in aggregate, and will be large for at least some individuals whose health outcomes may be substantially improved. Another indirect benefit of HIPAA's portability provisions is a reduction in so-called ''job lock''—a phenomenon in which individuals keep jobs they would prefer to leave to avoid losing coverage for preexisting conditions. If workers move into more productive jobs, the overall economy will benefit.

It should be noted that the benefits of HIPAA's portability provisions in any given year will be concentrated in a relatively small population that gains coverage under HIPAA for needed care that would otherwise not be covered. The number that might so benefit has been estimated at 100,000 individuals.

The direct costs of HIPAA's portability provisions generally include the cost of extending coverage to additional services, as well as certain attendant administrative costs. The cost of extended coverage is estimated at $515 million annually. The major administrative costs include the cost of providing certificates of creditable coverage, and possibly the cost of carrying out special enrollments and offsets of preexisting condition exclusion periods. The Departments did not attempt to fully estimate the administrative costs of the HIPAA statute but in crafting this regulation did attempt to constrain these costs.

The Departments believe that the cost of HIPAA is borne by covered workers. Cost can be shifted to workers through increases in employee premium shares or reductions (or smaller increases) in pay or other components of compensation, or by increases in deductibles or other cost sharing or other reductions in the richness of health benefits. Whereas the benefits of HIPAA are concentrated in a relatively small population, the costs are distributed broadly across plans and enrollees.

The Departments have considered whether the costs imposed by HIPAA's statutory portability provisions have had any major indirect negative effects, and concluded that such effects are possible but probably small.

Any mandate to increase the richness or availability of health insurance adds to the cost of insurance. It is possible that some small number of employers and employees already at the brink of affordability would drop coverage in response to the implementation of HIPAA. The Departments also note that the estimated $515 million cost associated with extensions of coverage under HIPAA amounts to a small fraction of one percent of total expenditures by private group health plans. This suggests that the cost of HIPAA is a small, possibly negligible, factor in most employers' decisions to offer health coverage and workers' decisions to enroll. The Departments believe that the benefits of HIPAA's statutory group market portability provisions justify their cost. The Departments' full assessment of the costs and benefits of HIPAA's statutory provisions and their basis for that assessment is detailed later in the preamble.

Effects of the Final Regulations

By clarifying and securing HIPAA's statutory portability protections, these regulations will help ensure that HIPAA rights are fully realized. The result is likely to be a small increase at the margin in the direct and indirect economic effects of HIPAA's statutory portability provisions. The Departments believe that the regulation's benefits will justify its costs.

Additional economic benefits derive from the regulations' clarifications of HIPAA's portability requirements. By clarifying employees' rights and plan sponsors' obligations under HIPAA's portability provisions, the regulations will reduce uncertainty over health benefits, thereby fostering labor market efficiency and the establishment and continuation of group health plans by employers.

Many provisions of the final regulations closely resemble provisions included in the interim final regulations that the final regulations supplant. This regulatory action, however, adds or amends both certain provisions directed at the scope of HIPAA's portability protections and certain provisions establishing administrative requirements intended to safeguard those protections.

Scope of Protections

These final regulations are intended to secure and implement HIPAA's group market portability provisions under certain special circumstances. The final regulations therefore contain a number of provisions intended to clearly delimit the scope of HIPAA's portability protections. Most of these provisions closely resemble and will have the same effect as provisions of the interim final regulations. Others, however, clarify or expand at the margin the range of situations to which HIPAA's portability protections apply or in which a loss of eligibility may trigger special enrollment rights. These include the requirement that health coverage under foreign government programs be treated as creditable coverage for purposes of limiting the application of preexisting condition exclusions; the extension of special enrollment rights to individuals who lose eligibility for coverage in connection with the application of lifetime benefit limits, movement out of an HMO's service area, or the termination of a health coverage option previously offered under a group health plan; and the establishment of a special enrollment right for a participant to change among available coverage options under a group health plan when adding one or more dependents in connection with marriage, adoption, or placement for adoption. Each of these provisions is expected to result in a small increase in the economic effects of HIPAA's statutory portability protections. The Departments have no basis to quantify these small increases. The potential size of affected sub populations is explored later in the preamble.

Administrative Requirements

In order to secure and implement HIPAA's group market special enrollment and portability provisions, both the HIPAA statute and these final regulations establish certain administrative requirements.

As noted above, the HIPAA statute generally requires plans and issuers to provide certifications of prior coverage to individuals leaving coverage. These regulations additionally require plans and issuers to notify individuals of their special enrollments rights, any preexisting condition exclusion provisions, and the applicability of such exclusions where individuals provide evidence of prior coverage that is of insufficient duration to fully offset exclusion periods. Plans will incur cost to comply with these administrative requirements. The Departments estimate the administrative cost to prepare and distribute certifications and notices to be $97 million per year. Nearly all of this, or $96 million, is attributable to the preparation and distribution of certifications as required under HIPAA's statutory provisions. These final regulations include numerous special provisions that serve to reduce plans' cost of providing certifications. A more strict interpretation of the statute would require plans to send an individual certificate to each affected enrollee. Such strict interpretation would result in plans sending 80.1 million certificates annually at cost of $157.6 million, which is $61.6 million more than the burden imposed by the final regulations.

Generally all of the major administrative requirements included in the final regulations were also included in the interim final regulations. The final regulations make minor additions to two requirements, however. They require plans to include educational statements in certificates of creditable coverage and to maintain in writing their procedures for requesting certificates. The cost of these additional requirements is expected to be small, and was not estimated separately from the overall cost of providing certificates.

Other changes included in these final regulations are likely to slightly reduce plans' cost to provide certain HIPAA-required notices. Included with the final regulation is new sample language for general and specific notices of preexisting condition exclusions, which may serve to reduce some plans' costs of providing these notices, and revised sample language for special enrollment rights notices. The final regulations also clarify the narrow scope of the requirement to notify certain affected participants of the specific application of preexisting condition exclusions. The Departments did not estimate the impact of these provisions separately from the overall cost of providing general and specific notices of preexisting condition exclusions and notices of special enrollment rights.

The Departments' full assessment of the costs and benefits of this regulation and their basis for that assessment is detailed later in this preamble.

Executive Order 12866—Department of Labor and Department of Health and Human Services

Under Executive Order 12866 (58 FR 551735, Oct. 4, 1993), the Departments must determine whether a regulatory action is ''significant'' and therefore subject to the requirements of the Executive Order and subject to review by the Office of Management and Budget (OMB). Under section 3(f), the order defines a ''significant regulatory action'' as an action that is likely to result in a rule: (1) Having an annual effect on the economy of $100 million or more, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as ''economically significant''); (2) creating serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

Pursuant to the terms of the Executive Order, this action is ''economically significant'' and subject to OMB review under Section 3(f) of the Executive Order. Consistent with the Executive Order, the Departments have assessed the costs and benefits of this action. The Departments' assessment, and the analysis underlying that assessment, is detailed below. The Departments performed a comprehensive, unified analysis to estimate the costs and benefits attributable to the regulations for purposes of compliance with Executive Order 12866, the Regulatory Flexibility Act, and the Paperwork Reduction Act.

Statement of Need for Action

These final regulations are needed to clarify and interpret the HIPAA portability provisions (increased portability through limitation on preexisting condition exclusions) under Section 701 of the Employee Retirement Income Security Act of 1974 (ERISA), Section 2701 of the Public Health Service Act, and Section 9801 of the Internal Revenue Code of 1986. The provisions are needed to improve the availability and portability of health coverage by limiting preexisting condition exclusions and their use, and requiring that group health plans and group health insurance issuers allow individuals to enroll under certain circumstances (special enrollment). Additional guidance was required to clarify certain definitions, such as the definition of creditable coverage; to clarify the method of determining the proper length of a preexisting condition exclusion period for an individual; to describe the circumstances under which an individual must be allowed a special enrollment opportunity; and to describe notices that group health plans and group health insurance issuers must provide to individuals.

Economic Effects

The Departments believe that this regulation's benefits will justify its costs. This belief is grounded in the assessment of costs and benefit that is summarized earlier in the preamble and detailed below.

Regulatory Flexibility Act—Department of Labor and Department of Health and Human Services

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) (RFA) imposes certain requirements with respect to Federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 *et seq.*) that are likely to have a significant economic impact on a substantial number of small entities. Unless an agency certifies that a rule will not have a significant economic impact on a substantial number of small entities, section 604 of the RFA requires the agency to present a final regulatory flexibility analysis at the time of the publication of the notice of final rulemaking describing the impact of the rule on small entities. Small entities include small businesses, organizations, and governmental jurisdictions.

Because these final rules are being issued without prior notices of proposed rulemaking, the RFA does not apply, and the Departments are not required to either certify that the rule will not have a significant impact on a substantial number of small entities or conduct a regulatory flexibility analysis. The Departments nonetheless crafted these regulations in careful consideration of their effects on small entities.

For purposes of this discussion, the Departments consider a small entity to be an employee benefit plan with fewer than 100 participants. The basis for this definition is found in section 104(a)(2) of ERISA, which permits the Secretary of Labor to prescribe simplified annual reports for pension plans which cover fewer than 100 participants. Under section 104(a)(3), the Secretary may also provide for simplified annual reporting and disclosure if the statutory requirements of part 1 of Title I of ERISA would otherwise be inappropriate for welfare benefit plans. Pursuant to the authority of section 104(a)(3), the Department of Labor has previously issued at 29 CFR 2520.104–20, 2520.104–21, 2520.104–41, 2520.104–46 and 2520.104b–10, certain simplified reporting provisions and limited exemptions from reporting and disclosure requirements for small plans, including unfunded or insured welfare plans covering fewer than 100 participants and which satisfy certain other requirements.

Further, while some small plans are maintained by large employers, most are maintained by small employers. Both small and large plans may enlist small third party service providers to perform administrative functions, but it is generally understood that third party service providers transfer their costs to their plan clients in the form of fees. Thus, the Departments believe that assessing the impact of this rule on small plans is an appropriate substitute for evaluating the effect on small entities. The definition of small entity

considered appropriate for this purpose differs, however, from a definition of small business based on size standards promulgated by the Small Business Administration (SBA) (13 CFR 121.201) pursuant to the Small Business Act (5 U.S.C. 631 *et seq.*). The Department of Labor solicited comments on the use of this standard for evaluating the effects of the interim final on small entities. No comments were received with respect to the standard.

The Departments believe that the benefits of this regulation will justify its costs. This belief is grounded in the assessment of costs and benefit that is summarized earlier in the preamble and detailed below in the ''Basis for Assessment of Economic Impact'' section. The direct financial value of coverage extensions pursuant to HIPAA's portability provisions are estimated to be approximately $180 million for small plans, or a small fraction of one percent of total small plan expenditures.[11]

In order to secure and implement HIPAA's portability provisions, the HIPAA statute and interim final regulations established certain administrative requirements, including requirements to provide certifications of creditable coverage and notices of special enrollment rights and preexisting condition exclusions. The Departments estimate the cost for small plans to prepare and distribute certifications and notices to be $13 million per year.[12] These costs will initially be borne by issuers who supply small group insurance products and by third-party administrators who provide services to small insured plans. These two types of entities will spread the costs across a much larger pool of small plans who will in turn transfer cost broadly to plan enrollees.

Special Analyses—Department of the Treasury

Notwithstanding the determinations of the Departments of Labor and of Health and Human Services, for purposes of the Department of the Treasury it has been determined that this Treasury decision is not a significant regulatory action. Pursuant to sections 603(a) and 605(b) of the Regulatory Flexibility Act, it is hereby certified that the collections of information referenced in this Treasury decision (*see* §§ 54.9801–3, 54.9801–4, 54.9801–5, and 54.9801–6) will not have a significant economic impact on a substantial number of small entities. Although a substantial number of small entities will be subject to the collection of information requirements in these regulations, the requirements will not have a significant economic impact on these entities. The average time required to complete a certification required under these regulations is estimated to be 4 to 5 minutes for all employers. This average is based on the assumption that most employers will automate the certification process. The paperwork requirements other than certifications that are contained in the regulations are estimated to impose less than 2% of the burden imposed by the certifications. Many small employers that maintain group health plans have their plans administered by an insurance company or third party administrators (TPAs). Most insurers and TPAs are expected to automate the certification process and therefore their average time to produce a certificate should be similar to the 4 to 5 minute average estimated for all employers. However, even for small employers that do not automate the certification process, the collection of information requirements in the regulation will not have a significant impact. Even if it is conservatively assumed that their average time to produce a certificate is 3 times as long as the highest estimate for all employers (*i.e.*, 15 minutes per certificate) and that all of their employees are covered by their group health plan and that half of the employees receive a certificate each year, the average burden per employee is less than 8 minutes per year. This can be rounded up to 8 minutes to more than account for the additional burden imposed by the other paperwork requirements of the final regulations. Thus, for example, for an employer with 10 employees, the annual burden would be not more than 1 hour and 20 minutes per year. At an estimated cost of $18 per hour, this would result in a cost of not more than $24 per year for the employer, which is not a significant economic impact. Because the collection of information requirements of this Treasury decision will not have a significant economic impact on a substantial number of small entities, a Regulatory Flexibility Analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required. Pursuant to section 7805(f) of the Code, the notice of proposed rulemaking preceding these regulations was submitted to the Small Business Administration for comment on its impact on small business.

Paperwork Reduction Act

Department of Labor

These final regulations include three separate collections of information as that term is defined in the Paperwork Reduction Act of 1995 (PRA 95), 44 U.S.C. 3502(3): the Notice of Enrollment Rights, Notice of Preexisting Condition Exclusion, and Certificate of Creditable Coverage. Each of these disclosures is currently approved by the Office of Management and Budget (OMB) through October 31, 2006 in accordance with PRA 95 under control numbers 1210–0101, 1210–0102, and 1210–0103.

Department of the Treasury

These final regulations include a collection of information as that term is defined in PRA 95: the Notice of Enrollment Rights, Notice of Preexisting Condition Exclusion, and Certificate of Creditable Coverage. Each of these disclosures is currently approved by OMB under control number 1545–1537.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number assigned by the Office of Management and Budget.

Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Department of Health and Human Services

These final regulations include three separate collections of information as that term is defined in PRA 95: the Notice of Enrollment Rights, Notice of Preexisting Condition Exclusion, and Certificate of Creditable Coverage. Each of these disclosures is currently approved by OMB through June 30, 2006 in accordance with PRA 95 under control number 0938–0702.

[11] Computer runs using Medical Expenditure Survey Household Component (MEPS–HC) and the Robert Wood Johnson Employer Healthy Benefits Survey determined that the share of covered private-sector job leavers at small firms average 35 percent of all covered private sector job leavers. From this, we inferred that the financial burden borne by small plans is approximately 35 percent of the total expenditures by private-sector group health plans.

[12] As noted above, the total cost for certificates and notices is estimated to be $97 million. We estimate that 13 percent of individuals receiving certificates and notices receive them from small group health plans, and on that basis estimates that 13% of the total cost falls on such plans. As noted below, we estimate that out of a total of 54 million individuals who leave coverage under group health plans, individual health insurance policies or public programs, 20 million, or 44 percent, are leaving private-sector group plans. Assuming that the proportion of these that are leaving small plans is equal to the proportion of covered, private-sector job leavers who leave small firms (estimated to be 35 percent, as noted above), 13 percent of those leaving any type of coverage are leaving coverage under small group plans.

Small Business Regulatory Enforcement Fairness Act

This final rule is subject to the provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*) and is being transmitted to Congress and the Comptroller General for review. The final rule, is a ''major rule,'' as that term is defined in 5 U.S.C. 804, because it may result in (1) an annual effect on the economy of $100 million or more; (2) a major increase in costs or prices for consumers, individual industries, or federal, State or local government agencies, or geographic regions; or (3) significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act of 1995 requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million. These final regulations have no such mandated consequential effect on State, local, or tribal governments, or on the private sector.

Federalism Statement Under Executive Order 13132—Department of Labor and Department of Health and Human Services

Executive Order 13132 outlines fundamental principles of federalism. It requires adherence to specific criteria by federal agencies in formulating and implementing policies that have ''substantial direct effects'' on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among the various levels of government. Federal agencies promulgating regulations that have these federalism implications must consult with State and local officials, and describe the extent of their consultation and the nature of the concerns of State and local officials in the preamble to the regulation.

In the Departments' view, these final regulations have federalism implications because they may have substantial direct effects on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among the various levels of government. However, in the Departments' view, the federalism implications of these final regulations are substantially mitigated because, with respect to health insurance issuers, the vast majority of States have enacted laws which meet or exceed the federal HIPAA portability standards.

In general, through section 514, ERISA supersedes State laws to the extent that they relate to any covered employee benefit plan, and preserves State laws that regulate insurance, banking or securities. While ERISA prohibits States from regulating a plan as an insurance or investment company or bank, HIPAA added a new section to ERISA (as well as to the PHS Act) narrowly preempting State requirements for issuers of group health insurance coverage. Specifically, with respect to seven provisions of the HIPAA portability rules, States may impose stricter obligations on health insurance issuers.[13] Moreover, with respect to other requirements for health insurance issuers, States may continue to apply State law requirements except to the extent that such requirements prevent the application of HIPAA's portability, access, and renewability provisions.

In enacting these new preemption provisions, Congress intended to preempt State insurance requirements only to the extent that they prevent the application of the basic protections set forth in HIPAA. HIPAA's conference report States that the conferees intended the narrowest preemption of State laws with regard to health insurance issuers. H.R. Conf. Rep. No. 736, 104th Cong. 2d Session 205 (1996). State insurance laws that are more stringent than the federal requirements are unlikely to ''prevent the application of'' the HIPAA portability provisions, and be preempted. Accordingly, States have significant latitude to impose requirements on health insurance insurers that are more restrictive than the federal law.

Guidance conveying this interpretation of HIPAA's preemption provisions was published in the **Federal Register** on April 8, 1997. 62 FR 16904. These final regulations clarify and implement the statute's minimum standards and do not significantly reduce the discretion given the States by the statute. Moreover, the Departments understand that the vast majority of States have requirements that meet or exceed the minimum requirements of the HIPAA portability provisions.

HIPAA provides that the States may enforce the provisions of HIPAA as they pertain to issuers, but that the Secretary of Health and Human Services must enforce any provisions that a State fails to substantially enforce. Currently, HHS enforces the HIPAA portability provisions in only one State in accordance with that State's specific request to do so. When exercising its responsibility to enforce the provisions of HIPAA, HHS works cooperatively with the State for the purpose of addressing the State's concerns and avoiding conflicts with the exercise of State authority. HHS has developed procedures to implement its enforcement responsibilities, and to afford the States the maximum opportunity to enforce HIPAA's requirements in the first instance. HHS's procedures address the handling of reports that States may not be substantially enforcing HIPAA's requirements, and the mechanism for allocating responsibility between the States and HHS. In compliance with Executive Order 13132's requirement that agencies examine closely any policies that may have federalism implications or limit the policymaking discretion of the States, DOL and HHS have engaged in numerous efforts to consult and work cooperatively with affected State and local officials.

For example, the Departments sought and received input from State insurance regulators and the National Association of Insurance Commissioners (NAIC). The NAIC is a non-profit corporation established by the insurance commissioners of the 50 States, the District of Columbia, and the four U.S. territories. In most States the Insurance Commissioner is appointed by the Governor, in approximately 14 States, the insurance commissioner is an elected official. Among other activities, it provides a forum for the development of uniform policy when uniformity is appropriate. Its members meet, discuss and offer solutions to mutual problems. The NAIC sponsors quarterly meetings to provide a forum for the exchange of ideas and in-depth consideration of insurance issues by regulators, industry representatives and consumers. CMS and the Department of Labor staff have consistently attended these quarterly meetings to listen to the concerns of the

[13] States may shorten the six-month look-back period prior to the enrollment date; shorten the 12-month and 18-month maximum preexisting condition exclusion periods; increase the 63-day significant break in coverage period; increase the 30-day period for newborns, adopted children, and children placed for adoption to enroll in the plan with no preexisting condition exclusion; further limit the circumstances in which a preexisting condition exclusion may be applied (beyond the federal exceptions for certain newborns, adopted children, children placed for adoption, pregnancy, and genetic information in the absence of a diagnosis; require additional special enrollment periods; and reduced the HMO affiliation period to less than 2 months (3 months for late enrollees).

State Insurance Departments regarding HIPAA portability issues. In addition to the general discussions, committee meetings, and task groups, the NAIC sponsors the standing CMS/DOL meeting on HIPAA issues for members during the quarterly conferences. This meeting provides CMS and the Department of Labor with the opportunity to provide updates on regulations, bulletins, enforcement actions, and outreach efforts regarding HIPAA.

The Departments received written comments on the interim regulation from the NAIC and from ten States. In general, these comments raised technical issues that the Departments considered in conjunction with similar issues raised by other commenters. In a letter sent before issuance of the interim regulation, the NAIC expressed concerns that the Departments interpret the new preemption provisions of HIPAA narrowly so as to give the States flexibility to impose more stringent requirements. As discussed above, the Departments address this concern in the preamble to the interim regulation.

In addition, the Departments specifically consulted with the NAIC in developing these final regulations. Through the NAIC, the Departments sought and received the input of State insurance departments regarding certain insurance industry definitions, enrollment procedures and standard coverage terms. This input is generally reflected in the discussion of comments received and changes made in Section B—Overview of the Regulations of the preamble to these regulations.

The Departments have also cooperated with the States in several ongoing outreach initiatives, through which information on HIPAA is shared among federal regulators, State regulators and the regulated community. In particular, the Department of Labor has established a Health Benefits Education Campaign with more than 70 partners, including CMS, NAIC and many business and consumer groups. CMS has sponsored conferences with the States—the Consumer Outreach and Advocacy conferences in March 1999 and June 2000, and the Implementation and Enforcement of HIPAA National State-Federal Conferences in August 1999, 2000, 2001, 2002, and 2003. Furthermore, both the Department of Labor and CMS Web sites offer links to important State Web sites and other resources, facilitating coordination between the State and federal regulators and the regulated community.

Throughout the process of developing these regulations, to the extent feasible within the specific preemption provisions of HIPAA, the Departments have attempted to balance the States' interests in regulating health insurance issuers, and the Congress' intent to provide uniform minimum protections to consumers in every State. By doing so, it is the Departments' view that they have complied with the requirements of Executive Order 13132.

Pursuant to the requirements set forth in Section 8(a) of Executive Order 13132, and by the signatures affixed to these final regulations, the Departments certify that the Employee Benefits Security Administration and the Centers for Medicare & Medicaid Services have complied with the requirements of Executive Order 13132 for the attached final regulation, Final Regulations for Health Coverage Portability for Group Health Plans and Group Health Insurance Issuers (RIN 1210–AA54 and RIN 0938–AL43), in a meaningful and timely manner.

Basis for Assessment of Economic Impact—Department of Labor and Department of Health and Human Services

As noted above, the primary economic effects of HIPAA's portability provisions ensue directly from the statute. These regulations, by clarifying and securing HIPAA's statutory protections, will delineate and possibly expand HIPAA's effects at the margin.

Effects of the Statute

In order to determine how many workers could benefit from crediting prior coverage against a new health plan's preexisting condition exclusion period, we examined the 18 million individuals who changed jobs in 2002. Of these, approximately 1 in 3 had health care coverage at those jobs and an additional 8 million dependents also received employer-sponsored health care coverage through these job changers. By allowing prior creditable coverage, 4 million job changers, who had at least 12 months of prior creditable coverage, were able to change jobs without the risk of a preexisting condition exclusions for them or their 5 million dependents. An additional 2 million workers who changed jobs and had some smaller amount of prior coverage, faced reduced waiting periods before receiving full coverage for them and their 3 million dependents.[14]

The most direct effect of HIPAA's statutory group market portability provisions is the extension of coverage to individuals and preexisting conditions not otherwise covered. This extension of coverage entails both benefits and costs. Individuals enjoying expanded coverage will realize benefits. In some instances these individuals will gain coverage for services they otherwise would have purchased out-of-pocket, thereby reaping a simple and direct financial benefit In other instances the extension of coverage will induce individuals to consume more (or different) health care services, reaping a benefit which has financial value, and which in some cases will produce additional indirect benefits both to the individual (improved health) and possibly to the economy at large (increased productivity).[15] The simple financial value of the direct benefits (essentially the dollar value of the extended coverage) is estimated to be $515 million.[16] The indirect benefits are

[14] We calculated these estimates using internal runs off the MEPS–HC. These runs gave the number of total job changers, total job changers that had employer-sponsored insurance (ESI), and whether this coverage had been for less than 12 months or not. Estimates for dependents were based off the ratio of policy-holders to total dependents from the March 2003 Current Population Survey (March CPS). This approach to the question of how many people are impacted by increased portability parallels that of the September 1995 U.S. General Accounting Office (GAO), Report HEHS–95–257, ''Health Insurance Portability: Reform Could Ensure Continued Coverage for up to 25 Million Americans,'' September 1995.

[15] For more detailed information, see Ellen O'Brien's article ''Employer' Benefits from Workers' Health Insurance'' Milbank Quarterly, Vol. 1 No. 1, 2003. She provides an extensive analysis of the literature on benefits accruing to employers from offering health benefits. She reports that researchers are beginning to calculate the costs to employers of unhealthy employees. Her work provides information on studies that have demonstrated that poor health may be related to lower productivity. For example, she discusses studies that have examined the effects on workplace productivity of specific health conditions and show that poor health reduces workers' productivity at work, and that effective health care treatments can reduce productivity losses and may even pay for themselves in terms of increased productivity.

[16] The estimate of $515 million is the 1999 projection published in the August 1, 1996 Congressional Budget Office (CBO) report, ''Estimate of Costs of Private Sector Mandates;'' Bill Number H.R. 3103, indexed. The index is derived from the average annual percent change from 1999 to 2004 in aggregate private health insurance expenditures, as reported in Table 3 of the ''National Health Care Projections Tables'' by the Centers for Medicare & Medicaid Services, Office of the Actuary. CBO estimated the direct cost to the private sector would total about $300 million in 1999. The specific items included in the estimate are: (1) Limiting the length of time employer-sponsored and group insurance plans could withhold coverage for pre-existing conditions, and (2) requiring that periods of continuous prior health plan coverage be credited against pre-existing condition exclusions of a new plan.

According to CBO, two-thirds of the cost reflects the provision to limit exclusions for pre-existing conditions. The key components of this estimate are: (1) The number of people who would have more of their medical expenses covered by insurance if exclusions were limited to one year or less, and (2) the average cost to insurers of that newly insured medical care. The provision

difficult to quantify (and the Departments have not attempted to do so), but may be large in aggregate, and will be large for at least some individuals whose health outcomes may be substantially improved.

Another indirect (though intended) benefit of HIPAA's portability provisions is a reduction in so-called ''job lock.'' Job lock occurs when an individual stays in a job with health insurance that he or she would prefer to leave out of concern that he or she would lose coverage for care of his or her own or a covered dependent's preexisting condition[17].

No attempt is made here to quantify increases in labor force mobility attributable to reduced job lock under HIPAA. However, it is noted that at least two indirect economic effects are likely to follow such increased mobility. First, the cost of coverage for some preexisting conditions will be transferred from one plan or issuer to another.[18] Second, if, as is likely, a result is movement of workers into more productive jobs, the overall economy will benefit.

It should be noted that the benefits of HIPAA's portability provisions in any given year will be concentrated in a relatively small population—generally, individuals who because of some combination of family health status and use of health services, job mobility, and plan provisions related to preexisting condition exclusions or enrollment opportunities, gain coverage under HIPAA for needed care that would otherwise not be covered.

According to CBO, any point in time, about 100,000 individuals would have a preexisting condition exclusion reduced for prior creditable coverage. An additional 45,000 would gain added coverage in the individual market.[19]

The direct costs of HIPAA's portability provisions generally include the cost of extending coverage to additional services, as well as certain attendant administrative costs. The cost of extended coverage is estimated at $515 million annually. The major administrative costs include the cost of providing certificates of creditable coverage, and possibly the cost of carrying out special enrollments and offsets of preexisting condition exclusion periods. The Departments did not attempt to fully estimate the administrative costs of the HIPAA statute but did, in crafting this regulation, attempt to constrain these costs, where possible. without compromising HIPAA's intent, as discussed below.

The Departments considered the probable incidence of these costs. The Departments believe that by and large the cost of HIPAA, like all of the cost of group health benefits, are borne by covered workers.[20] The most direct ways this cost can be shifted to workers is through increases in employee premium shares or reductions (or smaller increases) in pay or other components of compensation. Other paths for shifting of HIPAA's cost to workers might include increases in deductibles or other cost sharing, or other reductions in the richness of health benefits.

Whereas the benefits of HIPAA are concentrated in a relatively small population, the costs are distributed broadly across plans and enrollees. The cost for affected large, self-insured or experience rated group plans is spread across all enrollees in the plan. The cost for small insured plans typically is spread across large populations of small plans and their enrollees, partly as a result of State laws that compress small group premium rates.

The Departments have considered whether the costs imposed by HIPAA's statutory portability provisions have had any major indirect negative effects, and concluded that such effects are possible but probably small.

Any mandate to increase the richness or availability of health insurance adds to the cost of insurance. It is possible that some small number of employers already at the brink of affordability would drop coverage in response to the implementation of HIPAA. The number of employers so affected is probably limited in part because as noted above, employers can shift HIPAA's cost to workers in various ways, including through increases in employee premium shares or cost sharing—though such increases might prompt some workers at the margin to decline coverage. Economic literature provides some estimates of the responsiveness of employers and workers to increases in the price of insurance.[21]

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crediting prior coverage against current exclusions will account for a third of the cost. This estimate is based on two components: (1) The number of people who would receive some added coverage, and (2) the additional full-year cost of coverage, adjusted to reflect the estimated number of months of that coverage.

[17] Findings on the effect of health insurance coverage on job mobility have been mixed. A thorough assessment of the job lock literature in the past 10 years concluded that the most convincing evidence suggests that health insurance plays an important role in job mobility decisions, but is unclear as to its implications (*see* Gruber, Jonathan and Brigitte C. Madrian, 2002, Health Insurance, Labor Supply and Job Mobility: A Critical Review of the Literature, NBER Working Paper Series, No. 8817). A major concern in this literature has been to find an identification strategy able to overcome the potential correlation between the holding of employer-sponsored health insurance and other factors affecting job mobility independent from health insurance (*see* Anna Sanz de Galdeano, 2004. Health Insurance and Job Mobility: Evidence from Clinton's Second Mandate, Center for Studies in Economics and Finance Working Paper, No. 122). This is illustrated by the 2004 Health Confidence Survey which finds that 27 percent of the non-aged population reported that they or an immediate family member had experienced some form of job lock, but only 15 percent of those attributed the job-lock to a preexisting condition (*see* Ruth Helman & Paul Frostin, ''Public Attitudes on the U.S. Health Care System: Findings from the Health Confidence Survey.'' Employee Benefits Research Institute, Issue Brief no. 275 (EBRI, November 2004)).

[18] This transfer generally implies offsetting costs and benefits. It is possible, however, that in some instances individuals' mobility will allow them to exploit opportunities for adverse selection by moving into a richer health plan (*see* Cutler, D. and Reber, S., 1998. Paying for health insurance: the tradeoff between competition and adverse selection. Quarterly Journal of Economics 113, 433–466, and Cutler, D. and Zeckhauser, R. 2000. The anatomy of health insurance, in Culyer, A., Newhouse, J.P. (Eds.), Handbook of Health Economics, Vol. 1A. Elsevier, Amsterdam, pp. 564–629. For a contrasting study see, Pauly, M.V., Mitchell, O. and Zeng, Y. 2004 ''Death Spiral Or Euthanasia? The Demise Of Generous Group Health Insurance Coverage'' NBER Working Paper No. 10464, for a discussion). Such movements would constitute extensions of coverage with costs and benefits resembling those of direct extensions of coverage under HIPAA.

[19] Congressional Budget Office, ''Estimate of Costs of Private Sector Mandates; Bill Number H.R. 3103, August 1, 1996.

[20] The voluntary nature of the employment-based health benefit system in conjunction with the open and dynamic character of labor markets make explicit as well as implicit negotiations on compensation a key determinant of the prevalence of employee benefits coverage. It is likely that 80% to 100% of the cost of employee benefits is borne by workers through reduced wages (*see* for example Jonathan Gruber and Alan B. Krueger, ''The Incidence of Mandated Employer-Provided Insurance: Lessons from Workers Compensation Insurance,'' *Tax Policy and Economy* (1991); Jonathan Gruber, ''The Incidence of Mandated Maternity Benefits,'' *American Economic Review,* Vol. 84 (June 1994), pp. 622–641; Lawrence H. Summers, ''Some Simple Economics of Mandated Benefits,'' *American Economic Review,* Vol. 79, No. 2 (May 1989); Louise Sheiner, ''Health Care Costs, Wages, and Aging,'' Federal Reserve Board of Governors working paper, April 1999; and Edward Montgomery, Kathryn Shaw, and Mary Ellen Benedict, ''Pensions and Wages: An Hedonic Price Theory Approach,'' *International Economic Review,* Vol. 33 No. 1, Feb. 1992). The prevalence of benefits is therefore largely dependent on the efficacy of this exchange. If workers perceive that there is the potential for inappropriate denial of benefits they will discount their value to adjust for this risk. This discount drives a wedge in the compensation negotiation, limiting its efficiency. With workers unwilling to bear the full cost of the benefit, fewer benefits will be provided. To the extent which workers perceive a federal regulation supported by enforcement authority to improve the security and quality of benefits, the differential between the employers' costs and workers' willingness to accept wage offsets is minimized.

[21] Research shows that while the share of employers offering insurance is generally stable and eligibility rates have only declined slightly over time, the overall increase in uninsured workers is due to the decline in worker take-up rates, which workers primarily attribute to cost. Research on

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The Departments note, however, that cost increases attributable to HIPAA are not price increases per se but reflect the cost to enrich benefits, implying that negative responses should be smaller than would be expected in connection with pure price increases. The Departments also note that the estimated $515 million cost associated with extensions of coverage under HIPAA amounts to a small fraction of one percent of total expenditures by private group health plans.[22] This compares with average annual group premium growth of 9.4 percent for family coverage between 1996 and 2002.[23] To the extent that such increases are small, they are likely to have a negligible effect on employers' decisions to provide health insurance and in workers' decisions to enroll.

Various other studies to date suggest that any negative indirect effects of HIPAA are relatively minor. In one study,[24] large employers and health benefit consultants reported few ongoing problems in adopting HIPAA's portability provisions. Many issuers interviewed for the report said that their plans tended to require few changes to comply with HIPAA. This is probably because many large employer plans had already incorporated portability protections, similar to those of HIPAA. A second study indicates that while the share of small firms (those with fewer than 200 workers) offering health insurance has increased slightly from 1996 to 2004, the share has drifted downward from its high of 68 percent in the economic boom year of 2000.[25] In addition, in aggregate, employers covered a larger proportion of health care costs for family plans in 2002 than in 1996, with a slight decrease in the share of single plans over the same time period.[26]

The data above suggest that the HIPAA changes may have been less significant in the decision about health insurance coverage than overall economic conditions and labor market forces. In fact, there is no evidence that any indirect economic effect, positive or negative, can be readily attributed to the statute. Therefore, it appears that HIPAA has not placed an unreasonable burden on health plans.

There has been a significant decrease in the prevalence of preexisting condition exclusion clauses among large plans. A major employee benefits survey[27] reported that in 1996, 59 percent of the employees in small firms (less than 200 employees) were subject to pre-existing condition limitations. In 2002, the figure had dropped to 33 percent. If preexisting condition limitation exists for new employees, the average number of months to wait before coverage declined from 10.7 months in 1996 to 10.0 months in 2002. A discussion of results from a 1998 version of the same survey noted that, overall, 42 percent of employers reported making changes to their plans' preexisting condition clauses due to HIPAA. The Departments are not aware of any surveys that have consistently tracked the prevalence of preexisting condition exclusions in smaller plans (less than 200 employees) since 1996.

Another significant trend involves the use of waiting periods. According to a survey of employers with 200 or more employees, the average number of days that new enrollees must wait before health coverage takes effect increased from 40 days in 1996 to 58 days in 1998. Some attribute this increase indirectly to HIPAA, suggesting that some plans may be replacing the preexisting condition exclusion period with a longer waiting period.

Effects of the Final Regulations

By clarifying and securing HIPAA's statutory portability protections, these regulations will help ensure that HIPAA rights are fully realized. The result is likely to be a small increase at the margin in the direct and indirect economic effects of HIPAA's statutory portability provisions.

Additional economic benefits derive from the regulations' clarifications of HIPAA's portability requirements. The regulations provide clarity through both their provisions and their examples of how those provisions apply in various circumstances. By clarifying employees' rights and plan sponsors' obligations under HIPAA's portability provisions, the regulations will reduce uncertainty and costly disputes over these rights and obligations. They will promote employers' and employees' common understanding of the value of group health plan benefits and confidence in the security and predictability of those benefits, thereby improving labor market efficiency and fostering the establishment and continuation of group health plans by employers.

Many provisions of the final regulations closely resemble provisions included in the interim final regulations that the final regulations supplant. The economic impact of this regulatory action therefore generally will be limited to the impact of provisions that were not so included. These include both provisions directed at the scope of HIPAA's portability protections and provisions establishing administrative requirements intended to safeguard those protections.

Scope of Protections

These final regulations are intended to secure and implement HIPAA's group market portability provisions under certain special circumstances. The final regulations therefore contain a number of provisions intended to clearly delimit the scope of HIPAA's portability protections. Most of these provisions closely resemble and will have the same effect as provisions of the interim final regulations. Others, however, clarify or expand at the margin the range of situations to which HIPAA's portability protections explicitly apply. These include the requirement that health coverage under foreign government programs be treated as creditable coverage for purposes of limiting the application of preexisting condition exclusions; the extension of special enrollment rights to individuals who lose eligibility for coverage in connection with the application of lifetime benefit limits, movement out of an HMO's service area, or the termination of a health coverage option previously offered under a group health plan; and the establishment of a special enrollment right for a participant to change among available coverage options under a group health plan when

elasticity of coverage, however, has focused on getting uninsured workers to adopt coverage (which appears to require large subsidies) rather than covered workers opting out of coverage. This makes it difficult to ascertain the loss in coverage that would result from a marginal increase in costs. (*See,* for example, David M. Cutler ''Employee Costs and the Decline in Health Insurance Coverage'' NBER Working Paper #9036. July 2002; Gruber, Jonathon and Ebonya Washington. ''Subsidies to Employee Health Insurance Premiums and the Health Insurance Market'' NBER Working Paper #9567. March 2003; and Cooper, PF and J. Vistnes. ''Workers' Decisions to Take-up Offered Insurance Coverage: Assessing the Importance of Out-of-Pocket Costs'' Med Care 2003, 41(7 Suppl): III35–43.) Finally, economic discussions on elasticity of insurance tend to view coverage as a discrete concept and does not consider that the value of coverage may have also changed.

[22] While these costs are expected in aggregate to be less than one percent of total expenditures by group health plans, the statute may disproportionately affect particular plans.

[23] This is the average annual rate of increase in total family premiums as reported in the Medical Expenditure Panel Survey, Insurance Component (MEPS–IC) public tables, 1996–2002.

[24] U.S. General Accounting Office, Report HEH–99–100, ''Private Health Insurance: Progress and Challenges in Implementing 1996 Federal Standards,'' pp. 6–7, May 1999.

[25] Gabel, Jon R. *et al.* ''Health Benefits in 2004: Four Years of Double Digit Premium Increases Take Their Toll on Coverage'' Health Affairs, Volume 23, Number 5, September/October 2004.

[26] As reported in the MEPS–IC 1996–2002 public tables.

[27] Employee Health Benefits 2002 Study, Kaiser Family Foundation.

adding one or more dependents in connection with marriage, adoption, or placement for adoption. Each of these provisions is expected to result in a small increase in the economic effects of HIPAA's statutory portability protections.

The Departments lack any firm basis for quantifying the number of individuals likely to be affected by these provisions, and therefore were unable to quantify the resultant increase in transfers. However, given the special and narrow circumstances to which these provisions apply, the number of affected individuals, and therefore the increase in transfers under these regulations, is expected to be small. In reaching this conclusion, the Departments considered the following.

In 2002, an estimated 359,000 employer sponsored insurance enrollees had moved from abroad in the previous year.[28] It is not known what fraction of these had been covered under foreign government programs, or of those, what fraction joined group health plans that included preexisting condition exclusions while suffering from and requiring additional care for preexisting conditions. Comparing GAO's estimate of the number of individuals who could potentially benefit from HIPAA's portability protections (20 million or more individuals with prior creditable coverage who join new health plans in a given year) with CBO estimates of the number who might actually have added coverage for needed care (145,000) produces a ratio of about 1 percent. If this proportion holds for group health plan enrollees who moved to the U.S. from abroad, and if all such enrollees were previously covered under a foreign government program (an upper bound), then about 4,000 individuals annually might gain coverage for needed care under the final regulation's provision treating coverage under such programs as creditable coverage.[29]

The provision that clarifies the special enrollment rights of individuals who lose eligibility for coverage in connection with the movement out of an HMO's service area is expected mainly to benefit certain individuals with COBRA continuation coverage. The number of individuals affected in any given year is expected to be small. It is estimated that in 2002, fewer than 10,000 COBRA enrollees were covered by HMOs, moved across State or county lines, and were potentially eligible for coverage under another family member's group plan.[30]

Lifetime benefit limits (LBL) are fairly common in-group health plans and are typically set at $1 million or more.[31] Based on tabulations made by an actuarial consulting firm,[32] in plans with LBLs of $1 million, annually about 27 per one million enrollees will exceed the benefit limits. In plans with a $500,000 LBL, the comparable figure is 181 per million enrollees; and in plans with a $2 million LBL, 5 per million enrollees. Combining these proportions with a distribution of LBLs by plan enrollment reported by a national employer survey, yields about 8,700 plan enrollees who will annually reach their plan's LBL. The Departments recognize that those individuals who do encounter such limits by definition have very high expenses, a large portion of which would be transferred to the group health plans into which they special enroll. It is possible, however, that a large share of such transfers would have occurred even without the provisions of these final regulations establishing a right to special enroll upon encountering lifetime limits. For example, the same individuals might have enrolled in these plans during open enrollment opportunities, either before or after encountering the limits. Alternatively, participants who have met their LBL might have left their jobs in order to create a special enrollment opportunity.

The Departments estimate that annually about 1 million families will be eligible for special enrollments due to marriage, 2 million due to births. About one-half of employees offered coverage at work have a choice of plan options.[33] Taken together, this suggests that the number of individuals gaining special enrollment rights to switch among options within group health plans when adding dependents may be large. However, it is unclear how many will elect to switch, or how many who do would have been so permitted even absent the applicable requirement of these final regulations. More important, it is unclear whether merely switching among options will increase or decrease the transfer from the affected health plans to the affected individuals. In any event, individuals exercising this special enrollment right to switch options are not gaining coverage under any particular group health plan but are merely modifying that coverage.

Administrative Requirements

In order to secure and implement HIPAA's group market special enrollment and portability provisions, both the HIPAA statute and these final regulations establish certain administrative requirements. As noted above, the HIPAA statute generally requires plans and issuers to provide certifications of prior coverage to individuals leaving coverage. These regulations additionally require plans and issuers to notify individuals of their special enrollments rights, any preexisting condition exclusion provisions, and the applicability of such exclusions where individuals provide evidence of prior coverage that is of insufficient duration to fully offset exclusion periods. Plans will incur cost to comply with these administrative requirements. The Departments estimate the administrative cost to prepare and distribute certifications and notices to be $97 million per year.[34]

Nearly all of this, or $96 million, is attributable to the preparation and distribution of certifications as required under HIPAA's statutory provisions. These final regulations include numerous special provisions that serve to reduce plans' cost of providing certifications. These provisions serve to streamline and standardize certifications' content and format, minimize the number of duplicative certifications issued, and encourage the use of telephone calls and other modes of communication when they will suffice in lieu of written certifications. The provisions are designed to minimize certifications' cost while ensuring that individuals and plans (respectively) can efficiently and effectively demonstrate and verify prior coverage. Demonstration and verification of prior coverage enable individuals to secure and plans to

[28] Calculation from the 2003 March CPS.

[29] This number is 1 percent of the number of ESI holders in 2002 who moved from abroad the previous year.

[30] Estimates using the March 2003 CPS. It should be noted that CPS is a weighted survey and that the number of actual observations of individuals that were COBRA enrollees with HMO coverage, moved across counties and/or States and were eligible for coverage under another family member's group plan was extremely small. As a result, this estimate is extremely noisy.

[31] See, for example, U.S. Bureau of Labor Statistics, *Employee Benefits in Medium and Large Establishments, 2000* (Washington, DC: U.S. Government Printing Office, 2003).

[32] Milliman USA memorandum dated December 6, 2001.

[33] Sally Trude, ''Who Has A Choice of Health Plans?'' Center for Studying Health Systems Change, *Issue Brief: Findings from HSC,* No. 27, Feb. 2000.

[34] The Departments assumed that a clerical-level employee at a total labor cost (wages, fringe benefits, and overhead) of $17.24 per-hour would generate the certificates. The Departments further assumed that the average time required to complete a certification is 4 to 5 minutes for all employers. This average is based on the assumption that most employers will automate the certification process. The cost of printing/copying, an envelope and postage is assumed to be $0.53 per employee.

appropriately honor individuals' portability rights under HIPAA.

First, an intermediate issuer will not have to issue a certificate of creditable coverage when an individual changes options under the same health plan. In lieu of the certificate, the issuer could simply transmit to the plan information regarding individuals' effective date of coverage and the last date of coverage. An individual would retain the right to get a certificate automatically and upon request if he/she leaves the plan.

Second, telephonic certification will fulfill the requirement to send a certificate if the receiving plan, prior plan, and the participant mutually agree to that arrangement. The individual can get a written certificate upon request.

Third, in situations where the issuer and the plan contract for the issuer to complete the certificates, the plan would not remain liable even if the issuer failed to send the certificates.

Fourth, the period of coverage listed on automatic certificates will be only the last continuous period of coverage without any break. This is the most efficient and simplest method of record keeping for plans and issuers.

Fifth, the period of coverage contained in the on-request certification will be all periods of coverage ending within 24 months before the date of the request. Essentially, a plan may simply look back two years and send copies of any automatic certificates issued during that period.

Sixth, a single certificate of creditable coverage can be provided with respect to both a participant and the participant's dependent if the information is identical for each individual. In addition, certificates may contain combined information for families.

Seventh, plans and issuers are not required to furnish an individual an automatic certificate with respect to a dependent until they know or should know of the dependent's cessation of coverage under the plan.

The above reductions in burdens on plans and issuers may cause more frequent circumstances in which participants are required to demonstrate creditable coverage. In order to help offset some of the additional burdens that will be shifted to the participants, the regulations provide the following protections:

First, if 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 dependent status, and the individual cooperates with the plan's or issuer's efforts to verify the dependent status.

Second, if the accuracy of a certificate is contested or a certificate is unavailable when needed, individuals have the right to demonstrate creditable coverage through the presentation of relevant corroborating evidence of creditable coverage during the relevant time period and by cooperating with the plan's efforts to verify the individual's coverage.

Third, plans and issuers that impose preexisting condition exclusion periods must notify participants of this fact. They must also explain that prior creditable coverage can reduce the length of a preexisting condition exclusion period, and that the plan or issuer will assist in obtaining a certificate of creditable coverage from any prior plan or issuer, if necessary. An exclusion may not be imposed until this notice is given. This is beneficial to participants insofar as it forewarns them of potential claim denials and enables them to more easily exercise their right to protection from such denials under HIPAA's portability provisions.

Fourth, after an individual has presented evidence of creditable coverage, the plan or issuer must give the individual a written notice of the length of any preexisting condition exclusion that remains after offsetting for creditable coverage.

Fifth, certificates of creditable coverage now contain educational language that more explicitly informs consumers of their HIPAA rights.

As noted earlier in this preamble, GAO and others recommended that educational statements be added to certifications. The Departments have provided a suitable statement for use by plans, thereby eliminating any need for plans to develop their own. The cost of providing such statements is therefore expected to be minimal.

The administrative cost associated with provision of certifications under the HIPAA statute and these final regulations was estimated as follows.

The ongoing burden associated with the issuance of automatic certifications by group plans is estimated as a function of (1) the number of events that trigger such issuances; (2) the statutory and regulatory specifications for the content of the certificates; and (3) the assumed burden associated with the preparation and distribution of each certificate.

Certifications must be issued when an event, defined as the loss of health coverage by a participant or by a dependent, occurs. Survey tabulations indicate that there were 54.3 million events in 2002.[35] Additionally, results from the March 1999 CPS indicate that about 3 percent of the events involve a dependent who lives at a different address than the participant. In such cases the plan is required to send out at least 2 separate certificates.

The model certificate illustrates how plans may incur a lesser burden when it is certified that prior periods of coverage were of at least 18 months duration; that is, in lieu of a specific date that coverage began and waiting/affiliation period information, such certifications may simply indicate that the prior period of coverage lasted at least 18 months. In contrast, certifications of shorter periods of prior coverage must contain the specific dates when coverage—and waiting/affiliation periods, if applicable—began.

Combining the options for the addresses with the time periods results in four categories of certifications: (1) One address and less than 18 months of prior creditable coverage (12 million annual events); (2) one address and 18 months or more of prior creditable coverage (42.3 million); (3) more than one address and prior creditable coverage of less than 18 months (.4 million); and (4) more than one address and 18 months or more of prior creditable coverage (1.3 million).

Consistent with the interim regulations, we assume that the per-certificate preparation effort requires 5 minutes for prior creditable coverage of less than 18 months and 4 minutes for creditable coverage that is greater than or equal to 18 months. The additional cost involved in sending certificates to multiple addresses for a given participant is assumed to be 50 percent of the cost of sending a certificate to one address.

The Departments assumed that the certificates would be generated by a clerical-level employee who costs the plans $17.24 per-hour in wages, benefits, and overhead [36]. The cost of printing/copying, envelope and postage is assumed to be $0.53 per envelope.

[35] This total is based on internal estimates. The ESI total (24.0 million or 20.4 private-sector and 3.6 public sector) was the sum of policy-holders who left jobs, according to the 2002 MEPS–HC, and their dependents, which were derived by multiplying this number by the CPS ratio of dependents to policy holders. Based on counts of the number of people with partial year coverage off the March 2003 CPS, we estimated the SCHIP and Medicaid total to be 14.9 million and the private individual market to be 15.4 million.

[36] The total labor cost is derived from wage and compensation data from the Bureau of Labor Statistics and includes an overhead componenet, which is a multiple of compensation based on the Government Cost Estimate.

The resulting annual burden is $96 million.

A more strict interpretation of the statute would require plans to send an individual certificate to each affected enrollee. Obviously, this requirement would significantly increase the administrative burden. Such strict interpretation would result in plans sending 80.1 million certificates annually at cost of $157.6 million, which is $61.6 million more than the burden imposed by the final regulations.

The final regulations require that plans, in response to requests made by or on behalf of individuals, provide certificates at any time while the individual is covered under the plan and for up to 24 months after coverage ceases. Such requests are most likely to be made by an individual who is unable to locate the certificate of creditable coverage from his/her prior health plan and is seeking to enroll in a group health plan that imposes preexisting condition exclusions or is seeking to reduce or eliminate any preexisting condition exclusions that may otherwise be applied by a source of individual coverage.

The Departments believe that the requested certificate burden is negligible for several reasons. First, as reported by a major health benefits survey [37] the proportion of enrollees that are in plans with preexisting condition exclusion has not changed from the 2000 share of 30 percent, which is down from the pre-HIPAA level of 60 percent. In addition, the educational statement contained within the certificate serves to highlight the importance of the document, thus encouraging its retention. Furthermore, the final rules permit individuals to establish and verify creditable coverage through other means. Finally, evidence of creditable coverage may be transmitted through means other than documentation, such as by a telephone call from the plan to a third party.

Apart from the provision of certifications of prior creditable coverage, the remaining $1 million in administrative expenses is attributable to notices of special enrollment rights and of the existence and application of preexisting condition exclusions, which are required under these final regulations. The Departments believe that these notices are necessary to ensure that individuals understand and can effectively exercise their special enrollment and portability rights under HIPAA, and that the benefits of ensuring this outweigh the associated administrative cost.

The regulations provide that a plan must provide all employees with a notice describing special enrollment rights at or before the time the employee is initially offered the opportunity to enroll in the plan. The final regulations provide model language that can be used to satisfy the special enrollment notice requirement.

The Departments believe that the vast majority of plans have incorporated special enrollment language into their plan enrollment materials. Thus, the cost of the special enrollment notice is assumed to be a minor component of the overall cost of providing plan enrollment materials.

The number of employees who are hired annually by firms that offer health coverage and who are eligible for such coverage was developed by using the proportion of workers with less than one year of tenure as reported by the 2002 MEPS–HC. We find that 10.8 million employees will be newly hired and eligible for health coverage on an annual basis. We assume that the special enrollment notice is a component of plan enrollment materials and requires one-third of a sheet of paper. Using a printing/copying cost of $0.05 per page, we assume that the per-notice cost is $0.0167. The resulting burden is estimated to be $180,687.

The final regulations provide that every plan with a preexisting condition exclusion must provide in writing a general notice of such provisions to individuals eligible for enrollment under the plan. The regulations specify what is required of the plan when it discusses the amount and terms of its preexisting condition exclusion, including the person to contact for further information regarding the exclusions. In addition, the regulations clarify that issuers must describe the actual maximum exclusion period that is applicable to a specific plan. A regulatory example provides sample language that the plans can use to develop the general notice.

Based on results from the 2000 Kaiser/HRET Employer survey, we assume that 35 percent of plans with fewer than 100 participants, and 28 percent of plans with 100 or more participants, apply preexisting condition exclusions to new enrollees. If we apply these proportions to the number of new employees hired each year by employers that offer health coverage, we find that 3.1 million employees will annually receive the general notice.

As with the special enrollment notice, we assume that the general notice of preexisting condition exclusions is a component of standard plan enrollment materials and also requires one-third of a sheet of paper. Assuming a printing/copying cost of $0.05 per page, the per-notice cost is $0.0167. The annual cost to distribute the notices is therefore estimated to be $51,852.

The regulations provide sample notice language, thus relieving the plans of the burden of developing their own forms.

Plans that impose preexisting condition exclusions must, in writing, notify participants who have failed to demonstrate sufficient prior coverage that the exclusions will affect them and indicate what the length of the preexisting condition exclusion period is, with respect to each individual. This notice is required only in situations in which the individual presents evidence of prior creditable coverage and its duration is less than the maximum length of the preexisting condition exclusion period. These final regulations clarify that the notice does not have to identify any medical conditions that are specific to the individual and subject to the exclusion.

Tabulations from the 2002 MEPS–HC indicate that, of those individuals in the private sector who changed jobs and hold insurance, 16 percent have prior creditable coverage of between 1 day and 12 months, which is the statutory preexisting condition exclusion maximum for individuals who enroll when first eligible. The comparable proportion for State and local governmental plans is 18 percent. Applying these proportion to the number of general preexisting exclusion notices required, yields 478,569 notices that will be prepared annually.

Because the notice must be customized to reflect each individual's applicable preexisting condition exclusion period, the per-notice time burden will be greater than that for the general notice of preexisting condition exclusions. Consistent with the interim final regulations, the Departments assume that the preparation of each notice will take two minutes of a clerical-level employee's time, plus $0.47 for printing, envelope, and postage, yielding a per-notice cost of $1.05. The resulting annual burden is estimated to be $582,497.

The estimated burden represents only the cost of producing and distributing the notices and does not include the expense involved in determining the adequacy of a participant's prior coverage, since such expense is considered to be part of the regular business practices necessary to comply with HIPAA's statutory portability protections.

[37] *Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits 2002 Annual Survey.*

Generally all of the major administrative requirements included in the final regulations were also included in the interim final regulations. The final regulations make minor additions to two requirements, however. They require plans to include educational statements in certificates of creditable coverage and to maintain in writing their procedures for requesting certificates. The cost of these additional requirements is expected to be small, and was not estimated separately from the overall cost of providing certificates.

The requirement that certification request procedures be in writing is essentially a clarification of the interim final regulations' requirement that plans have such procedures. The Departments believe it is likely that most plans already maintain written procedures, and therefore expect the cost of this requirement to be small. The Departments did not estimate the cost of this requirement separately from the cost of providing certifications on request.

Other changes included in these final regulations are likely to slightly reduce plans' cost to provide certain HIPAA-required notices. Included with the final regulation is new sample language for general and specific notices of preexisting condition exclusions, which may serve to reduce some plans' costs of providing these notices, and revised sample language for special enrollment rights notices. The final regulations also clarify the narrow scope of the requirement to notify certain affected participants of the specific application of preexisting condition exclusions, thereby potentially relieving some plans of the burden associated with a more expansive interpretation of that requirement. The Departments did not estimate the impact of these provisions separately from the overall cost of providing general and specific notices of preexisting condition exclusions and notices of special enrollment rights.

Statutory Authority

The Department of the Treasury final rule is adopted pursuant to the authority contained in sections 7805 and 9833 of the Code (26 U.S.C. 7805, 9833).

The Department of Labor final rule is adopted pursuant to the authority contained in 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 1191, 1191a, 1191b, and 1191c, sec. 101(g), Public Law 104–191, 101 Stat. 1936; sec. 401(b), Public Law 105–200, 112 Stat. 645 (42 U.S.C. 651 note); Secretary of Labor's Order 1–2003, 68 FR 5374 (Feb. 3, 2003).

The Department of HHS final rule is adopted pursuant to the authority contained in sections 2701 through 2763, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92), as added by HIPAA (Public Law 104–191, 110 Stat. 1936), and amended by MHPA and NMHPA (Public Law 104–204, 110 Stat. 2935), and WHCRA (Public Law 105–277, 112 Stat. 2681–436).

List of Subjects

26 CFR Part 54

Excise taxes, Health care, Health insurance, Pensions, Reporting and recordkeeping requirements.

26 CFR Part 602

Reporting and recordkeeping requirements.

29 CFR Part 2590

Continuation coverage, Disclosure, Employee benefit plans, Group health plans, Health care, Health insurance, Medical child support, Reporting and recordkeeping requirements.

45 CFR Parts 144 and 146

Health care, Health insurance, Reporting and recordkeeping requirements, and State regulation of health insurance.

Adoption of Amendments to the Regulations

Internal Revenue Service

26 CFR Chapter I

■ Accordingly, 26 CFR parts 54 and 602 are amended as follows:

PART 54—PENSION EXCISE TAXES

■ **Paragraph 1.** The authority citation for part 54 is amended by:

■ 1. Removing the citations for 54.9801–1T, 54.9801–2T, 54.9801–3T, 54.9801–4T, 54.9801–5T, 54.9801–6T, 54.9831–1T, and 54.9833–1T.

■ 2. Adding entries in numerical order for 54.9801–1, 54.9801–2, 54.9801–3, 54.9801–4, 54.9801–5, 54.9801–6, 54.9802–1, 54.9831–1, and 54.9833–1.

The additions read as follows:

Authority: 26 U.S.C. 7805. * * *

Section 54.9801–1 also issued under 26 U.S.C. 9833.

Section 54.9801–2 also issued under 26 U.S.C. 9833.

Section 54.9801–3 also issued under 26 U.S.C. 9801(c)(4), 9801(e)(3), and 9833.

Section 54.9801–4 also issued under 26 U.S.C. 9801(c)(1)(I) and 9833.

Section 54.9801–5 also issued under 26 U.S.C. 9801(c)(4), 9801(e)(3), and 9833.

Section 54.9801–6 also issued under 26 U.S.C. 9833.

Section 54.9802–1 also issued under 26 U.S.C. 9833. * * *

Section 54.9831–1 also issued under 26 U.S.C. 9833.

Section 54.9833–1 also issued under 26 U.S.C. 9833.

■ **Par. 2.** Sections 54.9801–1T, 54.9801–2T, 54.9801–3T, 54.9801–4T, 54.9801–5T, 54.9801–6T, 54.9831–1T, and 54.9833–1T are removed.

■ **Par. 3.** Sections 54.9801–1, 54.9801–2, 54.9801–3, 54.9801–4, 54.9801–5, 54.9801–6, 54.9831–1, and 54.9833–1 are added to read as follows:

§ 54.9801–1 Basis and scope.

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

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

(1) Limitations on a preexisting condition exclusion period.

(2) Certificates and disclosure of previous coverage.

(3) Rules relating to creditable coverage.

(4) Special enrollment periods.

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

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

§ 54.9801–2 Definitions.

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

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

COBRA definitions:

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

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

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

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

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

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

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

Condition means a *medical condition.*

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

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

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

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

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

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

Genetic information means information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

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

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

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

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

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

Health maintenance organization or *HMO* means—

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

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

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

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

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

Issuer means a *health insurance issuer.*

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

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

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

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

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

Plan year means the year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is—

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

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

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

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

Preexisting condition exclusion means *preexisting condition exclusion* within the meaning of § 54.9801–3(a)(1).

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

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

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

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

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

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

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

§ 54.9801–3 Limitations on preexisting condition exclusion period.

(a) *Preexisting condition exclusion*—(1) *Defined*—(i) A *preexisting condition exclusion* means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage under a group health plan or group health insurance coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage under a group health plan or group health insurance coverage, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

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

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

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

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

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

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

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

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

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

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

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

Example 6. (i) *Facts.* A group health plan provides coverage for medically necessary items and services, generally including treatment of heart conditions. However, the plan does not cover those same items and services when used for treatment of congenital heart conditions.

(ii) *Conclusion.* In this *Example 6*, the exclusion of coverage for treatment of congenital heart conditions is a preexisting condition exclusion because it operates to exclude benefits relating to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 7. (i) *Facts.* A group health plan generally provides coverage for medically necessary items and services. However, the plan excludes coverage for the treatment of cleft palate.

(ii) *Conclusion.* In this *Example 7*, the exclusion of coverage for treatment of cleft palate is not a preexisting condition exclusion because the exclusion applies regardless of when the condition arose relative to the effective date of coverage. The plan provision, therefore, is not subject to the limitations on preexisting condition exclusions in this section.

Example 8. (i) *Facts.* A group health plan provides coverage for treatment of cleft palate, but only if the individual being treated has been continuously covered under the plan from the date of birth.

(ii) *Conclusion.* In this *Example 8*, the exclusion of coverage for treatment of cleft palate for individuals who have not been covered under the plan from the date of birth operates to exclude benefits in relation to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

(2) *General rules.* Subject to paragraph (b) of this section (prohibiting the imposition of a preexisting condition exclusion with respect to certain individuals and conditions), a group health plan may impose, with respect to a participant or beneficiary, a preexisting condition exclusion only if the requirements of this paragraph (a)(2) are satisfied. (*See* section 701 of ERISA

and section 2701 of the PHS Act, under which these requirements are also imposed on a health insurance issuer offering group health insurance coverage.)

(i) *6-month look-back rule.* A preexisting condition exclusion must relate to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period (or such shorter period as applies under the plan) ending on the enrollment date.

(A) For purposes of this paragraph (a)(2)(i), medical advice, diagnosis, care, or treatment is taken into account only if it is recommended by, or received from, an individual licensed or similarly authorized to provide such services under State law and operating within the scope of practice authorized by State law.

(B) For purposes of this paragraph (a)(2)(i), the 6-month period ending on the enrollment date begins on the 6-month anniversary date preceding the enrollment date. For example, for an enrollment date of August 1, 1998, the 6-month period preceding the enrollment date is the period commencing on February 1, 1998 and continuing through July 31, 1998. As another example, for an enrollment date of August 30, 1998, the 6-month period preceding the enrollment date is the period commencing on February 28, 1998 and continuing through August 29, 1998.

(C) The rules of this paragraph (a)(2)(i) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *A* is diagnosed with a medical condition 8 months before *A*'s enrollment date in Employer *R*'s group health plan. *A*'s doctor recommends that *A* take a prescription drug for 3 months, and *A* follows the recommendation.

(ii) *Conclusion.* In this *Example 1*, Employer *R*'s plan may impose a preexisting condition exclusion with respect to *A*'s condition because *A* received treatment during the 6-month period ending on *A*'s enrollment date in Employer *R*'s plan by taking the prescription medication during that period. However, if *A* did not take the prescription drug during the 6-month period, Employer *R*'s plan would not be able to impose a preexisting condition exclusion with respect to that condition.

Example 2. (i) *Facts.* Individual *B* is treated for a medical condition 7 months before the enrollment date in Employer *S*'s group health plan. As part of such treatment, *B*'s physician recommends that a follow-up examination be given 2 months later. Despite this recommendation, *B* does not receive a follow-up examination, and no other medical advice, diagnosis, care, or treatment for that condition is recommended to *B* or received by *B* during the 6-month period ending on *B*'s enrollment date in Employer *S*'s plan.

(ii) *Conclusion.* In this *Example 2*, Employer *S*'s plan may not impose a preexisting condition exclusion with respect to the condition for which *B* received treatment 7 months prior to the enrollment date.

Example 3. (i) *Facts.* Same facts as *Example 2*, except that Employer *S*'s plan learns of the condition and attaches a rider to *B*'s certificate of coverage excluding coverage for the condition. Three months after enrollment, *B*'s condition recurs, and Employer *S*'s plan denies payment under the rider.

(ii) *Conclusion.* In this *Example 3*, the rider is a preexisting condition exclusion and Employer *S*'s plan may not impose a preexisting condition exclusion with respect to the condition for which *B* received treatment 7 months prior to the enrollment date. (In addition, such a rider would violate the provisions of § 54.9802–1, even if *B* had received treatment for the condition within the 6-month period ending on the enrollment date.)

Example 4. (i) *Facts.* Individual *C* has asthma and is treated for that condition several times during the 6-month period before *C*'s enrollment date in Employer *T*'s plan. Three months after the enrollment date, *C* begins coverage under Employer *T*'s plan. Two months later, *C* is hospitalized for asthma.

(ii) *Conclusion.* In this *Example 4*, Employer *T*'s plan may impose a preexisting condition exclusion with respect to *C*'s asthma because care relating to *C*'s asthma was received during the 6-month period ending on *C*'s enrollment date (which, under the rules of paragraph (a)(3)(i) of this section, is the first day of the waiting period).

Example 5. (i) *Facts.* Individual *D*, who is subject to a preexisting condition exclusion imposed by Employer *U*'s plan, has diabetes, as well as retinal degeneration, a foot condition, and poor circulation (all of which are conditions that may be directly attributed to diabetes). *D* receives treatment for these conditions during the 6-month period ending on *D*'s enrollment date in Employer *U*'s plan. After enrolling in the plan, *D* stumbles and breaks a leg.

(ii) *Conclusion.* In this *Example 5*, the leg fracture is not a condition related to *D*'s diabetes, retinal degeneration, foot condition, or poor circulation, even though they may have contributed to the accident. Therefore, benefits to treat the leg fracture cannot be subject to a preexisting condition exclusion. However, any additional medical services that may be needed because of *D*'s preexisting diabetes, poor circulation, or retinal degeneration that would not be needed by another patient with a broken leg who does not have these conditions may be subject to the preexisting condition exclusion imposed under Employer *U*'s plan.

(ii) *Maximum length of preexisting condition exclusion.* A preexisting condition exclusion is not permitted to extend for more than 12 months (18 months in the case of a late enrollee) after the enrollment date. For example, for an enrollment date of August 1, 1998, the 12-month period after the enrollment date is the period commencing on August 1, 1998 and continuing through July 31, 1999; the 18-month period after the enrollment date is the period commencing on August 1, 1998 and continuing through January 31, 2000.

(iii) *Reducing a preexisting condition exclusion period by creditable coverage*—(A) The period of any preexisting condition exclusion that would otherwise apply to an individual under a group health plan is reduced by the number of days of creditable coverage the individual has as of the enrollment date, as counted under § 54.9801–4. Creditable coverage may be evidenced through a certificate of creditable coverage (required under § 54.9801–5(a)), or through other means in accordance with the rules of § 54.9801–5(c).

(B) The rules of this paragraph (a)(2)(iii) are illustrated by the following example:

Example. (i) *Facts.* Individual *D* works for Employer *X* and has been covered continuously under *X*'s group health plan. *D*'s spouse works for Employer *Y*. *Y* maintains a group health plan that imposes a 12-month preexisting condition exclusion (reduced by creditable coverage) on all new enrollees. *D* enrolls in *Y*'s plan, but also stays covered under *X*'s plan. *D* presents *Y*'s plan with evidence of creditable coverage under *X*'s plan.

(ii) *Conclusion.* In this *Example*, *Y*'s plan must reduce the preexisting condition exclusion period that applies to *D* by the number of days of coverage that *D* had under *X*'s plan as of *D*'s enrollment date in *Y*'s plan (even though *D*'s coverage under *X*'s plan was continuing as of that date).

(iv) *Other standards.* See § 54.9802–1 for other standards that may apply with respect to certain benefit limitations or restrictions under a group health plan. Other laws may also apply, such as the Uniformed Services Employment and Reemployment Rights Act (USERRA), which can affect the application of a preexisting condition exclusion to certain individuals who are reinstated in a group health plan following active military service.

(3) *Enrollment definitions*—(i) *Enrollment date* means the first day of coverage (as described in paragraph (a)(3)(ii) of this section) or, if there is a waiting period, the first day of the waiting period. If an individual receiving benefits under a group health plan changes benefit packages, or if the plan changes group health insurance issuers, the individual's enrollment date does not change.

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

(iii) *Waiting period* means the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective. If an employee or dependent enrolls as a late enrollee or special enrollee, any period before such late or special enrollment is not a waiting period. If an individual seeks coverage in the individual market, a waiting period begins on the date the individual submits a substantially complete application for coverage and ends on —

(A) If the application results in coverage, the date coverage begins;

(B) If the application does not result in coverage, the date on which the application is denied by the issuer or the date on which the offer of coverage lapses.

(iv) The rules of paragraphs (a)(3)(i), (ii), and (iii) of this section are illustrated by the following examples:

Example 1. (i) *Facts.* Employer *V*'s group health plan provides for coverage to begin on the first day of the first payroll period following the date an employee is hired and completes the applicable enrollment forms, or on any subsequent January 1 after completion of the applicable enrollment forms. Employer *V*'s plan imposes a preexisting condition exclusion for 12 months (reduced by the individual's creditable coverage) following an individual's enrollment date. Employee *E* is hired by Employer *V* on October 13, 1998, and on October 14, 1998 *E* completes and files all the forms necessary to enroll in the plan. *E*'s coverage under the plan becomes effective on October 25, 1998 (which is the beginning of the first payroll period after *E*'s date of hire).

(ii) *Conclusion.* In this *Example 1*, *E*'s enrollment date is October 13, 1998 (which is the first day of the waiting period for *E*'s enrollment and is also *E*'s date of hire). Accordingly, with respect to *E*, the permissible 6-month period in paragraph (a)(2)(i) is the period from April 13, 1998 through October 12, 1998, the maximum permissible period during which Employer *V*'s plan can apply a preexisting condition exclusion under paragraph (a)(2)(ii) is the period from October 13, 1998 through October 12, 1999, and this period must be reduced under paragraph (a)(2)(iii) by *E*'s days of creditable coverage as of October 13, 1998.

Example 2. (i) *Facts.* A group health plan has two benefit package options, Option 1 and Option 2. Under each option a 12-month preexisting condition exclusion is imposed. Individual *B* is enrolled in Option 1 on the first day of employment with the employer maintaining the plan, remains enrolled in Option 1 for more than one year, and then decides to switch to Option 2 at open season.

(ii) *Conclusion.* In this *Example 2*, *B* cannot be subject to any preexisting condition exclusion under Option 2 because any preexisting condition exclusion period would have to begin on *B*'s enrollment date, which is *B*'s first day of coverage, rather than the date that *B* enrolled in Option 2. Therefore, the preexisting condition exclusion period expired before *B* switched to Option 2.

Example 3. (i) *Facts.* On May 13, 1997, Individual *E* is hired by an employer and enrolls in the employer's group health plan. The plan provides benefits solely through an insurance policy offered by Issuer *S*. On December 27, 1998, *E*'s leg is injured in an accident and the leg is amputated. On January 1, 1999, the plan switches coverage to a policy offered by Issuer *T*. Issuer *T*'s policy excludes benefits for any prosthesis if the body part was lost before the effective date of coverage under the policy.

(ii) *Conclusion.* In this *Example 3*, *E*'s enrollment date is May 13, 1997, *E*'s first day of coverage. Therefore, the permissible 6-month look-back period for the preexisting condition exclusion imposed under Issuer *T*'s policy begins on November 13, 1996 and ends on May 12, 1997. In addition, the 12-month maximum permissible preexisting condition exclusion period begins on May 13, 1997 and ends on May 12, 1998. Accordingly, because no medical advice, diagnosis, care, or treatment was recommended to or received by *E* for the leg during the 6-month look-back period (even though medical care was provided within the 6-month period preceding the effective date of *E*'s coverage under Issuer *T*'s policy), the plan may not impose any preexisting condition exclusion with respect to *E*. Moreover, even if *E* had received treatment during the 6-month look-back period, the plan still would not be permitted to impose a preexisting condition exclusion because the 12-month maximum permissible preexisting condition exclusion period expired on May 12, 1998 (before the effective date of *E*'s coverage under Issuer *T*'s policy). See 29 CFR 2590.701–3(a)(3)(iv) *Example 3* and 45 CFR 146.111(a)(3)(iv) *Example 3* for a conclusion that Issuer *T* is similarly prohibited from imposing a preexisting condition exclusion with respect to *E*.

Example 4. (i) *Facts.* A group health plan limits eligibility for coverage to full-time employees of Employer *Y*. Coverage becomes effective on the first day of the month following the date the employee becomes eligible. Employee *C* begins working full-time for Employer *Y* on April 11. Prior to this date, *C* worked part-time for *Y*. *C* enrolls in the plan and coverage is effective May 1.

(ii) *Conclusion.* In this *Example 4*, *C*'s enrollment date is April 11 and the period from April 11 through April 30 is a waiting period. The period while *C* was working part-time, and therefore not in an eligible class of employees, is not part of the waiting period.

Example 5. (i) *Facts.* To be eligible for coverage under a multiemployer group health plan in the current calendar quarter, the plan requires an individual to have worked 250 hours in covered employment during the previous quarter. If the hours requirement is satisfied, coverage becomes effective on the first day of the current calendar quarter. Employee *D* begins work on January 28 and does not work 250 hours in covered employment during the first quarter (ending March 31). *D* works at least 250 hours in the second quarter (ending June 30) and is enrolled in the plan with coverage effective July 1 (the first day of the third quarter).

(ii) *Conclusion.* In this *Example 5*, *D*'s enrollment date is the first day of the quarter during which *D* satisfies the hours requirement, which is April 1. The period from April 1 through June 30 is a waiting period.

(v) *Late enrollee* means an individual whose enrollment in a plan is a late enrollment.

(vi) (A) *Late enrollment* means enrollment of an individual under a group health plan other than—

(*1*) On the earliest date on which coverage can become effective for the individual under the terms of the plan; or

(*2*) Through special enrollment. (For rules relating to special enrollment, see § 54.9801–6.)

(B) If an individual ceases to be eligible for coverage under the plan, and then subsequently becomes eligible for coverage under the plan, only the individual's most recent period of eligibility is taken into account in determining whether the individual is a late enrollee under the plan with respect to the most recent period of coverage. Similar rules apply if an individual again becomes eligible for coverage following a suspension of coverage that applied generally under the plan.

(vii) *Examples.* The rules of paragraphs (a)(3)(v) and (vi) of this section are illustrated by the following examples:

Example 1. (i) *Facts.* Employee *F* first becomes eligible to be covered by Employer *W*'s group health plan on January 1, 1999 but elects not to enroll in the plan until a later annual open enrollment period, with coverage effective January 1, 2001. *F* has no special enrollment right at that time.

(ii) *Conclusion.* In this *Example 1*, *F* is a late enrollee with respect to *F*'s coverage that became effective under the plan on January 1, 2001.

Example 2. (i) *Facts.* Same facts as *Example 1*, except that *F* terminates employment with Employer *W* on July 1, 1999 without having had any health insurance coverage under the plan. *F* is rehired by Employer *W* on January 1, 2000 and is eligible for and elects coverage under Employer *W*'s plan effective on January 1, 2000.

(ii) *Conclusion.* In this *Example 2*, *F* would not be a late enrollee with respect to *F*'s coverage that became effective on January 1, 2000.

(b) *Exceptions pertaining to preexisting condition exclusions*—(1) *Newborns*—(i) *In general.* Subject to paragraph (b)(3) of this section, a group health plan may not impose any preexisting condition exclusion on a child who, within 30 days after birth, is covered under any creditable coverage. Accordingly, if a child is enrolled in a group health plan (or other creditable coverage) within 30 days after birth and subsequently enrolls in another group health plan without a significant break in coverage (as described in § 54.9801–4(b)(2)(iii)), the other plan may not impose any preexisting condition exclusion on the child.

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

Example 1. (i) *Facts.* Individual *E*, who has no prior creditable coverage, begins working for Employer *W* and has accumulated 210 days of creditable coverage under Employer *W*'s group health plan on the date *E* gives birth to a child. Within 30 days after the birth, the child is enrolled in the plan. Ninety days after the birth, both *E* and the child terminate coverage under the plan. Both *E* and the child then experience a break in coverage of 45 days before *E* is hired by Employer *X* and the two are enrolled in Employer *X*'s group health plan.

(ii) *Conclusion.* In this *Example 1*, because *E*'s child is enrolled in Employer *W*'s plan within 30 days after birth, no preexisting condition exclusion may be imposed with respect to the child under Employer *W*'s plan. Likewise, Employer *X*'s plan may not impose any preexisting condition exclusion on *E*'s child because the child was covered under creditable coverage within 30 days after birth and had no significant break in coverage before enrolling in Employer *X*'s plan. On the other hand, because *E* had only 300 days of creditable coverage prior to *E*'s enrollment date in Employer *X*'s plan, Employer *X*'s plan may impose a preexisting condition exclusion on *E* for up to 65 days (66 days if the 12-month period after *E*'s enrollment date in *X*'s plan includes February 29).

Example 2. (i) *Facts.* Individual *F* is enrolled in a group health plan in which coverage is provided through a health insurance issuer. *F* gives birth. Under State law applicable to the health insurance issuer, health care expenses incurred for the child during the 30 days following birth are covered as part of *F*'s coverage. Although *F* may obtain coverage for the child beyond 30 days by timely requesting special enrollment and paying an additional premium, the issuer is prohibited under State law from recouping the cost of any expenses incurred for the child within the 30-day period if the child is not later enrolled.

(ii) *Conclusion.* In this *Example 2*, the child is covered under creditable coverage within 30 days after birth, regardless of whether the child enrolls as a special enrollee under the plan. Therefore, no preexisting condition exclusion may be imposed on the child unless the child has a significant break in coverage.

(2) *Adopted children.* Subject to paragraph (b)(3) of this section, a group health plan may not impose any preexisting condition exclusion on a child who is adopted or placed for adoption before attaining 18 years of age and who, within 30 days after the adoption or placement for adoption, is covered under any creditable coverage. Accordingly, if a child is enrolled in a group health plan (or other creditable coverage) within 30 days after adoption or placement for adoption and subsequently enrolls in another group health plan without a significant break in coverage (as described in § 54.9801–4(b)(2)(iii)), the other plan may not impose any preexisting condition exclusion on the child. This rule does not apply to coverage before the date of such adoption or placement for adoption.

(3) *Significant break in coverage.* Paragraphs (b)(1) and (2) of this section no longer apply to a child after a significant break in coverage. (*See* § 54.9801–4(b)(2)(iii) for rules relating to the determination of a significant break in coverage.)

(4) *Special enrollment.* For special enrollment rules relating to new dependents, see § 54.9801–6(b).

(5) *Pregnancy.* A group health plan may not impose a preexisting condition exclusion relating to pregnancy.

(6) *Genetic information*—(i) A group health plan may not impose a preexisting condition exclusion relating to a condition based solely on genetic information. However, if an individual is diagnosed with a condition, even if the condition relates to genetic information, the plan may impose a preexisting condition exclusion with respect to the condition, subject to the other limitations of this section.

(ii) The rules of this paragraph (b)(6) are illustrated by the following example:

Example. (i) *Facts.* Individual *A* enrolls in a group health plan that imposes a 12-month maximum preexisting condition exclusion. Three months before *A*'s enrollment, *A*'s doctor told *A* that, based on genetic information, *A* has a predisposition towards breast cancer. *A* was not diagnosed with breast cancer at any time prior to *A*'s enrollment date in the plan. Nine months after *A*'s enrollment date in the plan, *A* is diagnosed with breast cancer.

(ii) *Conclusion.* In this *Example*, the plan may not impose a preexisting condition exclusion with respect to *A*'s breast cancer because, prior to *A*'s enrollment date, *A* was not diagnosed with breast cancer.

(c) *General notice of preexisting condition exclusion.* A group health plan imposing a preexisting condition exclusion must provide a written general notice of preexisting condition exclusion to participants under the plan and cannot impose a preexisting condition exclusion with respect to a participant or a dependent of the participant until such a notice is provided. (See 29 CFR 2590.701–3(c) and 45 CFR 146.111(c), which also impose this requirement on a health insurance issuer offering group health insurance coverage subject to a preexisting condition exclusion.)

(1) *Manner and timing.* A plan must provide the general notice of preexisting condition exclusion as part of any written application materials distributed by the plan for enrollment. If the plan does not distribute such materials, the notice must be provided by the earliest date following a request for enrollment that the plan, acting in a reasonable and prompt fashion, can provide the notice.

(2) *Content.* The general notice of preexisting condition exclusion must notify participants of the following:

(i) The existence and terms of any preexisting condition exclusion under the plan. This description includes the length of the plan's look-back period (which is not to exceed 6 months under paragraph (a)(2)(i) of this section); the maximum preexisting condition exclusion period under the plan (which cannot exceed 12 months (or 18 months for late enrollees) under paragraph (a)(2)(ii) of this section); and how the plan will reduce the maximum preexisting condition exclusion period by creditable coverage (described in paragraph (a)(2)(iii) of this section).

(ii) A description of the rights of individuals to demonstrate creditable coverage, and any applicable waiting periods, through a certificate of creditable coverage (as required by § 54.9801–5(a)) or through other means (as described in § 54.9801–5(c)). This must include a description of the right of the individual to request a certificate from a prior plan or issuer, if necessary, and a statement that the current plan will assist in obtaining a certificate from any prior plan or issuer, if necessary.

(iii) A person to contact (including an address or telephone number) for obtaining additional information or assistance regarding the preexisting condition exclusion.

(3) *Duplicate notices not required.* If a notice satisfying the requirements of this paragraph (c) is provided to an individual by another party, the plan's obligation to provide a general notice of preexisting condition exclusion with respect to that individual is satisfied. (See 29 CFR 2590.701–3(c)(3) and 45 CFR 146.111(c)(3), which provide that

the issuer's obligation is similarly satisfied.)

(4) *Example with sample language.* The rules of this paragraph (c) are illustrated by the following example, which includes sample language that plans can use as a basis for preparing their own notices to satisfy the requirements of this paragraph (c):

Example. (i) *Facts.* A group health plan makes coverage effective on the first day of the first calendar month after hire and on each January 1 following an open season. The plan imposes a 12-month maximum preexisting condition exclusion (18 months for late enrollees) and uses a 6-month look-back period. As part of the enrollment application materials, the plan provides the following statement:

This plan imposes a preexisting condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior ''creditable coverage.'' Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the preexisting condition exclusion and creditable coverage should be directed to Individual *B* at Address *M* or Telephone Number *N*.

(ii) *Conclusion.* In this *Example*, the plan satisfies the general notice requirement of this paragraph (c).

(d) *Determination of creditable coverage*—(1) *Determination within reasonable time.* If a group health plan receives creditable coverage information under § 54.9801–5, the plan is required, within a reasonable time following receipt of the information, to make a determination regarding the amount of the individual's creditable coverage and the length of any exclusion that remains. Whether this determination is made within a reasonable time depends on the relevant facts and circumstances. Relevant facts and circumstances include whether a plan's application of a preexisting condition exclusion would prevent an individual from having access to urgent medical care. (See 29 CFR 2590.701–3(d) and 45 CFR 146.111(d), which also impose this requirement on a health insurance issuer offering group health insurance coverage.)

(2) *No time limit on presenting evidence of creditable coverage.* A plan may not impose any limit on the amount of time that an individual has to present a certificate or other evidence of creditable coverage.

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

Example. (i) *Facts.* A group health plan imposes a preexisting condition exclusion period of 12 months. After receiving the general notice of preexisting condition exclusion, Individual *H* develops an urgent health condition before receiving a certificate of creditable coverage from *H*'s prior group health plan. *H* attests to the period of prior coverage, presents corroborating documentation of the coverage period, and authorizes the plan to request a certificate on *H*'s behalf in accordance with the rules of § 54.9801–5.

(ii) *Conclusion.* In this *Example*, the plan must review the evidence presented by *H* and make a determination of creditable coverage within a reasonable time that is consistent with the urgency of *H*'s health condition. (This determination may be modified as permitted under paragraph (f) of this section.)

(e) *Individual notice of period of preexisting condition exclusion.* After an individual has presented evidence of creditable coverage and after the plan has made a determination of creditable coverage under paragraph (d) of this section, the plan must provide the individual a written notice of the length of preexisting condition exclusion that remains after offsetting for prior creditable coverage. This individual notice is not required to identify any medical conditions specific to the individual that could be subject to the exclusion. A plan is not required to provide this notice if the plan does not impose any preexisting condition exclusion on the individual or if the plan's preexisting condition exclusion is completely offset by the individual's prior creditable coverage. (See 29 CFR 2590.701–3(e) and 45 CFR 146.111(e), which also impose this requirement on a health insurance issuer offering group health insurance coverage.)

(1) *Manner and timing.* The individual notice must be provided by the earliest date following a determination that the plan, acting in a reasonable and prompt fashion, can provide the notice.

(2) *Content.* A plan must disclose—

(i) Its determination of any preexisting condition exclusion period that applies to the individual (including the last day on which the preexisting condition exclusion applies);

(ii) The basis for such determination, including the source and substance of any information on which the plan relied;

(iii) An explanation of the individual's right to submit additional evidence of creditable coverage; and

(iv) A description of any applicable appeal procedures established by the plan.

(3) *Duplicate notices not required.* If a notice satisfying the requirements of this paragraph (e) is provided to an individual by another party, the plan's obligation to provide this individual notice of preexisting condition exclusion with respect to that individual is satisfied. (See 29 CFR 2590.701–3(e)(3) and 45 CFR 146.111(e)(3), which provide that the issuer's obligation is similarly satisfied.)

(4) *Examples.* The rules of this paragraph (e) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan imposes a preexisting condition exclusion period of 12 months. After receiving the general notice of preexisting condition exclusion, Individual *G* presents a certificate of creditable coverage indicating 240 days of creditable coverage. Within seven days of receipt of the certificate, the plan determines that *G* is subject to a preexisting condition exclusion of 125 days, the last day of which is March 5. Five days later, the plan notifies *G* that, based on the certificate *G* submitted, *G* is subject to a preexisting condition exclusion period of 125 days, ending on March 5. The notice also explains the opportunity to submit additional evidence of creditable coverage and the plan's appeal procedures. The notice does not identify any of *G*'s medical conditions that could be subject to the exclusion.

(ii) *Conclusion.* In this *Example 1*, the plan satisfies the requirements of this paragraph (e).

Example 2. (i) *Facts.* Same facts as in *Example 1*, except that the plan determines that *G* has 430 days of creditable coverage based on *G*'s certificate indicating 430 days of creditable coverage under *G*'s prior plan.

(ii) *Conclusion.* In this *Example 2*, the plan is not required to notify *G* that *G* will not be subject to a preexisting condition exclusion.

(f) *Reconsideration.* Nothing in this section prevents a plan from modifying

an initial determination of creditable coverage if it determines that the individual did not have the claimed creditable coverage, provided that—

(1) A notice of the new determination (consistent with the requirements of paragraph (e) of this section) is provided to the individual; and

(2) Until the notice of the new determination is provided, the plan, for purposes of approving access to medical services (such as a pre-surgery authorization), acts in a manner consistent with the initial determination.

§ 54.9801–4 Rules relating to creditable coverage.

(a) *General rules*—(1) *Creditable coverage.* For purposes of this section, except as provided in paragraph (a)(2) of this section, the term *creditable coverage* means coverage of an individual under any of the following:

(i) A group health plan as defined in § 54.9831–1(a).

(ii) Health insurance coverage as defined in § 54.9801–2 (whether or not the entity offering the coverage is subject to Chapter 100 of Subtitle K, and without regard to whether the coverage is offered in the group market, the individual market, or otherwise).

(iii) Part A or B of Title XVIII of the Social Security Act (Medicare).

(iv) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).

(v) Title 10 U.S.C. Chapter 55 (medical and dental care for members and certain former members of the uniformed services, and for their dependents; for purposes of Title 10 U.S.C. Chapter 55, *uniformed services* means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service).

(vi) A medical care program of the Indian Health Service or of a tribal organization.

(vii) A State health benefits risk pool. For purposes of this section, a *State health benefits risk pool* means—

(A) An organization qualifying under section 501(c)(26);

(B) A qualified high risk pool described in section 2744(c)(2) of the PHS Act; or

(C) Any other arrangement sponsored by a State, the membership composition of which is specified by the State and which is established and maintained primarily to provide health coverage for individuals who are residents of such State and who, by reason of the existence or history of a medical condition —

(*1*) Are unable to acquire medical care coverage for such condition through insurance or from an HMO, or

(*2*) Are able to acquire such coverage only at a rate which is substantially in excess of the rate for such coverage through the membership organization.

(viii) A health plan offered under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program).

(ix) A public health plan. For purposes of this section, a public health plan means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

(x) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(xi) Title XXI of the Social Security Act (State Children's Health Insurance Program).

(2) *Excluded coverage.* Creditable coverage does not include coverage of solely excepted benefits (described in § 54.9831–1).

(3) *Methods of counting creditable coverage.* For purposes of reducing any preexisting condition exclusion period, as provided under § 54.9801–3(a)(2)(iii), the amount of an individual's creditable coverage generally is determined by using the standard method described in paragraph (b) of this section. A plan may use the alternative method under paragraph (c) of this section with respect to any or all of the categories of benefits described under paragraph (c)(3) of this section or may provide that a health insurance issuer offering health insurance coverage under the plan may use the alternative method of counting creditable coverage.

(b) *Standard method*—(1) *Specific benefits not considered.* Under the standard method, the amount of creditable coverage is determined without regard to the specific benefits included in the coverage.

(2) *Counting creditable coverage*—(i) *Based on days.* For purposes of reducing the preexisting condition exclusion period that applies to an individual, the amount of creditable coverage is determined by counting all the days on which the individual has one or more types of creditable coverage. Accordingly, if on a particular day an individual has creditable coverage from more than one source, all the creditable coverage on that day is counted as one day. Any days in a waiting period for coverage are not creditable coverage.

(ii) *Days not counted before significant break in coverage.* Days of creditable coverage that occur before a significant break in coverage are not required to be counted.

(iii) *Significant break in coverage defined*—A significant break in coverage means a period of 63 consecutive days during each of which an individual does not have any creditable coverage. (*See* section 731(b)(2)(iii) of ERISA and section 2723(b)(2)(iii) of the PHS Act, which exclude from preemption State insurance laws that require a break of more than 63 days before an individual has a significant break in coverage for purposes of State law.)

(iv) *Periods that toll a significant break.* Days in a waiting period and days in an affiliation period are not taken into account in determining whether a significant break in coverage has occurred. In addition, for an individual who elects COBRA continuation coverage during the second election period provided under the Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period are not taken into account in determining whether a significant break in coverage has occurred.

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

Example 1. (i) *Facts.* Individual *A* has creditable coverage under Employer *P*'s plan for 18 months before coverage ceases. *A* is provided a certificate of creditable coverage on *A*'s last day of coverage. Sixty-four days after the last date of coverage under *P*'s plan, a is hired by Employer *Q* and enrolls in *Q*'s group health plan. *Q*'s plan has a 12-month preexisting condition exclusion.

(ii) *Conclusion.* In this *Example 1, A* has a break in coverage of 63 days. Because *A*'s break in coverage is a significant break in coverage, *Q*'s plan may disregard *A*'s prior coverage and a may be subject to a 12-month preexisting condition exclusion.

Example 2. (i) *Facts.* Same facts as *Example 1,* except that *A* is hired by *Q* and enrolls in *Q*'s plan on the 63rd day after the last date of coverage under *P*'s plan.

(ii) *Conclusion.* In this *Example 2, A* has a break in coverage of 62 days. Because *A*'s break in coverage is not a significant break in coverage, *Q*'s plan must count *A*'s prior creditable coverage for purposes of reducing the plan's preexisting condition exclusion period that applies to *A.*

Example 3. (i) *Facts.* Same facts as *Example 1,* except that *Q*'s plan provides benefits through an insurance policy that, as required by applicable State insurance laws, defines a significant break in coverage as 90 days.

(ii) *Conclusion.* In this *Example 3,* under State law, the issuer that provides group health insurance coverage to *Q*'s plan must count *A*'s period of creditable coverage prior

to the 63-day break. (However, if *Q*'s plan was a self-insured plan, the coverage would not be subject to State law. Therefore, the health coverage would not be governed by the longer break rules and *A*'s previous health coverage could be disregarded.)

Example 4. [Reserved]

Example 5. (i) *Facts.* Individual *C* has creditable coverage under Employer *S*'s plan for 200 days before coverage ceases. *C* is provided a certificate of creditable coverage on *C*'s last day of coverage. *C* then does not have any creditable coverage for 51 days before being hired by Employer *T*. *T*'s plan has a 3-month waiting period. *C* works for *T* for 2 months and then terminates employment. Eleven days after terminating employment with *T*, *C* begins working for Employer *U*. *U*'s plan has no waiting period, but has a 6-month preexisting condition exclusion.

(ii) *Conclusion.* In this *Example 5, C* does not have a significant break in coverage because, after disregarding the waiting period under *T*'s plan, *C* had only a 62-day break in coverage (51 days plus 11 days). accordingly, *C* has 200 days of creditable coverage, and *U*'s plan may not apply its 6-month preexisting condition exclusion with respect to *C*.

Example 6. [Reserved]

Example 7. (i) *Facts.* Individual *E* has creditable coverage under Employer *X*'s plan. *E* is provided a certificate of creditable coverage on *E*'s last day of coverage. On the 63rd day without coverage, *E* submits a substantially complete application for a health insurance policy in the individual market. *E*'s application is accepted and coverage is made effective 10 days later.

(ii) *Conclusion.*

In this *Example 7*, because *E* applied for the policy before the end of the 63rd day, the period between the date of application and the first day of coverage is a waiting period and no significant break in coverage occurred even though the actual period without coverage was 73 days.

Example 8. (i) *Facts.* Same facts as *Example 7*, except that *E*'s application for a policy in the individual market is denied.

(ii) *Conclusion.* In this *Example 8,* even though *E* did not obtain coverage following application, the period between the date of application and the date the coverage was denied is a waiting period. However, to avoid a significant break in coverage, no later than the day after the application for the policy is denied *E* would need to do one of the following: submit a substantially complete application for a different individual market policy; obtain coverage in the group market; or be in a waiting period for coverage in the group market.

(vi) *Other permissible counting methods*—(a) *Rule.* Notwithstanding any other provisions of this paragraph (b)(2), for purposes of reducing a preexisting condition exclusion period (but not for purposes of issuing a certificate under § 54.9801–5), a group health plan may determine the amount of creditable coverage in any other manner that is at least as favorable to the individual as the method set forth in this paragraph (b)(2), subject to the requirements of other applicable law.

(B) *Example.* The rule of this paragraph (b)(2)(vi) is illustrated by the following example:

Example. (i) *Facts.* Individual *F* has coverage under Group Health Plan *Y* from January 3, 1997 through March 25, 1997. *F* then becomes covered by Group Health Plan *Z*. *F's* enrollment date in Plan *Z* is May 1, 1997. Plan *Z* has a 12-month preexisting condition exclusion.

(ii) *Conclusion.* In this *Example*, Plan *Z* may determine, in accordance with the rules prescribed in paragraphs (b)(2)(i), (ii), and (iii) of this section, that *F* has 82 days of creditable coverage (29 days in January, 28 days in February, and 25 days in March). Thus, the preexisting condition exclusion will no longer apply to *F* on February 8, 1998 (82 days before the 12-month anniversary of *F*'s enrollment (May 1)). For administrative convenience, however, Plan *Z* may consider that the preexisting condition exclusion will no longer apply to *F* on the first day of the month (February 1).

(c) *Alternative method*—(1) *Specific benefits considered.* Under the alternative method, a group health plan determines the amount of creditable coverage based on coverage within any category of benefits described in paragraph (c)(3) of this section and not based on coverage for any other benefits. The plan may use the alternative method for any or all of the categories. The plan may apply a different preexisting condition exclusion period with respect to each category (and may apply a different preexisting condition exclusion period for benefits that are not within any category). The creditable coverage determined for a category of benefits applies only for purposes of reducing the preexisting condition exclusion period with respect to that category. An individual's creditable coverage for benefits that are not within any category for which the alternative method is being used is determined under the standard method of paragraph (b) of this section.

(2) *Uniform application.* A plan using the alternative method is required to apply it uniformly to all participants and beneficiaries under the plan. A plan that provides benefits (in part or in whole) through one or more policies or contracts of insurance will not fail the uniform application requirement of this paragraph (c)(2) if the alternative method is used (or not used) separately with respect to participants and beneficiaries under any policy or contact, provided that the alternative method is applied uniformly with respect to all coverage under that policy or contract. The use of the alternative method is required to be set forth in the plan.

(3) *Categories of benefits.* The alternative method for counting creditable coverage may be used for coverage for the following categories of benefits—

(i) Mental health;

(ii) Substance abuse treatment;

(iii) Prescription drugs;

(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 § 54.9801–5(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 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)), 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 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 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 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.

§ 54.9801–5 Evidence of creditable coverage.

(a) *Certificate of creditable coverage*—(1) *Entities required to provide certificate*—(i) *In general.* A group health plan is required to furnish certificates of creditable coverage in accordance with this paragraph (a). (See section 701(e) of ERISA and section 2701(e) of the PHS Act, under which this obligation is also imposed on each health insurance issuer offering group health insurance coverage under the plan.)

(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, a group health plan is deemed to have satisfied the certification requirement with respect to a participant or beneficiary if any other entity actually provides a certificate that includes the information required under paragraph (a)(3) of this section with respect to the participant or beneficiary.

(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 an employer sponsoring a plan 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 plan does not violate the certification requirements of this paragraph (a) (though the issuer would have violated the certification requirements pursuant to section 701(e) of ERISA and section 2701(e) of the PHS Act).

(iv) *Special rules relating to issuers providing coverage under a plan*—(A)(1) *Responsibility of issuer for coverage period.* See 29 CFR 2590.701–5 and 45 CFR 146.115, under which an issuer is not required to provide information regarding coverage provided to an individual by another party.

(*2*) *Example.* The rule referenced by 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 (under section 701(e) of ERISA and section 2701(e) of the PHS Act) 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 4980B(g)(3)) 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 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 4980B(f)(6) (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 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 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, 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 (including any form approved by the Secretary as a writing).

(B) *Other permissible forms.* No written certificate is required to be provided under this paragraph (a) with respect to a particular event described in paragraph (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 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 § 54.9831–1(c). In addition, the information in the certificate regarding coverage is not required to specify categories of benefits described in § 54.9801–4(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. 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 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 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 § 54.9801–3(b), under which such a child cannot be subject to a preexisting condition exclusion.

(6) *Special certification rules for entities not subject to Chapter 100 of Subtitle K*—(i) *Issuers.* For rules requiring that issuers in the group and individual markets provide certificates consistent with the rules in this section, see section 701(e) of ERISA and sections 2701(e), 2721(b)(1)(B), and 2743 of the PHS Act.

(ii) *Other entities.* For special rules requiring that certain other entities not subject to Chapter 100 of Subtitle K 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, and 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.

(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 § 54.9801–4(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 9801(c)(4), which permits individuals to demonstrate the duration of creditable coverage through means other than certificates, and section 9801(e)(3), 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 received and is unable to obtain another certificate.

(3) *Evidence of creditable coverage*—(i) *Consideration of evidence*—(A) A plan 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 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 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 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 may refuse to credit coverage where the individual fails to cooperate with the plan's or issuer's efforts to verify coverage, the plan 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.

§ 54.9801–6 Special enrollment periods.

(a) *Special enrollment for certain individuals who lose coverage*—(1) *In general.* A group health plan is required to permit current employees and dependents (as defined in § 54.9801–2) 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. (See section 701(f)(1) of ERISA and section 2701(f)(1) of the PHS Act, under which this obligation is also imposed on a health insurance issuer offering group health insurance coverage.)

(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 is not required to enroll any other dependent unless that dependent satisfies the criteria of this paragraph (a)(2)(ii), or the employee satisfies the criteria of paragraph (a)(2)(i) of this section.

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

Example 1. (i) *Facts.* Individual *A* works for Employer *X*. *A*,*A*'s spouse, and *A*'s dependent children are eligible but not enrolled for coverage under X's group health plan. *A*'s spouse works for Employer *Y* and at the time coverage was offered under X's plan, *A* was enrolled in coverage under *Y*'s plan. Then, *A* loses eligibility for coverage under *Y*'s plan.

(ii) *Conclusion.* In this *Example 1,* because *A* satisfies the conditions for special enrollment under paragraph (a)(2)(i) of this section, *A*, *A*'s spouse, and *A*'s dependent children are eligible for special enrollment under *X*'s plan.

Example 2. (i) *Facts.* Individual *A* and *A*'s spouse are eligible but not enrolled for coverage under Group Health Plan *P* maintained by *A*'s employer. When *A* was first presented with an opportunity to enroll *A* and *A*'s spouse, they did not have other coverage. Later, *A* and *A*'s spouse enroll in Group Health Plan *Q* maintained by the employer of *A*'s spouse. During a subsequent open enrollment period in *P*, *A* and *A*'s spouse did not enroll because of their coverage under *Q*. They then lose eligibility for coverage under *Q*.

(ii) *Conclusion.* In this *Example 2,* because *A* and *A*'s spouse were covered under *Q* when they did not enroll in *P* during open enrollment, they satisfy the conditions for special enrollment under paragraphs (a)(2)(i) and (ii) of this section. Consequently, *A* and *A*'s spouse are eligible for special enrollment under *P*.

Example 3. (i) *Facts.* Individual *B* works for Employer *X*. *B* and *B*'s spouse are eligible but not enrolled for coverage under *X*'s group health plan. *B*'s spouse works for Employer *Y* and at the time coverage was offered under *X*'s plan, *B*'s spouse was enrolled in self-only coverage under *Y*'s group health plan. Then, *B*'s spouse loses eligibility for coverage under *Y*'s plan.

(ii) *Conclusion.* In this *Example 3,* because *B*'s spouse satisfies the conditions for special enrollment under paragraph (a)(2)(ii) of this section, both *B* and *B*'s spouse are eligible for special enrollment under *X*'s plan.

Example 4. (i) *Facts.* Individual *A* works for Employer *X*. *X* maintains a group health plan with two benefit packages—an HMO option and an indemnity option. Self-only and family coverage are available under both options. *A* enrolls for self-only coverage in the HMO option. *A*'s spouse works for Employer *Y* and was enrolled for self-only coverage under *Y*'s plan at the time coverage was offered under *X*'s plan. Then, *A*'s spouse loses coverage under *Y*'s plan. *A* requests special enrollment for *A* and *A*'s spouse under the plan's indemnity option.

(ii) *Conclusion.* In this *Example 4,* because *A*'s spouse satisfies the conditions for special enrollment under paragraph (a)(2)(ii) of this section, both *A* and *A*'s spouse can enroll in either benefit package under *X*'s plan. Therefore, if *A* requests enrollment in accordance with the requirements of this section, the plan must allow *A* and *A*'s spouse to enroll in the indemnity option.

(3) *Conditions for special enrollment*—(i) *Loss of eligibility for coverage.* In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph (a)(3)(i) are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). Loss of eligibility under this paragraph (a)(3)(i) does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Loss of eligibility for coverage under this paragraph (a)(3)(i) includes (but is not limited to)—

(A) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;

(B) In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);

(C) In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;

(D) A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and

(E) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in § 54.9802–1(d)) that includes the individual.

(ii) *Termination of employer contributions.* In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph (a)(3)(ii) are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent.

(iii) *Exhaustion of COBRA continuation coverage.* In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions of this paragraph (a)(3)(iii) are satisfied at the time the COBRA continuation coverage is exhausted. For purposes of this paragraph (a)(3)(iii), an individual who satisfies the conditions for special enrollment of paragraph (a)(3)(i) of this section, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions of this paragraph (a)(3)(iii). (*Exhaustion of COBRA continuation coverage* is defined in § 54.9801–2.)

(iv) *Written statement.* A plan may require an employee declining coverage (for the employee or any dependent of the employee) to State in writing whether the coverage is being declined due to other health coverage only if, at or before the time the employee declines coverage, the employee is provided with notice of the requirement to provide the statement (and the consequences of the employee's failure to provide the statement). If a plan requires such a statement, and an employee does not provide it, the plan is not required to provide special enrollment to the employee or any dependent of the

employee under this paragraph (a)(3). A plan must treat an employee as having satisfied the plan requirement permitted under this paragraph (a)(3)(iv) if the employee provides a written statement that coverage was being declined because the employee or dependent had other coverage; a plan cannot require anything more for the employee to satisfy the plan's requirement to provide a written statement. (For example, the plan cannot require that the statement be notarized.)

(v) The rules of this paragraph (a)(3) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *D* enrolls in a group health plan maintained by Employer *Y*. At the time *D* enrolls, *Y* pays 70 percent of the cost of employee coverage and *D* pays the rest. *Y* announces that beginning January 1, *Y* will no longer make employer contributions towards the coverage. Employees may maintain coverage, however, if they pay the total cost of the coverage.

(ii) *Conclusion.* In this *Example 1,* employer contributions towards *D*'s coverage ceased on January 1 and the conditions of paragraph (a)(3)(ii) of this section are satisfied on this date (regardless of whether *D* elects to pay the total cost and continue coverage under *Y*'s plan).

Example 2. (i) *Facts.* A group health plan provides coverage through two options—Option 1 and Option 2. Employees can enroll in either option only within 30 days of hire or on January 1 of each year. Employee *A* is eligible for both options and enrolls in Option 1. Effective July 1 the plan terminates coverage under Option 1 and the plan does not create an immediate open enrollment opportunity into Option 2.

(ii) *Conclusion.* In this *Example 2, A* has experienced a loss of eligibility for coverage that satisfies paragraph (a)(3)(i) of this section, and has satisfied the other conditions for special enrollment under paragraph (a)(2)(i) of this section. Therefore, if *A* satisfies the other conditions of this paragraph (a), the plan must permit *A* to enroll in Option 2 as a special enrollee. (*A* may also be eligible to enroll in another group health plan, such as a plan maintained by the employer of *A*'s spouse, as a special enrollee.) The outcome would be the same if Option 1 was terminated by an issuer and the plan made no other coverage available to *A*.

Example 3. (i) *Facts.* Individual *C* is covered under a group health plan maintained by Employer *X*. While covered under *X*'s plan, *C* was eligible for but did not enroll in a plan maintained by Employer *Z*, the employer of *C*'s spouse. *C* terminates employment with *X* and loses eligibility for coverage under *X*'s plan. *C* has a special enrollment right to enroll in *Z*'s plan, but *C* instead elects COBRA continuation coverage under *X*'s plan. *C* exhausts COBRA continuation coverage under *X*'s plan and requests special enrollment in *Z*'s plan.

(ii) *Conclusion.* In this *Example 3, C* has satisfied the conditions for special enrollment under paragraph (a)(3)(iii) of this section, and has satisfied the other conditions for special enrollment under paragraph (a)(2)(i) of this section. The special enrollment right that *C* had into *Z*'s plan immediately after the loss of eligibility for coverage under *X*'s plan was an offer of coverage under *Z*'s plan. When *C* later exhausts COBRA coverage under *X*'s plan, *C* has a second special enrollment right in *Z*'s plan.

(4) *Applying for special enrollment and effective date of coverage*—(i) A plan or issuer must allow an employee a period of at least 30 days after an event described in paragraph (a)(3) of this section (other than an event described in paragraph (a)(3)(i)(D)) to request enrollment (for the employee or the employee's dependent). In the case of an event described in paragraph (a)(3)(i)(D) of this section (relating to loss of eligibility for coverage due to the operation of a lifetime limit on all benefits), a plan or issuer must allow an employee a period of at least 30 days after a claim is denied due to the operation of a lifetime limit on all benefits.

(ii) Coverage must begin no later than the first day of the first calendar month beginning after the date the plan or issuer receives the request for special enrollment.

(b) *Special enrollment with respect to certain dependent beneficiaries*—(1) In general. A group health plan that makes coverage available with respect to dependents is required to permit individuals described in paragraph (b)(2) of this section to be enrolled for coverage in a benefit package under the terms of the plan. Paragraph (b)(3) of this section describes the required special enrollment period and the date by which coverage must begin. The special enrollment rights under this paragraph (b) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan. (*See* 29 CFR 2590.701–6(b) and 45 CFR 146.117(b), under which this obligation is also imposed on a health insurance issuer offering group health insurance coverage.)

(2) *Individuals eligible for special enrollment.* An individual is described in this paragraph (b)(2) if the individual is otherwise eligible for coverage in a benefit package under the plan and if the individual is described in paragraph (b)(2)(i), (ii), (iii), (iv), (v), or (vi) of this section.

(i) *Current employee only.* A current employee is described in this paragraph (b)(2)(i) if a person becomes a dependent of the individual through marriage, birth, adoption, or placement for adoption.

(ii) *Spouse of a participant only.* An individual is described in this paragraph (b)(2)(ii) if either—

(A) The individual becomes the spouse of a participant; or

(B) The individual is a spouse of a participant and a child becomes a dependent of the participant through birth, adoption, or placement for adoption.

(iii) *Current employee and spouse.* A current employee and an individual who is or becomes a spouse of such an employee, are described in this paragraph (b)(2)(iii) if either—

(A) The employee and the spouse become married; or

(B) The employee and spouse are married and a child becomes a dependent of the employee through birth, adoption, or placement for adoption.

(iv) *Dependent of a participant only.* An individual is described in this paragraph (b)(2)(iv) if the individual is a dependent (as defined in § 54.9801–2) of a participant and the individual has become a dependent of the participant through marriage, birth, adoption, or placement for adoption.

(v) *Current employee and a new dependent.* A current employee and an individual who is a dependent of the employee, are described in this paragraph (b)(2)(v) if the individual becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.

(vi) *Current employee, spouse, and a new dependent.* A current employee, the employee's spouse, and the employee's dependent are described in this paragraph (b)(2)(vi) if the dependent becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.

(3) *Applying for special enrollment and effective date of coverage*—(i) *Request.* A plan must allow an individual a period of at least 30 days after the date of the marriage, birth, adoption, or placement for adoption (or, if dependent coverage is not generally made available at the time of the marriage, birth, adoption, or placement for adoption, a period of at least 30 days after the date the plan makes dependent coverage generally available) to request enrollment (for the individual or the individual's dependent).

(ii) *Reasonable procedures for special enrollment.* [Reserved]

(iii) *Date coverage must begin*—(A) *Marriage.* In the case of marriage, coverage must begin no later than the first day of the first calendar month beginning after the date the plan (or any issuer offering health insurance

coverage under the plan) receives the request for special enrollment.

(B) *Birth, adoption, or placement for adoption.* Coverage must begin in the case of a dependent's birth on the date of birth and in the case of a dependent's adoption or placement for adoption no later than the date of such adoption or placement for adoption (or, if dependent coverage is not made generally available at the time of the birth, adoption, or placement for adoption, the date the plan makes dependent coverage available).

(4) *Examples.* The rules of this paragraph (b) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer maintains a group health plan that offers all employees employee-only coverage, employee-plus-spouse coverage, or family coverage. Under the terms of the plan, any employee may elect to enroll when first hired (with coverage beginning on the date of hire) or during an annual open enrollment period held each December (with coverage beginning the following January 1). Employee *A* is hired on September 3. *A* is married to *B*, and they have no children. On March 15 in the following year a child *C* is born to *A* and *B*. Before that date, *A* and *B* have not been enrolled in the plan.

(ii) *Conclusion.* In this *Example 1,* the conditions for special enrollment of an employee with a spouse and new dependent under paragraph (b)(2)(vi) of this section are satisfied. If *A* satisfies the conditions of paragraph (b)(3) of this section for requesting enrollment timely, the plan will satisfy this paragraph (b) if it allows *A* to enroll either with employee-only coverage, with employee-plus-spouse coverage (for *A* and *B*), or with family coverage (for *A, B,* and *C*). The plan must allow whatever coverage is chosen to begin on March 15, the date of *C*'s birth.

Example 2. (i) *Facts.* Individual *D* works for Employer *X. X* maintains a group health plan with two benefit packages—an HMO option and an indemnity option. Self-only and family coverage are available under both options. *D* enrolls for self-only coverage in the HMO option. Then, a child, *E,* is placed for adoption with *D.* Within 30 days of the placement of *E* for adoption, *D* requests enrollment for *D* and *E* under the plan's indemnity option.

(ii) *Conclusion.* In this *Example 2, D* and *E* satisfy the conditions for special enrollment under paragraphs (b)(2)(v) and (b)(3) of this section. Therefore, the plan must allow *D* and *E* to enroll in the indemnity coverage, effective as of the date of the placement for adoption.

(c) *Notice of special enrollment.* At or before the time an employee is initially offered the opportunity to enroll in a group health plan, the plan must furnish the employee with a notice of special enrollment that complies with the requirements of this paragraph (c).

(1) *Description of special enrollment rights.* The notice of special enrollment must include a description of special enrollment rights. The following model language may be used to satisfy this requirement:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within [insert ''30 days'' or any longer period that applies under the plan] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within [insert ''30 days'' or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact [insert the name, title, telephone number, and any additional contact information of the appropriate plan representative].

(2) *Additional information that may be required.* The notice of special enrollment must also include, if applicable, the notice described in paragraph (a)(3)(iv) of this section (the notice required to be furnished to an individual declining coverage if the plan requires the reason for declining coverage to be in writing).

(d) *Treatment of special enrollees*—(1) If an individual requests enrollment while the individual is entitled to special enrollment under either paragraph (a) or (b) of this section, the individual is a special enrollee, even if the request for enrollment coincides with a late enrollment opportunity under the plan. Therefore, the individual cannot be treated as a late enrollee.

(2) Special enrollees must be offered all the benefit packages available to similarly situated individuals who enroll when first eligible. For this purpose, any difference in benefits or cost-sharing requirements for different individuals constitutes a different benefit package. In addition, a special enrollee cannot be required to pay more for coverage than a similarly situated individual who enrolls in the same coverage when first eligible. The length of any preexisting condition exclusion that may be applied to a special enrollee cannot exceed the length of any preexisting condition exclusion that is applied to similarly situated individuals who enroll when first eligible. For rules prohibiting the application of a preexisting condition exclusion to certain newborns, adopted children, and children placed for adoption, see § 54.9801–3(b).

(3) The rules of this section are illustrated by the following example:

Example 2. (i) *Facts.* Employer *Y* maintains a group health plan that has an enrollment period for late enrollees every November 1 through November 30 with coverage effective the following January 1. On October 18, Individual *B* loses coverage under another group health plan and satisfies the requirements of paragraphs (a)(2), (3), and (4) of this section. *B* submits a completed application for coverage on November 2.

(ii) *Conclusion.* In this *Example, B* is a special enrollee. Therefore, even though *B*'s request for enrollment coincides with an open enrollment period, *B*'s coverage is required to be made effective no later than December 1 (rather than the plan's January 1 effective date for late enrollees).

§ 54.9831–1 Special rules relating to group health plans.

(a) *Group health plan*—(1) *Defined.* A group health plan means a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.

(2) *Determination of number of plans.* [Reserved]

(b) *General exception for certain small group health plans.* The requirements of §§ 54.9801–1 through 54.9801–6, 54.9802–1, 54.9802–1T, 54.9811–1T, 54.9812–1T, and 54.9833–1 do not apply to any group health plan for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees.

(c) *Excepted benefits*—(1) *In general.* The requirements of §§ 54.9801–1 through 54.9801–6, 54.9802–1, 54.9802–1T, 54.9811–1T, 54.9812–1T, and 54.9833–1 do not apply to any group health plan in relation to its provision of the benefits described in paragraph (c)(2), (3), (4), or (5) of this section (or any combination of these benefits).

(2) *Benefits excepted in all circumstances.* The following benefits are excepted in all circumstances—

(i) Coverage only for accident (including accidental death and dismemberment);

(ii) Disability income coverage;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Coverage issued as a supplement to liability insurance;

(v) Workers' compensation or similar coverage;

(vi) Automobile medical payment insurance;

(vii) Credit-only insurance (for example, mortgage insurance); and

(viii) Coverage for on-site medical clinics.

(3) *Limited excepted benefits*—(i) *In general.* Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan as described in paragraph (c)(3)(ii) of this section. In addition, benefits provided under a health flexible spending arrangement are excepted benefits if they satisfy the requirements of paragraph (c)(3)(v) of this section.

(ii) *Not an integral part of a group health plan.* For purposes of this paragraph (c)(3), benefits are not an integral part of a group health plan (whether the benefits are provided through the same plan or a separate plan) only if the following two requirements are satisfied—

(A) Participants must have the right to elect not to receive coverage for the benefits; and

(B) If a participant elects to receive coverage for the benefits, the participant must pay an additional premium or contribution for that coverage.

(iii) *Limited scope*—(A) *Dental benefits.* Limited scope dental benefits are benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth).

(B) *Vision benefits.* Limited scope vision benefits are benefits substantially of which are for treatment of the eye.

(iv) *Long-term care.* Long-term care benefits are benefits that are either—

(A) Subject to State long-term care insurance laws;

(B) For qualified long-term care services, as defined in section 7702B(c)(1), or provided under a qualified long-term care insurance contract, as defined in section 7702B(b); or

(C) Based on cognitive impairment or a loss of functional capacity that is expected to be chronic.

(v) *Health flexible spending arrangements.* Benefits provided under a health flexible spending arrangement (as defined in section 106(c)(2)) are excepted for a class of participants only if they satisfy the following two requirements—

(A) Other group health plan coverage, not limited to excepted benefits, is made available for the year to the class of participants by reason of their employment; and

(B) The arrangement is structured so that the maximum benefit payable to any participant in the class for a year cannot exceed two times the participant's salary reduction election under the arrangement for the year (or, if greater, cannot exceed $500 plus the amount of the participant's salary reduction election). For this purpose, any amount that an employee can elect to receive as taxable income but elects to apply to the health flexible spending arrangement is considered a salary reduction election (regardless of whether the amount is characterized as salary or as a credit under the arrangement).

(4) *Noncoordinated benefits*—(i) *Excepted benefits that are not coordinated.* Coverage for only a specified disease or illness (for example, cancer-only policies) or hospital indemnity or other fixed indemnity insurance is excepted only if it meets each of the conditions specified in paragraph (c)(4)(ii) of this section. To be hospital indemnity or other fixed indemnity insurance, the insurance must pay a fixed dollar amount per day (or per other period) of hospitalization or illness (for example, $100/day) regardless of the amount of expenses incurred.

(ii) *Conditions.* Benefits are described in paragraph (c)(4)(i) of this section only if—

(A) The benefits are provided under a separate policy, certificate, or contract of insurance;

(B) There is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and

(C) The benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor.

(iii) *Example.* The rules of this paragraph (c)(4) are illustrated by the following example:

Example. (i) *Facts.* An employer sponsors a group health plan that provides coverage through an insurance policy. The policy provides benefits only for hospital stays at a fixed percentage of hospital expenses up to a maximum of $100 a day.

(ii) *Conclusion.* In this *Example,* even though the benefits under the policy satisfy the conditions in paragraph (c)(4)(ii) of this section, because the policy pays a percentage of expenses incurred rather than a fixed dollar amount, the benefits under the policy are not excepted benefits under this paragraph (c)(4). This is the result even if, in practice, the policy pays the maximum of $100 for every day of hospitalization.

(5) *Supplemental benefits.* (i) The following benefits are excepted only if they are provided under a separate policy, certificate, or contract of insurance—

(A) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act; also known as Medigap or MedSupp insurance);

(B) Coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code (also known as TRICARE supplemental programs); and

(C) Similar supplemental coverage provided to coverage under a group health plan. To be similar supplemental coverage, the coverage must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles. Similar supplemental coverage does not include coverage that becomes secondary or supplemental only under a coordination-of-benefits provision.

(ii) The rules of this paragraph (c)(5) are illustrated by the following example:

Example. (i) *Facts.* An employer sponsors a group health plan that provides coverage for both active employees and retirees. The coverage for retirees supplements benefits provided by Medicare, but does not meet the requirements for a supplemental policy under section 1882(g)(1) of the Social Security Act.

(ii) *Conclusion.* In this *Example,* the coverage provided to retirees does not meet the definition of supplemental excepted benefits under this paragraph (c)(5) because the coverage is not Medicare supplemental insurance as defined under section 1882(g)(1) of the Social Security Act, is not a TRICARE supplemental program, and is not supplemental to coverage provided under a group health plan.

(d) *Treatment of partnerships.* For purposes of this part:

(1) *Treatment as a group health plan.* (*See* 29 CFR 2590.732(d)(1) and 45 CFR 146.145(d)(1), under which a plan providing medical care, maintained by a partnership, and usually not treated as an employee welfare benefit plan under ERISA is treated as a group health plan for purposes of Part 7 of Subtitle B of Title I of ERISA and Title XXVII of the PHS Act.)

(2) *Employment relationship.* In the case of a group health plan, the term *employer* also includes the partnership in relation to any bona fide partner. In addition, the term *employee* also includes any bona fide partner. Whether or not an individual is a bona fide partner is determined based on all the relevant facts and circumstances, including whether the individual performs services on behalf of the partnership.

(3) *Participants of group health plans.* In the case of a group health plan, the term *participant* also includes any individual described in paragraph (d)(3)(i) or (ii) of this section if the individual is, or may become, eligible to receive a benefit under the plan or the individual's beneficiaries may be eligible to receive any such benefit.

(i) In connection with a group health plan maintained by a partnership, the individual is a partner in relation to the partnership.

(ii) In connection with a group health plan maintained by a self-employed individual (under which one or more employees are participants), the individual is the self-employed individual.

(e) *Determining the average number of employees.* [Reserved]

§ 54.9833–1 Effective dates.

Sections 54.9801–1 through 54.9801–6, 54.9831–1, and this section are applicable for plan years beginning on or after July 1, 2005.

PART 602—OMB CONTROL NUMBERS UNDER THE PAPERWORK REDUCTION ACT

■ **Par. 4.** The authority citation for part 602 continues to read as follows:

Authority: 26 U.S.C. 7805.

■ **Par. 5.** In § 602.101, paragraph (b) is amended by:

■ a. Removing the entries in the table for §§ 54.9801–3T, 54.9801–4T, 54.9801–5T, and 54.9801–6T.

■ b. Adding the following entries in numerical order to the table:

§ 602.101 OMB Control numbers.

* * * * *

(b) * * *

CFR part or section where identified and described	Current OMB control No.
* * *	* *
54.9801–3	1545–1537
54.9801–4	1545–1537
54.9801–5	1545–1537
54.9801–6	1545–1537
* * *	* *

Mark E. Matthews,

Deputy Commissioner for Services and Enforcement, Internal Revenue Service.

Approved: July 14, 2004.

Gregory F. Jenner,

Acting Assistant Secretary of the Treasury.

Employee Benefits Security Administration

29 CFR Chapter XXV

■ For the reasons set forth above, Chapter XXV of Title 29 of the Code of Federal Regulations is amended as set forth below:

PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLANS

■ 1. The authority citation for Part 2590 is revised to read as follows:

Authority: 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 1191, 1191a, 1191b, and 1191c, sec. 101(g), Public Law 104–191, 101 Stat. 1936; sec. 401(b), Public Law 105–200, 112 Stat. 645 (42 U.S.C. 651 note); Secretary of Labor's Order 1–2003, 68 FR 5374 (Feb. 3, 2003).

■ 2. The heading for Subpart B is revised to read as follows:

Subpart B—Health Coverage Portability, Nondiscrimination, and Renewability

■ 3. Sections 2590.701–1, 2590.701–2, 2590.701–3, 2590.701–4, 2590.701–5, 2590.701–6, and 2590.701–7 are revised to read as follows:

§ 2590.701–1 Basis and scope.

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

(b) *Scope.* A group health plan or health insurance issuer offering group health insurance coverage may provide greater rights to participants and beneficiaries than those set forth in this Subpart B. This Subpart B sets forth minimum requirements for group health plans and health insurance issuers offering group health insurance coverage concerning:

(1) Limitations on a preexisting condition exclusion period.

(2) Certificates and disclosure of previous coverage.

(3) Rules relating to counting creditable coverage.

(4) Special enrollment periods.

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

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

§ 2590.701–2 Definitions.

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

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

COBRA definitions:

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

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

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

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

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

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

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

Condition means a *medical condition.*

Creditable coverage means *creditable coverage* within the meaning of § 2590.701–4(a).

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

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

Enrollment date definitions (*enrollment date, first day of coverage,*

and *waiting period*) are set forth in § 2590.701–3(a)(3)(i), (ii), and (iii).

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

Genetic information means information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

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

Group health plan or *plan* means a *group health plan* within the meaning of § 2590.732(a).

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

Health insurance coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance.

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

Health maintenance organization or *HMO* means—

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

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

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

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

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

Internal Revenue Code means the Internal Revenue Code of 1986, as amended (Title 26, United States Code).

Issuer means a *health insurance issuer.*

Late enrollment definitions (*late enrollee* and *late enrollment*) are set forth in § 2590.701–3(a)(3)(v) and (vi).

Medical care means amounts paid for—

(1) The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(2) Transportation primarily for and essential to medical care referred to in paragraph (1) of this definition; and

(3) Insurance covering medical care referred to in paragraphs (1) and (2) of this definition.

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

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

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

Plan year means the year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is—

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

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

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

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

Preexisting condition exclusion means *preexisting condition exclusion* within the meaning of § 2590.701–3(a)(1).

Public health plan means *public health plan* within the meaning of § 2590.701–4(a)(1)(ix).

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

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

Significant break in coverage means a *significant break in coverage* within the meaning of § 2590.701–4(b)(2)(iii).

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

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

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

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

§ 2590.701–3 Limitations on preexisting condition exclusion period.

(a) *Preexisting condition exclusion*—(1) *Defined*—(i) A *preexisting condition exclusion* means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage under a group health plan or group health insurance coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage under a group health plan or group health insurance coverage, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

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

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

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

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

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

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

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

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

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

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

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

Example 6. (i) *Facts.* A group health plan provides coverage for medically necessary items and services, generally including treatment of heart conditions. However, the plan does not cover those same items and services when used for treatment of congenital heart conditions.

(ii) *Conclusion.* In this *Example 6,* the exclusion of coverage for treatment of congenital heart conditions is a preexisting condition exclusion because it operates to exclude benefits relating to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 7. (i) *Facts.* A group health plan generally provides coverage for medically necessary items and services. However, the plan excludes coverage for the treatment of cleft palate.

(ii) *Conclusion.* In this *Example 7,* the exclusion of coverage for treatment of cleft palate is not a preexisting condition exclusion because the exclusion applies regardless of when the condition arose relative to the effective date of coverage. The plan provision, therefore, is not subject to the limitations on preexisting condition exclusions in this section.

Example 8. (i) *Facts.* A group health plan provides coverage for treatment of cleft palate, but only if the individual being treated has been continuously covered under the plan from the date of birth.

(ii) *Conclusion.* In this *Example 8,* the exclusion of coverage for treatment of cleft palate for individuals who have not been covered under the plan from the date of birth operates to exclude benefits in relation to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

(2) *General rules.* Subject to paragraph (b) of this section (prohibiting the imposition of a preexisting condition exclusion with respect to certain individuals and conditions), a group health plan, and a health insurance issuer offering group health insurance coverage, may impose, with respect to a participant or beneficiary, a preexisting condition exclusion only if the requirements of this paragraph (a)(2) are satisfied.

(i) *6-month look-back rule.* A preexisting condition exclusion must relate to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period (or such shorter period as applies under the plan) ending on the enrollment date.

(A) For purposes of this paragraph (a)(2)(i), medical advice, diagnosis, care, or treatment is taken into account only if it is recommended by, or received from, an individual licensed or similarly authorized to provide such services under State law and operating within the scope of practice authorized by State law.

(B) For purposes of this paragraph (a)(2)(i), the 6-month period ending on the enrollment date begins on the 6-month anniversary date preceding the enrollment date. For example, for an enrollment date of August 1, 1998, the 6-month period preceding the enrollment date is the period commencing on February 1, 1998 and continuing through July 31, 1998. As another example, for an enrollment date of August 30, 1998, the 6-month period preceding the enrollment date is the period commencing on February 28, 1998 and continuing through August 29, 1998.

(C) The rules of this paragraph (a)(2)(i) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *A* is diagnosed with a medical condition 8 months before *A*'s enrollment date in Employer *R*'s group health plan. *A*'s doctor recommends that *A* take a prescription drug for 3 months, and *A* follows the recommendation.

(ii) *Conclusion.* In this *Example 1,* Employer *R*'s plan may impose a preexisting condition exclusion with respect to *A*'s condition because *A* received treatment during the 6-month period ending on *A*'s enrollment date in Employer *R*'s plan by taking the prescription medication during that period. However, if *A* did not take the prescription drug during the 6-month period, Employer *R*'s plan would not be able to impose a preexisting condition exclusion with respect to that condition.

Example 2. (i) *Facts.* Individual *B* is treated for a medical condition 7 months before the enrollment date in Employer *S*'s group health plan. As part of such treatment, *B*'s physician recommends that a follow-up examination be given 2 months later. Despite this recommendation, *B* does not receive a

follow-up examination, and no other medical advice, diagnosis, care, or treatment for that condition is recommended to *B* or received by *B* during the 6-month period ending on *B*'s enrollment date in Employer *S*'s plan.

(ii) *Conclusion.* In this *Example 2,* Employer *S*'s plan may not impose a preexisting condition exclusion with respect to the condition for which *B* received treatment 7 months prior to the enrollment date.

Example 3. (i) *Facts.* Same facts as Example 2, except that Employer *S*'s plan learns of the condition and attaches a rider to *B*'s certificate of coverage excluding coverage for the condition. Three months after enrollment, *B*'s condition recurs, and Employer *S*'s plan denies payment under the rider.

(ii) *Conclusion.* In this *Example 3,* the rider is a preexisting condition exclusion and Employer *S*'s plan may not impose a preexisting condition exclusion with respect to the condition for which *B* received treatment 7 months prior to the enrollment date. (In addition, such a rider would violate the provisions of § 2590.702, even if *B* had received treatment for the condition within the 6-month period ending on the enrollment date.)

Example 4. (i) *Facts.* Individual *C* has asthma and is treated for that condition several times during the 6-month period before *C*'s enrollment date in Employer *T*'s plan. Three months after the enrollment date, *C* begins coverage under Employer T's plan. Two months later, *C* is hospitalized for asthma.

(ii) *Conclusion.* In this *Example 4,* Employer *T*'s plan may impose a preexisting condition exclusion with respect to *C*'s asthma because care relating to *C*'s asthma was received during the 6-month period ending on *C*'s enrollment date (which, under the rules of paragraph (a)(3)(i) of this section, is the first day of the waiting period).

Example 5. (i) *Facts.* Individual *D*, who is subject to a preexisting condition exclusion imposed by Employer *U*'s plan, has diabetes, as well as retinal degeneration, a foot condition, and poor circulation (all of which are conditions that may be directly attributed to diabetes). *D* receives treatment for these conditions during the 6-month period ending on *D*'s enrollment date in Employer *U*'s plan. After enrolling in the plan, *D* stumbles and breaks a leg.

(ii) *Conclusion.* In this *Example 5*, the leg fracture is not a condition related to *D*'s diabetes, retinal degeneration, foot condition, or poor circulation, even though they may have contributed to the accident. Therefore, benefits to treat the leg fracture cannot be subject to a preexisting condition exclusion. However, any additional medical services that may be needed because of *D*'s preexisting diabetes, poor circulation, or retinal degeneration that would not be needed by another patient with a broken leg who does not have these conditions may be subject to the preexisting condition exclusion imposed under Employer *U*'s plan.

(ii) *Maximum length of preexisting condition exclusion.* A preexisting condition exclusion is not permitted to extend for more than 12 months (18 months in the case of a late enrollee) after the enrollment date. For example, for an enrollment date of August 1, 1998, the 12-month period after the enrollment date is the period commencing on August 1, 1998 and continuing through July 31, 1999; the 18-month period after the enrollment date is the period commencing on August 1, 1998 and continuing through January 31, 2000.

(iii) *Reducing a preexisting condition exclusion period by creditable coverage*—(A) The period of any preexisting condition exclusion that would otherwise apply to an individual under a group health plan is reduced by the number of days of creditable coverage the individual has as of the enrollment date, as counted under § 2590.701–4. Creditable coverage may be evidenced through a certificate of creditable coverage (required under § 2590.701–5(a)), or through other means in accordance with the rules of § 2590.701–5(c).

(B) The rules of this paragraph (a)(2)(iii) are illustrated by the following example:

Example. (i) *Facts.* Individual *D* works for Employer *X* and has been covered continuously under *X*'s group health plan. *D*'s spouse works for Employer *Y. Y* maintains a group health plan that imposes a 12-month preexisting condition exclusion (reduced by creditable coverage) on all new enrollees. *D* enrolls in *Y*'s plan, but also stays covered under *X*'s plan. *D* presents *Y*'s plan with evidence of creditable coverage under *X*'s plan.

(ii) *Conclusion.* In this *Example, Y*'s plan must reduce the preexisting condition exclusion period that applies to *D* by the number of days of coverage that *D* had under *X*'s plan as of *D*'s enrollment date in *Y*'s plan (even though *D*'s coverage under *X*'s plan was continuing as of that date).

(iv) *Other standards.* See § 2590.702 for other standards in this Subpart B that may apply with respect to certain benefit limitations or restrictions under a group health plan. Other laws may also apply, such as the Uniformed Services Employment and Reemployment Rights Act (USERRA), which can affect the application of a preexisting condition exclusion to certain individuals who are reinstated in a group health plan following active military service.

(3) *Enrollment definitions*—(i) *Enrollment date* means the first day of coverage (as described in paragraph (a)(3)(ii) of this section) or, if there is a waiting period, the first day of the waiting period. If an individual receiving benefits under a group health plan changes benefit packages, or if the plan changes group health insurance issuers, the individual's enrollment date does not change.

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

(iii) *Waiting period* means the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective. If an employee or dependent enrolls as a late enrollee or special enrollee, any period before such late or special enrollment is not a waiting period. If an individual seeks coverage in the individual market, a waiting period begins on the date the individual submits a substantially complete application for coverage and ends on—

(A) If the application results in coverage, the date coverage begins;

(B) If the application does not result in coverage, the date on which the application is denied by the issuer or the date on which the offer of coverage lapses.

(iv) The rules of paragraphs (a)(3)(i), (ii), and (iii) of this section are illustrated by the following examples:

Example 1. (i) *Facts.* Employer *V*'s group health plan provides for coverage to begin on the first day of the first payroll period following the date an employee is hired and completes the applicable enrollment forms, or on any subsequent January 1 after completion of the applicable enrollment forms. Employer *V*'s plan imposes a preexisting condition exclusion for 12 months (reduced by the individual's creditable coverage) following an individual's enrollment date. Employee *E* is hired by Employer *V* on October 13, 1998 and on October 14, 1998 *E* completes and files all the forms necessary to enroll in the plan. *E*'s coverage under the plan becomes effective on October 25, 1998 (which is the beginning of the first payroll period after *E*'s date of hire).

(ii) *Conclusion.* In this *Example 1, E*'s enrollment date is October 13, 1998 (which is the first day of the waiting period for *E*'s enrollment and is also *E*'s date of hire). Accordingly, with respect to *E*, the permissible 6-month period in paragraph (a)(2)(i) is the period from April 13, 1998 through October 12, 1998, the maximum permissible period during which Employer *V*'s plan can apply a preexisting condition exclusion under paragraph (a)(2)(ii) is the period from October 13, 1998 through October 12, 1999, and this period must be reduced under paragraph (a)(2)(iii) by *E*'s days of creditable coverage as of October 13, 1998.

Example 2. (i) *Facts.* A group health plan has two benefit package options, Option 1 and Option 2. Under each option a 12-month

preexisting condition exclusion is imposed. Individual *B* is enrolled in Option 1 on the first day of employment with the employer maintaining the plan, remains enrolled in Option 1 for more than one year, and then decides to switch to Option 2 at open season.

(ii) *Conclusion.* In this *Example 2, B* cannot be subject to any preexisting condition exclusion under Option 2 because any preexisting condition exclusion period would have to begin on *B*'s enrollment date, which is *B*'s first day of coverage, rather than the date that *B* enrolled in Option 2. Therefore, the preexisting condition exclusion period expired before *B* switched to Option 2.

Example 3. (i) *Facts.* On May 13, 1997, Individual *E* is hired by an employer and enrolls in the employer's group health plan. The plan provides benefits solely through an insurance policy offered by Issuer *S*. On December 27, 1998, *E*'s leg is injured in an accident and the leg is amputated. On January 1, 1999, the plan switches coverage to a policy offered by Issuer *T*. Issuer *T*'s policy excludes benefits for any prosthesis if the body part was lost before the effective date of coverage under the policy.

(ii) *Conclusion.* In this *Example 3, E*'s enrollment date is May 13, 1997, *E*'s first day of coverage. Therefore, the permissible 6-month look-back period for the preexisting condition exclusion imposed under Issuer *T*'s policy begins on November 13, 1996 and ends on May 12, 1997. In addition, the 12-month maximum permissible preexisting condition exclusion period begins on May 13, 1997 and ends on May 12, 1998. Accordingly, because no medical advice, diagnosis, care, or treatment was recommended to or received by *E* for the leg during the 6-month look-back period (even though medical care was provided within the 6-month period preceding the effective date of *E*'s coverage under Issuer *T*'s policy), Issuer *T* may not impose any preexisting condition exclusion with respect to *E*. Moreover, even if *E* had received treatment during the 6-month look-back period, Issuer *T* still would not be permitted to impose a preexisting condition exclusion because the 12-month maximum permissible preexisting condition exclusion period expired on May 12, 1998 (before the effective date of *E*'s coverage under Issuer *T*'s policy).

Example 4. (i) *Facts.* A group health plan limits eligibility for coverage to full-time employees of Employer *Y*. Coverage becomes effective on the first day of the month following the date the employee becomes eligible. Employee *C* begins working full-time for Employer *Y* on April 11. Prior to this date, *C* worked part-time for *Y*. *C* enrolls in the plan and coverage is effective May 1.

(ii) *Conclusion.* In this *Example 4, C*'s enrollment date is April 11 and the period from April 11 through April 30 is a waiting period. The period while *C* was working part-time, and therefore not in an eligible class of employees, is not part of the waiting period.

Example 5. (i) *Facts.* To be eligible for coverage under a multiemployer group health plan in the current calendar quarter, the plan requires an individual to have worked 250 hours in covered employment during the previous quarter. If the hours requirement is satisfied, coverage becomes effective on the first day of the current calendar quarter. Employee *D* begins work on January 28 and does not work 250 hours in covered employment during the first quarter (ending March 31). *D* works at least 250 hours in the second quarter (ending June 30) and is enrolled in the plan with coverage effective July 1 (the first day of the third quarter).

(ii) *Conclusion.* In this *Example 5, D*'s enrollment date is the first day of the quarter during which *D* satisfies the hours requirement, which is April 1. The period from April 1 through June 30 is a waiting period.

(v) *Late enrollee* means an individual whose enrollment in a plan is a late enrollment.

(vi) (A) *Late enrollment* means enrollment of an individual under a group health plan other than—

(*1*) On the earliest date on which coverage can become effective for the individual under the terms of the plan; or

(*2*) Through special enrollment. (For rules relating to special enrollment, see § 2590.701–6.)

(B) If an individual ceases to be eligible for coverage under the plan, and then subsequently becomes eligible for coverage under the plan, only the individual's most recent period of eligibility is taken into account in determining whether the individual is a late enrollee under the plan with respect to the most recent period of coverage. Similar rules apply if an individual again becomes eligible for coverage following a suspension of coverage that applied generally under the plan.

(vii) *Examples.* The rules of paragraphs (a)(3)(v) and (vi) of this section are illustrated by the following examples:

Example 1. (i) *Facts.* Employee *F* first becomes eligible to be covered by Employer *W*'s group health plan on January 1, 1999 but elects not to enroll in the plan until a later annual open enrollment period, with coverage effective January 1, 2001. *F* has no special enrollment right at that time.

(ii) *Conclusion.* In this *Example 1, F* is a late enrollee with respect to *F*'s coverage that became effective under the plan on January 1, 2001.

Example 2. (i) *Facts.* Same facts as *Example 1,* except that *F* terminates employment with Employer *W* on July 1, 1999 without having had any health insurance coverage under the plan. *F* is rehired by Employer *W* on January 1, 2000 and is eligible for and elects coverage under Employer *W*'s plan effective on January 1, 2000.

(ii) *Conclusion.* In this *Example 2, F* would not be a late enrollee with respect to *F*'s coverage that became effective on January 1, 2000.

(b) *Exceptions pertaining to preexisting condition exclusions*—(1) *Newborns*—(i) *In general.* Subject to paragraph (b)(3) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion on a child who, within 30 days after birth, is covered under any creditable coverage. Accordingly, if a child is enrolled in a group health plan (or other creditable coverage) within 30 days after birth and subsequently enrolls in another group health plan without a significant break in coverage (as described in § 2590.701–4(b)(2)(iii)), the other plan may not impose any preexisting condition exclusion on the child.

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

Example 1. (i) *Facts.* Individual *E*, who has no prior creditable coverage, begins working for Employer *W* and has accumulated 210 days of creditable coverage under Employer *W*'s group health plan on the date *E* gives birth to a child. Within 30 days after the birth, the child is enrolled in the plan. Ninety days after the birth, both *E* and the child terminate coverage under the plan. Both *E* and the child then experience a break in coverage of 45 days before *E* is hired by Employer *X* and the two are enrolled in Employer *X*'s group health plan.

(ii) *Conclusion.* In this *Example 1,* because *E*'s child is enrolled in Employer *W*'s plan within 30 days after birth, no preexisting condition exclusion may be imposed with respect to the child under Employer *W*'s plan. Likewise, Employer *X*'s plan may not impose any preexisting condition exclusion on *E*'s child because the child was covered under creditable coverage within 30 days after birth and had no significant break in coverage before enrolling in Employer *X*'s plan. On the other hand, because *E* had only 300 days of creditable coverage prior to *E*'s enrollment date in Employer *X*'s plan, Employer *X*'s plan may impose a preexisting condition exclusion on *E* for up to 65 days (66 days if the 12-month period after *E*'s enrollment date in *X*'s plan includes February 29).

Example 2. (i) *Facts.* Individual *F* is enrolled in a group health plan in which coverage is provided through a health insurance issuer. *F* gives birth. Under State law applicable to the health insurance issuer, health care expenses incurred for the child during the 30 days following birth are covered as part of *F*'s coverage. Although *F* may obtain coverage for the child beyond 30 days by timely requesting special enrollment and paying an additional premium, the issuer is prohibited under State law from recouping the cost of any expenses incurred for the child within the 30-day period if the child is not later enrolled.

(ii) *Conclusion.* In this *Example 2,* the child is covered under creditable coverage within 30 days after birth, regardless of whether the child enrolls as a special enrollee under the plan. Therefore, no preexisting condition exclusion may be imposed on the child unless the child has a significant break in coverage.

(2) *Adopted children.* Subject to paragraph (b)(3) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion on a child who is adopted or placed for adoption before attaining 18 years of age and who, within 30 days after the adoption or placement for adoption, is covered under any creditable coverage. Accordingly, if a child is enrolled in a group health plan (or other creditable coverage) within 30 days after adoption or placement for adoption and subsequently enrolls in another group health plan without a significant break in coverage (as described in § 2590.701–4(b)(2)(iii)), the other plan may not impose any preexisting condition exclusion on the child. This rule does not apply to coverage before the date of such adoption or placement for adoption.

(3) *Significant break in coverage.* Paragraphs (b)(1) and (2) of this section no longer apply to a child after a significant break in coverage. (*See* § 2590.701–4(b)(2)(iii) for rules relating to the determination of a significant break in coverage.)

(4) *Special enrollment.* For special enrollment rules relating to new dependents, see § 2590.701–6(b).

(5) *Pregnancy.* A group health plan, and a health insurance issuer offering group health insurance coverage, may not impose a preexisting condition exclusion relating to pregnancy.

(6) *Genetic information*—(i) A group health plan, and a health insurance issuer offering group health insurance coverage, may not impose a preexisting condition exclusion relating to a condition based solely on genetic information. However, if an individual is diagnosed with a condition, even if the condition relates to genetic information, the plan may impose a preexisting condition exclusion with respect to the condition, subject to the other limitations of this section.

(ii) The rules of this paragraph (b)(6) are illustrated by the following example:

Example. (i) *Facts.* Individual *A* enrolls in a group health plan that imposes a 12-month maximum preexisting condition exclusion. Three months before *A*'s enrollment, *A*'s doctor told *A* that, based on genetic information, *A* has a predisposition towards breast cancer. *A* was not diagnosed with breast cancer at any time prior to *A*'s enrollment date in the plan. Nine months after *A*'s enrollment date in the plan, *A* is diagnosed with breast cancer.

(ii) *Conclusion.* In this *Example,* the plan may not impose a preexisting condition exclusion with respect to *A*'s breast cancer because, prior to *A*'s enrollment date, *A* was not diagnosed with breast cancer.

(c) *General notice of preexisting condition exclusion.* A group health plan imposing a preexisting condition exclusion, and a health insurance issuer offering group health insurance coverage subject to a preexisting condition exclusion, must provide a written general notice of preexisting condition exclusion to participants under the plan and cannot impose a preexisting condition exclusion with respect to a participant or a dependent of the participant until such a notice is provided.

(1) *Manner and timing.* A plan or issuer must provide the general notice of preexisting condition exclusion as part of any written application materials distributed by the plan or issuer for enrollment. If the plan or issuer does not distribute such materials, the notice must be provided by the earliest date following a request for enrollment that the plan or issuer, acting in a reasonable and prompt fashion, can provide the notice.

(2) *Content.* The general notice of preexisting condition exclusion must notify participants of the following:

(i) The existence and terms of any preexisting condition exclusion under the plan. This description includes the length of the plan's look-back period (which is not to exceed 6 months under paragraph (a)(2)(i) of this section); the maximum preexisting condition exclusion period under the plan (which cannot exceed 12 months (or 18-months for late enrollees) under paragraph (a)(2)(ii) of this section); and how the plan will reduce the maximum preexisting condition exclusion period by creditable coverage (described in paragraph (a)(2)(iii) of this section).

(ii) A description of the rights of individuals to demonstrate creditable coverage, and any applicable waiting periods, through a certificate of creditable coverage (as required by § 2590.701–5(a)) or through other means (as described in § 2590.701–5(c)). This must include a description of the right of the individual to request a certificate from a prior plan or issuer, if necessary, and a statement that the current plan or issuer will assist in obtaining a certificate from any prior plan or issuer, if necessary.

(iii) A person to contact (including an address or telephone number) for obtaining additional information or assistance regarding the preexisting condition exclusion.

(3) *Duplicate notices not required.* If a notice satisfying the requirements of this paragraph (c) is provided to an individual, the obligation to provide a general notice of preexisting condition exclusion with respect to that individual is satisfied for both the plan and the issuer.

(4) *Example with sample language.* The rules of this paragraph (c) are illustrated by the following example, which includes sample language that plans and issuers can use as a basis for preparing their own notices to satisfy the requirements of this paragraph (c):

Example. (i) *Facts.* A group health plan makes coverage effective on the first day of the first calendar month after hire and on each January 1 following an open season. The plan imposes a 12-month maximum preexisting condition exclusion (18 months for late enrollees) and uses a 6-month look-back period. As part of the enrollment application materials, the plan provides the following statement:

This plan imposes a preexisting condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior ''creditable coverage.'' Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the preexisting condition exclusion and creditable coverage should be directed to Individual *B* at Address *M* or Telephone Number *N.*

(ii) Conclusion. In this Example, the plan satisfies the general notice requirement of this paragraph (c), and thus also satisfies this requirement for any issuer providing the coverage.

(d) *Determination of creditable coverage*—(1) *Determination within reasonable time.* If a group health plan or health insurance issuer offering group health insurance coverage receives

creditable coverage information under § 2590.701–5, the plan or issuer is required, within a reasonable time following receipt of the information, to make a determination regarding the amount of the individual's creditable coverage and the length of any exclusion that remains. Whether this determination is made within a reasonable time depends on the relevant facts and circumstances. Relevant facts and circumstances include whether a plan's application of a preexisting condition exclusion would prevent an individual from having access to urgent medical care.

(2) *No time limit on presenting evidence of creditable coverage.* A plan or issuer may not impose any limit on the amount of time that an individual has to present a certificate or other evidence of creditable coverage.

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

Example. (i) *Facts.* A group health plan imposes a preexisting condition exclusion period of 12 months. After receiving the general notice of preexisting condition exclusion, Individual *H* develops an urgent health condition before receiving a certificate of creditable coverage from *H*'s prior group health plan. *H* attests to the period of prior coverage, presents corroborating documentation of the coverage period, and authorizes the plan to request a certificate on *H*'s behalf in accordance with the rules of § 2590.701–5.

(ii) *Conclusion.* In this *Example,* the plan must review the evidence presented by *H* and make a determination of creditable coverage within a reasonable time that is consistent with the urgency of *H*'s health condition. (This determination may be modified as permitted under paragraph (f) of this section.)

(e) *Individual notice of period of preexisting condition exclusion.* After an individual has presented evidence of creditable coverage and after the plan or issuer has made a determination of creditable coverage under paragraph (d) of this section, the plan or issuer must provide the individual a written notice of the length of preexisting condition exclusion that remains after offsetting for prior creditable coverage. This individual notice is not required to identify any medical conditions specific to the individual that could be subject to the exclusion. A plan or issuer is not required to provide this notice if the plan or issuer does not impose any preexisting condition exclusion on the individual or if the plan's preexisting condition exclusion is completely offset by the individual's prior creditable coverage.

(1) *Manner and timing.* The individual notice must be provided by the earliest date following a determination that the plan or issuer, acting in a reasonable and prompt fashion, can provide the notice.

(2) *Content.* A plan or issuer must disclose—

(i) Its determination of any preexisting condition exclusion period that applies to the individual (including the last day on which the preexisting condition exclusion applies);

(ii) The basis for such determination, including the source and substance of any information on which the plan or issuer relied;

(iii) An explanation of the individual's right to submit additional evidence of creditable coverage; and

(iv) A description of any applicable appeal procedures established by the plan or issuer.

(3) *Duplicate notices not required.* If a notice satisfying the requirements of this paragraph (e) is provided to an individual, the obligation to provide this individual notice of preexisting condition exclusion with respect to that individual is satisfied for both the plan and the issuer.

(4) *Examples.* The rules of this paragraph (e) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan imposes a preexisting condition exclusion period of 12 months. After receiving the general notice of preexisting condition exclusion, Individual *G* presents a certificate of creditable coverage indicating 240 days of creditable coverage. Within seven days of receipt of the certificate, the plan determines that *G* is subject to a preexisting condition exclusion of 125 days, the last day of which is March 5. Five days later, the plan notifies *G* that, based on the certificate *G* submitted, *G* is subject to a preexisting condition exclusion period of 125 days, ending on March 5. The notice also explains the opportunity to submit additional evidence of creditable coverage and the plan's appeal procedures. The notice does not identify any of *G*'s medical conditions that could be subject to the exclusion.

(ii) *Conclusion.* In this *Example 1,* the plan satisfies the requirements of this paragraph (e).

Example 2. (i) *Facts.* Same facts as in *Example 1,* except that the plan determines that *G* has 430 days of creditable coverage based on *G*'s certificate indicating 430 days of creditable coverage under *G*'s prior plan.

(ii) *Conclusion.* In this *Example 2,* the plan is not required to notify *G* that *G* will not be subject to a preexisting condition exclusion.

(f) *Reconsideration.* Nothing in this section prevents a plan or issuer from modifying an initial determination of creditable coverage if it determines that the individual did not have the claimed creditable coverage, provided that—

(1) A notice of the new determination (consistent with the requirements of paragraph (e) of this section) is provided to the individual; and

(2) Until the notice of the new determination is provided, the plan or issuer, for purposes of approving access to medical services (such as a pre-surgery authorization), acts in a manner consistent with the initial determination.

§ 2590.701–4 Rules relating to creditable coverage.

(a) *General rules*—(1) *Creditable coverage.* For purposes of this section, except as provided in paragraph (a)(2) of this section, the term *creditable coverage* means coverage of an individual under any of the following:

(i) A group health plan as defined in § 2590.732(a).

(ii) Health insurance coverage as defined in § 2590.701–2 (whether or not the entity offering the coverage is subject to Part 7 of Subtitle B of Title I of the Act, and without regard to whether the coverage is offered in the group market, the individual market, or otherwise).

(iii) Part A or B of Title XVIII of the Social Security Act (Medicare).

(iv) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).

(v) Title 10 U.S.C. Chapter 55 (medical and dental care for members and certain former members of the uniformed services, and for their dependents; for purposes of Title 10 U.S.C. Chapter 55, *uniformed services* means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service).

(vi) A medical care program of the Indian Health Service or of a tribal organization.

(vii) A State health benefits risk pool. For purposes of this section, a *State health benefits risk pool* means—

(A) An organization qualifying under section 501(c)(26) of the Internal Revenue Code;

(B) A qualified high risk pool described in section 2744(c)(2) of the PHS Act; or

(C) Any other arrangement sponsored by a State, the membership composition of which is specified by the State and which is established and maintained primarily to provide health coverage for individuals who are residents of such State and who, by reason of the existence or history of a medical condition—

(*1*) Are unable to acquire medical care coverage for such condition through insurance or from an HMO, or

(*2*) Are able to acquire such coverage only at a rate which is substantially in excess of the rate for such coverage through the membership organization.

(viii) A health plan offered under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program).

(ix) A public health plan. For purposes of this section, a *public health plan* means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

(x) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(xi) Title XXI of the Social Security Act (State Children's Health Insurance Program).

(2) *Excluded coverage.* Creditable coverage does not include coverage of solely excepted benefits (described in § 2590.732).

(3) *Methods of counting creditable coverage.* For purposes of reducing any preexisting condition exclusion period, as provided under § 2590.701–3(a)(2)(iii), the amount of an individual's creditable coverage generally is determined by using the standard method described in paragraph (b) of this section. A plan or issuer may use the alternative method under paragraph (c) of this section with respect to any or all of the categories of benefits described under paragraph (c)(3) of this section.

(b) *Standard method*—(1) *Specific benefits not considered.* Under the standard method, the amount of creditable coverage is determined without regard to the specific benefits included in the coverage.

(2) *Counting creditable coverage*—(i) *Based on days.* For purposes of reducing the preexisting condition exclusion period that applies to an individual, the amount of creditable coverage is determined by counting all the days on which the individual has one or more types of creditable coverage. Accordingly, if on a particular day an individual has creditable coverage from more than one source, all the creditable coverage on that day is counted as one day. Any days in a waiting period for coverage are not creditable coverage.

(ii) *Days not counted before significant break in coverage.* Days of creditable coverage that occur before a significant break in coverage are not required to be counted.

(iii) *Significant break in coverage defined*—A significant break in coverage means a period of 63 consecutive days during each of which an individual does not have any creditable coverage. (*See also* § 2590.731(c)(2)(iii) regarding the applicability to issuers of State insurance laws that require a break of more than 63 days before an individual has a significant break in coverage for purposes of State insurance law.)

(iv) *Periods that toll a significant break.* Days in a waiting period and days in an affiliation period are not taken into account in determining whether a significant break in coverage has occurred. In addition, for an individual who elects COBRA continuation coverage during the second election period provided under the Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period are not taken into account in determining whether a significant break in coverage has occurred.

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

Example 1. (i) *Facts.* Individual *A* has creditable coverage under Employer *P*'s plan for 18 months before coverage ceases. *A* is provided a certificate of creditable coverage on *A*'s last day of coverage. Sixty-four days after the last date of coverage under *P*'s plan, *A* is hired by Employer *Q* and enrolls in *Q*'s group health plan. *Q*'s plan has a 12-month preexisting condition exclusion.

(ii) *Conclusion.* In this *Example 1, A* has a break in coverage of 63 days. Because *A*'s break in coverage is a significant break in coverage, *Q*'s plan may disregard *A*'s prior coverage and *A* may be subject to a 12-month preexisting condition exclusion.

Example 2. (i) *Facts.* Same facts as *Example 1,* except that *A* is hired by *Q* and enrolls in *Q*'s plan on the 63rd day after the last date of coverage under *P*'s plan.

(ii) *Conclusion.* In this *Example 2, A* has a break in coverage of 62 days. Because *A*'s break in coverage is not a significant break in coverage, *Q*'s plan must count *A*'s prior creditable coverage for purposes of reducing the plan's preexisting condition exclusion period that applies to *A.*

Example 3. (i) *Facts.* Same facts as *Example 1,* except that *Q*'s plan provides benefits through an insurance policy that, as required by applicable State insurance laws, defines a significant break in coverage as 90 days.

(ii) *Conclusion.* In this *Example 3,* under State law, the issuer that provides group health insurance coverage to *Q*'s plan must count *A*'s period of creditable coverage prior to the 63-day break. (However, if *Q*'s plan was a self-insured plan, the coverage would not be subject to State law. Therefore, the health coverage would not be governed by the longer break rules and *A*'s previous health coverage could be disregarded.)

Example 4. —[Reserved]

Example 5. (i) *Facts.* Individual *C* has creditable coverage under Employer *S*'s plan for 200 days before coverage ceases. *C* is provided a certificate of creditable coverage on *C*'s last day of coverage. *C* then does not have any creditable coverage for 51 days before being hired by Employer *T. T*'s plan has a 3-month waiting period. *C* works for *T* for 2 months and then terminates employment. Eleven days after terminating employment with *T, C* begins working for Employer *U. U*'s plan has no waiting period, but has a 6-month preexisting condition exclusion.

(ii) *Conclusion.* In this *Example 5, C* does not have a significant break in coverage because, after disregarding the waiting period under *T*'s plan, *C* had only a 62-day break in coverage (51 days plus 11 days). Accordingly, *C* has 200 days of creditable coverage, and *U*'s plan may not apply its 6-month preexisting condition exclusion with respect to *C.*

Example 6. —[Reserved]

Example 7. (i) *Facts.* Individual *E* has creditable coverage under Employer *X*'s plan. *E* is provided a certificate of creditable coverage on *E*'s last day of coverage. On the 63rd day without coverage, *E* submits a substantially complete application for a health insurance policy in the individual market. *E*'s application is accepted and coverage is made effective 10 days later.

(ii) *Conclusion.* In this *Example 7,* because *E* applied for the policy before the end of the 63rd day, the period between the date of application and the first day of coverage is a waiting period and no significant break in coverage occurred even though the actual period without coverage was 73 days.

Example 8. (i) *Facts.* Same facts as *Example 7,* except that *E*'s application for a policy in the individual market is denied.

(ii) *Conclusion.* In this *Example 8,* even though *E* did not obtain coverage following application, the period between the date of application and the date the coverage was denied is a waiting period. However, to avoid a significant break in coverage, no later than the day after the application for the policy is denied *E* would need to do one of the following: submit a substantially complete application for a different individual market policy; obtain coverage in the group market; or be in a waiting period for coverage in the group market.

(vi) *Other permissible counting methods*—(A) *Rule.* Notwithstanding any other provisions of this paragraph (b)(2), for purposes of reducing a preexisting condition exclusion period (but not for purposes of issuing a certificate under § 2590.701–5), a group health plan, and a health insurance issuer offering group health insurance coverage, may determine the amount of creditable coverage in any other manner that is at least as favorable to the individual as the method set forth in this paragraph (b)(2), subject to the requirements of other applicable law.

(B) *Example.* The rule of this paragraph (b)(2)(vi) is illustrated by the following example:

Example. (i) *Facts.* Individual *F* has coverage under Group Health Plan *Y* from January 3, 1997 through March 25, 1997. *F*

then becomes covered by Group Health Plan *Z*. *F*'s enrollment date in Plan *Z* is May 1, 1997. Plan *Z* has a 12-month preexisting condition exclusion.

(ii) *Conclusion.* In this *Example*, Plan *Z* may determine, in accordance with the rules prescribed in paragraphs (b)(2)(i), (ii), and (iii) of this section, that *F* has 82 days of creditable coverage (29 days in January, 28 days in February, and 25 days in March). Thus, the preexisting condition exclusion will no longer apply to *F* on February 8, 1998 (82 days before the 12-month anniversary of *F*'s enrollment (May 1)). For administrative convenience, however, Plan *Z* may consider that the preexisting condition exclusion will no longer apply to *F* on the first day of the month (February 1).

(c) *Alternative method*—(1) *Specific benefits considered.* Under the alternative method, a group health plan, or a health insurance issuer offering group health insurance coverage, determines the amount of creditable coverage based on coverage within any category of benefits described in paragraph (c)(3) of this section and not based on coverage for any other benefits. The plan or issuer may use the alternative method for any or all of the categories. The plan or issuer may apply a different preexisting condition exclusion period with respect to each category (and may apply a different preexisting condition exclusion period for benefits that are not within any category). The creditable coverage determined for a category of benefits applies only for purposes of reducing the preexisting condition exclusion period with respect to that category. An individual's creditable coverage for benefits that are not within any category for which the alternative method is being used is determined under the standard method of paragraph (b) of this section.

(2) *Uniform application.* A plan or issuer using the alternative method is required to apply it uniformly to all participants and beneficiaries under the plan or health insurance coverage. The use of the alternative method is required to be set forth in the plan.

(3) *Categories of benefits.* The alternative method for counting creditable coverage may be used for coverage for the following categories of benefits—

(i) Mental health;

(ii) Substance abuse treatment;

(iii) Prescription drugs;

(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.

§ 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 paragraph (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 received 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.

§ 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 insurance 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 employee satisfies the criteria of paragraph (a)(2)(i) of this section.

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

Example 1. (i) *Facts.* Individual *A* works for Employer *X*. *A*, *A*'s spouse, and *A*'s dependent children are eligible but not enrolled for coverage under *X*'s group health plan. *A*'s spouse works for Employer *Y* and at the time coverage was offered under *X*'s plan, *A* was enrolled in coverage under *Y*'s plan. Then, *A* loses eligibility for coverage under *Y*'s plan.

(ii) *Conclusion.* In this *Example 1,* because *A* satisfies the conditions for special enrollment under paragraph (a)(2)(i) of this section, *A*, *A*'s spouse, and *A*'s dependent children are eligible for special enrollment under *X*'s plan.

Example 2. (i) *Facts.* Individual *A* and *A*'s spouse are eligible but not enrolled for coverage under Group Health Plan *P* maintained by *A*'s employer. When *A* was first presented with an opportunity to enroll *A* and *A*'s spouse, they did not have other coverage. Later, *A* and *A*'s spouse enroll in Group Health Plan *Q* maintained by the employer of *A*'s spouse. During a subsequent open enrollment period in *P*, *A* and *A*'s spouse did not enroll because of their coverage under *Q*. They then lose eligibility for coverage under *Q*.

(ii) *Conclusion.* In this *Example 2*, because *A* and *A*'s spouse were covered under *Q* when they did not enroll in *P* during open

enrollment, they satisfy the conditions for special enrollment under paragraphs (a)(2)(i) and (ii) of this section. Consequently, *A* and *A*'s spouse are eligible for special enrollment under *P*.

Example 3. (i) *Facts.* Individual *B* works for Employer *X*. *B* and *B*'s spouse are eligible but not enrolled for coverage under *X*'s group health plan. *B*'s spouse works for Employer *Y* and at the time coverage was offered under *X*'s plan, *B*'s spouse was enrolled in self-only coverage under *Y*'s group health plan. Then, *B*'s spouse loses eligibility for coverage under *Y*'s plan.

(ii) *Conclusion.* In this *Example 3*, because *B*'s spouse satisfies the conditions for special enrollment under paragraph (a)(2)(ii) of this section, both *B* and *B*'s spouse are eligible for special enrollment under *X*'s plan.

Example 4. (i) *Facts.* Individual *A* works for Employer *X*. *X* maintains a group health plan with two benefit packages—an HMO option and an indemnity option. Self-only and family coverage are available under both options. *A* enrolls for self-only coverage in the HMO option. *A*'s spouse works for Employer *Y* and was enrolled for self-only coverage under *Y*'s plan at the time coverage was offered under *X*'s plan. Then, *A*'s spouse loses coverage under *Y*'s plan. *A* requests special enrollment for *A* and *A*'s spouse under the plan's indemnity option.

(ii) *Conclusion.* In this *Example 4,* because *A*'s spouse satisfies the conditions for special enrollment under paragraph (a)(2)(ii) of this section, both *A* and *A*'s spouse can enroll in either benefit package under *X*'s plan. Therefore, if *A* requests enrollment in accordance with the requirements of this section, the plan must allow *A* and *A*'s spouse to enroll in the indemnity option.

(3) *Conditions for special enrollment*—(i) *Loss of eligibility for coverage.* In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph (a)(3)(i) are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). Loss of eligibility under this paragraph (a)(3)(i) does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Loss of eligibility for coverage under this paragraph (a)(3)(i) includes (but is not limited to)—

(A) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;

(B) In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);

(C) In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;

(D) A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and

(E) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in § 2590.702(d)) that includes the individual.

(ii) *Termination of employer contributions.* In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph (a)(3)(ii) are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent.

(iii) *Exhaustion of COBRA continuation coverage.* In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions of this paragraph (a)(3)(iii) are satisfied at the time the COBRA continuation coverage is exhausted. For purposes of this paragraph (a)(3)(iii), an individual who satisfies the conditions for special enrollment of paragraph (a)(3)(i) of this section, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions of this paragraph (a)(3)(iii). (*Exhaustion of COBRA continuation coverage* is defined in § 2590.701–2.)

(iv) *Written statement.* A plan may require an employee declining coverage (for the employee or any dependent of the employee) to State in writing whether the coverage is being declined due to other health coverage only if, at or before the time the employee declines coverage, the employee is provided with notice of the requirement to provide the statement (and the consequences of the employee's failure to provide the statement). If a plan requires such a statement, and an employee does not provide it, the plan is not required to provide special enrollment to the employee or any dependent of the employee under this paragraph (a)(3). A plan must treat an employee as having satisfied the plan requirement permitted under this paragraph (a)(3)(iv) if the employee provides a written statement that coverage was being declined because the employee or dependent had other coverage; a plan cannot require anything more for the employee to satisfy the plan's requirement to provide a written statement. (For example, the plan cannot require that the statement be notarized.)

(v) The rules of this paragraph (a)(3) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *D* enrolls in a group health plan maintained by Employer *Y*. At the time *D* enrolls, *Y* pays 70 percent of the cost of employee coverage and *D* pays the rest. *Y* announces that beginning January 1, *Y* will no longer make employer contributions towards the coverage. Employees may maintain coverage, however, if they pay the total cost of the coverage.

(ii) *Conclusion.* In this *Example 1,* employer contributions towards *D*'s coverage ceased on January 1 and the conditions of paragraph (a)(3)(ii) of this section are satisfied on this date (regardless of whether *D* elects to pay the total cost and continue coverage under *Y*'s plan).

Example 2. (i) *Facts.* A group health plan provides coverage through two options—Option 1 and Option 2. Employees can enroll in either option only within 30 days of hire or on January 1 of each year. Employee *A* is eligible for both options and enrolls in Option 1. Effective July 1 the plan terminates coverage under Option 1 and the plan does not create an immediate open enrollment opportunity into Option 2.

(ii) *Conclusion.* In this *Example 2, A* has experienced a loss of eligibility for coverage that satisfies paragraph (a)(3)(i) of this section, and has satisfied the other conditions for special enrollment under paragraph (a)(2)(i) of this section. Therefore, if *A* satisfies the other conditions of this paragraph (a), the plan must permit *A* to enroll in Option 2 as a special enrollee. (*A* may also be eligible to enroll in another group health plan, such as a plan maintained by the employer of *A*'s spouse, as a special enrollee.) The outcome would be the same if Option 1 was terminated by an issuer and the plan made no other coverage available to *A*.

Example 3. (i) *Facts.* Individual *C* is covered under a group health plan maintained by Employer *X*. While covered under *X*'s plan, *C* was eligible for but did not enroll in a plan maintained by Employer *Z*, the employer of *C*'s spouse. *C* terminates employment with *X* and loses eligibility for coverage under *X*'s plan. *C* has a special

enrollment right to enroll in *Z*'s plan, but *C* instead elects COBRA continuation coverage under *X*'s plan. *C* exhausts COBRA continuation coverage under *X*'s plan and requests special enrollment in *Z*'s plan.

(ii) *Conclusion.* In this *Example 3, C* has satisfied the conditions for special enrollment under paragraph (a)(3)(iii) of this section, and has satisfied the other conditions for special enrollment under paragraph (a)(2)(i) of this section. The special enrollment right that *C* had into *Z*'s plan immediately after the loss of eligibility for coverage under *X*'s plan was an offer of coverage under *Z*'s plan. When *C* later exhausts COBRA coverage under *X*'s plan, *C* has a second special enrollment right in *Z*'s plan.

(4) *Applying for special enrollment and effective date of coverage*—(i) A plan or issuer must allow an employee a period of at least 30 days after an event described in paragraph (a)(3) of this section (other than an event described in paragraph (a)(3)(i)(D)) to request enrollment (for the employee or the employee's dependent). In the case of an event described in paragraph (a)(3)(i)(D) of this section (relating to loss of eligibility for coverage due to the operation of a lifetime limit on all benefits), a plan or issuer must allow an employee a period of at least 30 days after a claim is denied due to the operation of a lifetime limit on all benefits.

(ii) Coverage must begin no later than the first day of the first calendar month beginning after the date the plan or issuer receives the request for special enrollment.

(b) *Special enrollment with respect to certain dependent beneficiaries*—(1) *In general.* A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, that makes coverage available with respect to dependents is required to permit individuals described in paragraph (b)(2) of this section to be enrolled for coverage in a benefit package under the terms of the plan. Paragraph (b)(3) of this section describes the required special enrollment period and the date by which coverage must begin. The special enrollment rights under this paragraph (b) 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.* An individual is described in this paragraph (b)(2) if the individual is otherwise eligible for coverage in a benefit package under the plan and if the individual is described in paragraph (b)(2)(i), (ii), (iii), (iv), (v), or (vi) of this section.

(i) *Current employee only.* A current employee is described in this paragraph (b)(2)(i) if a person becomes a dependent of the individual through marriage, birth, adoption, or placement for adoption.

(ii) *Spouse of a participant only.* An individual is described in this paragraph (b)(2)(ii) if either —

(A) The individual becomes the spouse of a participant; or

(B) The individual is a spouse of a participant and a child becomes a dependent of the participant through birth, adoption, or placement for adoption.

(iii) *Current employee and spouse.* A current employee and an individual who is or becomes a spouse of such an employee, are described in this paragraph (b)(2)(iii) if either—

(A) The employee and the spouse become married; or

(B) The employee and spouse are married and a child becomes a dependent of the employee through birth, adoption, or placement for adoption.

(iv) *Dependent of a participant only.* An individual is described in this paragraph (b)(2)(iv) if the individual is a dependent (as defined in § 2590.701–2) of a participant and the individual has become a dependent of the participant through marriage, birth, adoption, or placement for adoption.

(v) *Current employee and a new dependent.* A current employee and an individual who is a dependent of the employee, are described in this paragraph (b)(2)(v) if the individual becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.

(vi) *Current employee, spouse, and a new dependent.* A current employee, the employee's spouse, and the employee's dependent are described in this paragraph (b)(2)(vi) if the dependent becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.

(3) *Applying for special enrollment and effective date of coverage*—(i) *Request.* A plan or issuer must allow an individual a period of at least 30 days after the date of the marriage, birth, adoption, or placement for adoption (or, if dependent coverage is not generally made available at the time of the marriage, birth, adoption, or placement for adoption, a period of at least 30 days after the date the plan makes dependent coverage generally available) to request enrollment (for the individual or the individual's dependent).

(ii) *Reasonable procedures for special enrollment.* [Reserved]

(iii) *Date coverage must begin*—(A) *Marriage.* In the case of marriage, coverage must begin no later than the first day of the first calendar month beginning after the date the plan or issuer receives the request for special enrollment.

(B) *Birth, adoption, or placement for adoption.* Coverage must begin in the case of a dependent's birth on the date of birth and in the case of a dependent's adoption or placement for adoption no later than the date of such adoption or placement for adoption (or, if dependent coverage is not made generally available at the time of the birth, adoption, or placement for adoption, the date the plan makes dependent coverage available).

(4) *Examples.* The rules of this paragraph (b) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer maintains a group health plan that offers all employees employee-only coverage, employee-plus-spouse coverage, or family coverage. Under the terms of the plan, any employee may elect to enroll when first hired (with coverage beginning on the date of hire) or during an annual open enrollment period held each December (with coverage beginning the following January 1). Employee *A* is hired on September 3. *A* is married to *B*, and they have no children. On March 15 in the following year a child *C* is born to *A* and *B*. Before that date, *A* and *B* have not been enrolled in the plan.

(ii) *Conclusion.* In this *Example 1,* the conditions for special enrollment of an employee with a spouse and new dependent under paragraph (b)(2)(vi) of this section are satisfied. If *A* satisfies the conditions of paragraph (b)(3) of this section for requesting enrollment timely, the plan will satisfy this paragraph (b) if it allows *A* to enroll either with employee-only coverage, with employee-plus-spouse coverage (for *A* and *B*), or with family coverage (for *A, B,* and *C*). The plan must allow whatever coverage is chosen to begin on March 15, the date of *C*'s birth.

Example 2. (i) *Facts.* Individual *D* works for Employer X. *X* maintains a group health plan with two benefit packages—an HMO option and an indemnity option. Self-only and family coverage are available under both options. *D* enrolls for self-only coverage in the HMO option. Then, a child, E, is placed for adoption with *D*. Within 30 days of the placement of *E* for adoption, *D* requests enrollment for *D* and *E* under the plan's indemnity option.

(ii) *Conclusion.* In this *Example 2, D* and *E* satisfy the conditions for special enrollment under paragraphs (b)(2)(v) and (b)(3) of this section. Therefore, the plan must allow *D* and *E* to enroll in the indemnity coverage, effective as of the date of the placement for adoption.

(c) *Notice of special enrollment.* At or before the time an employee is initially offered the opportunity to enroll in a group health plan, the plan must furnish the employee with a notice of special enrollment that complies with the requirements of this paragraph (c).

(1) *Description of special enrollment rights.* The notice of special enrollment must include a description of special enrollment rights. The following model language may be used to satisfy this requirement:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within [insert ''30 days'' or any longer period that applies under the plan] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within [insert ''30 days'' or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact [insert the name, title, telephone number, and any additional contact information of the appropriate plan representative].

(2) *Additional information that may be required.* The notice of special enrollment must also include, if applicable, the notice described in paragraph (a)(3)(iv) of this section (the notice required to be furnished to an individual declining coverage if the plan requires the reason for declining coverage to be in writing).

(d) *Treatment of special enrollees*—(1) If an individual requests enrollment while the individual is entitled to special enrollment under either paragraph (a) or (b) of this section, the individual is a special enrollee, even if the request for enrollment coincides with a late enrollment opportunity under the plan. Therefore, the individual cannot be treated as a late enrollee.

(2) Special enrollees must be offered all the benefit packages available to similarly situated individuals who enroll when first eligible. For this purpose, any difference in benefits or cost-sharing requirements for different individuals constitutes a different benefit package. In addition, a special enrollee cannot be required to pay more for coverage than a similarly situated individual who enrolls in the same coverage when first eligible. The length of any preexisting condition exclusion that may be applied to a special enrollee cannot exceed the length of any preexisting condition exclusion that is applied to similarly situated individuals who enroll when first eligible. For rules prohibiting the application of a preexisting condition exclusion to certain newborns, adopted children, and children placed for adoption, see § 2590.701–3(b).

(3) The rules of this section are illustrated by the following example:

Example. (i) *Facts.* Employer *Y* maintains a group health plan that has an enrollment period for late enrollees every November 1 through November 30 with coverage effective the following January 1. On October 18, Individual *B* loses coverage under another group health plan and satisfies the requirements of paragraphs (a)(2), (3), and (4) of this section. *B* submits a completed application for coverage on November 2.

(ii) *Conclusion.* In this *Example, B* is a special enrollee. Therefore, even though *B*'s request for enrollment coincides with an open enrollment period, *B*'s coverage is required to be made effective no later than December 1 (rather than the plan's January 1 effective date for late enrollees).

§ 2590.701–7 HMO affiliation period as an alternative to a preexisting condition exclusion.

(a) *In general.* A group health plan offering health insurance coverage through an HMO, or an HMO that offers health insurance coverage in connection with a group health plan, may impose an affiliation period only if each of the following requirements is satisfied—

(1) No preexisting condition exclusion is imposed with respect to any coverage offered by the HMO in connection with the particular group health plan.

(2) No premium is charged to a participant or beneficiary for the affiliation period.

(3) The affiliation period for the HMO coverage is imposed consistent with the requirements of § 2590.702 (prohibiting discrimination based on a health factor).

(4) The affiliation period does not exceed 2 months (or 3 months in the case of a late enrollee).

(5) The affiliation period begins on the enrollment date, or in the case of a late enrollee, the affiliation period begins on the day that would be the first day of coverage but for the affiliation period.

(6) The affiliation period for enrollment in the HMO under a plan runs concurrently with any waiting period.

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

Example 1. (i) *Facts.* An employer sponsors a group health plan. Benefits under the plan are provided through an HMO, which imposes a two-month affiliation period. In order to be eligible under the plan, employees must have worked for the employer for six months. Individual *A* begins working for the employer on February 1.

(ii) *Conclusion.* In this *Example 1*, Individual *A*'s enrollment date is February 1 (see § 2590.701–3(a)(2)), and both the waiting period and the affiliation period begin on this date and run concurrently. Therefore, the affiliation period ends on March 31, the waiting period ends on July 31, and *A* is eligible to have coverage begin on August 1.

Example 2. (i) *Facts.* A group health plan has two benefit package options, a fee-for-service option and an HMO option. The HMO imposes a 1-month affiliation period. Individual *B* is enrolled in the fee-for-service option for more than one month and then decides to switch to the HMO option at open season.

(ii) *Conclusion.* In this *Example 2,* the HMO may not impose the affiliation period with respect to *B* because any affiliation period would have to begin on *B*'s enrollment date in the plan rather than the date that *B* enrolled in the HMO option. Therefore, the affiliation period would have expired before *B* switched to the HMO option.

Example 3. (i) *Facts.* An employer sponsors a group health plan that provides benefits through an HMO. The plan imposes a two-month affiliation period with respect to salaried employees, but it does not impose an affiliation period with respect to hourly employees.

(ii) *Conclusion.* In this *Example 3,* the plan may impose the affiliation period with respect to salaried employees without imposing any affiliation period with respect to hourly employees (unless, under the circumstances, treating salaried and hourly employees differently does not comply with the requirements of § 2590.702).

(c) *Alternatives to affiliation period.* An HMO may use alternative methods in lieu of an affiliation period to address adverse selection, as approved by the State insurance commissioner or other official designated to regulate HMOs. However, an arrangement that is in the nature of a preexisting condition exclusion cannot be an alternative to an affiliation period. Nothing in this part requires a State to receive proposals for or approve alternatives to affiliation periods.

■ 4. Section 2590.701–8 is added and reserved to read as follows:

§ 2590.701–8 Interaction with the Family and Medical Leave Act. [Reserved]

■ 5. Revise the heading of subpart D to read as follows:

Subpart D—General Provisions Related to Subparts B and C

■ 6. Sections 2590.731, 2590.732 and 2590.736 are revised to read as follows:

§ 2590.731 Preemption; State flexibility; construction.

(a) *Continued applicability of State law with respect to health insurance issuers.* Subject to paragraph (b) of this

section and except as provided in paragraph (c) of this section, part 7 of subtitle B of Title I of the Act is not to be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part.

(b) *Continued preemption with respect to group health plans.* Nothing in part 7 of subtitle B of Title I of the Act affects or modifies the provisions of section 514 of the Act with respect to group health plans.

(c) *Special rules*—(1) *In general.* Subject to paragraph (c)(2) of this section, the provisions of part 7 of subtitle B of Title I of the Act relating to health insurance coverage offered by a health insurance issuer supersede any provision of State law which establishes, implements, or continues in effect a standard or requirement applicable to imposition of a preexisting condition exclusion specifically governed by section 701 which differs from the standards or requirements specified in such section.

(2) *Exceptions.* Only in relation to health insurance coverage offered by a health insurance issuer, the provisions of this part do not supersede any provision of State law to the extent that such provision—

(i) Shortens the period of time from the ''6-month period'' described in section 701(a)(1) of the Act and § 2590.701–3(a)(1)(i) (for purposes of identifying a preexisting condition);

(ii) Shortens the period of time from the ''12 months'' and ''18 months'' described in section 701(a)(2) of the Act and § 2590.701–3(a)(1)(ii) (for purposes of applying a preexisting condition exclusion period);

(iii) Provides for a greater number of days than the ''63-day period'' described in sections 701(c)(2)(A) and (d)(4)(A) of the Act and §§ 2590.701–3(a)(1)(iii) and 2590.701–4 (for purposes of applying the break in coverage rules);

(iv) Provides for a greater number of days than the ''30-day period'' described in sections 701(b)(2) and (d)(1) of the Act and § 2590.701–3(b) (for purposes of the enrollment period and preexisting condition exclusion periods for certain newborns and children that are adopted or placed for adoption);

(v) Prohibits the imposition of any preexisting condition exclusion in cases not described in section 701(d) of the Act or expands the exceptions described therein;

(vi) Requires special enrollment periods in addition to those required under section 701(f) of the Act; or

(vii) Reduces the maximum period permitted in an affiliation period under section 701(g)(1)(B) of the Act.

(d) *Definitions*—(1) *State law.* For purposes of this section the term *State law* includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. *A* law of the United States applicable only to the District of Columbia is treated as a State law rather than a law of the United States.

(2) *State.* For purposes of this section the term *State* includes a State (as defined in § 2590.701–2), any political subdivisions of a State, or any agency or instrumentality of either.

§ 2590.732 Special rules relating to group health plans.

(a) *Group health plan*—(1) *Defined.* A group health plan means an employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees (including both current and former employees) or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(2) *Determination of number of plans.* [Reserved]

(b) *General exception for certain small group health plans.* The requirements of this part, other than § 2590.711, do not apply to any group health plan (and group health insurance coverage) for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees.

(c) *Excepted benefits*—(1) *In general.* The requirements of this Part do not apply to any group health plan (or any group health insurance coverage) in relation to its provision of the benefits described in paragraph (c)(2), (3), (4), or (5) of this section (or any combination of these benefits).

(2) *Benefits excepted in all circumstances.* The following benefits are excepted in all circumstances—

(i) Coverage only for accident (including accidental death and dismemberment);

(ii) Disability income coverage;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Coverage issued as a supplement to liability insurance;

(v) Workers' compensation or similar coverage;

(vi) Automobile medical payment insurance;

(vii) Credit-only insurance (for example, mortgage insurance); and

(viii) Coverage for on-site medical clinics.

(3) *Limited excepted benefits*—(i) *In general.* Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan as described in paragraph (c)(3)(ii) of this section. In addition, benefits provided under a health flexible spending arrangement are excepted benefits if they satisfy the requirements of paragraph (c)(3)(v) of this section.

(ii) *Not an integral part of a group health plan.* For purposes of this paragraph (c)(3), benefits are not an integral part of a group health plan (whether the benefits are provided through the same plan or a separate plan) only if the following two requirements are satisfied—

(A) Participants must have the right to elect not to receive coverage for the benefits; and

(B) If a participant elects to receive coverage for the benefits, the participant must pay an additional premium or contribution for that coverage.

(iii) *Limited scope*—(A) *Dental benefits.* Limited scope dental benefits are benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth).

(B) *Vision benefits.* Limited scope vision benefits are benefits substantially all of which are for treatment of the eye.

(iv) *Long-term care.* Long-term care benefits are benefits that are either—

(A) Subject to State long-term care insurance laws;

(B) For qualified long-term care services, as defined in section 7702B(c)(1) of the Internal Revenue Code, or provided under a qualified long-term care insurance contract, as defined in section 7702B(b) of the Internal Revenue Code; or

(C) Based on cognitive impairment or a loss of functional capacity that is expected to be chronic.

(v) *Health flexible spending arrangements.* Benefits provided under a health flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code) are excepted for a class of participants only if they satisfy the following two requirements—

(A) Other group health plan coverage, not limited to excepted benefits, is made available for the year to the class of participants by reason of their employment; and

(B) The arrangement is structured so that the maximum benefit payable to any participant in the class for a year

cannot exceed two times the participant's salary reduction election under the arrangement for the year (or, if greater, cannot exceed $500 plus the amount of the participant's salary reduction election). For this purpose, any amount that an employee can elect to receive as taxable income but elects to apply to the health flexible spending arrangement is considered a salary reduction election (regardless of whether the amount is characterized as salary or as a credit under the arrangement).

(4) *Noncoordinated benefits*—(i) *Excepted benefits that are not coordinated.* Coverage for only a specified disease or illness (for example, cancer-only policies) or hospital indemnity or other fixed indemnity insurance is excepted only if it meets each of the conditions specified in paragraph (c)(4)(ii) of this section. To be hospital indemnity or other fixed indemnity insurance, the insurance must pay a fixed dollar amount per day (or per other period) of hospitalization or illness (for example, $100/day) regardless of the amount of expenses incurred.

(ii) *Conditions.* Benefits are described in paragraph (c)(4)(i) of this section only if—

(A) The benefits are provided under a separate policy, certificate, or contract of insurance;

(B) There is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and

(C) The benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor.

(iii) *Example.* The rules of this paragraph (c)(4) are illustrated by the following example:

Example. (i) *Facts.* An employer sponsors a group health plan that provides coverage through an insurance policy. The policy provides benefits only for hospital stays at a fixed percentage of hospital expenses up to a maximum of $100 a day.

(ii) *Conclusion.* In this *Example,* even though the benefits under the policy satisfy the conditions in paragraph (c)(4)(ii) of this section, because the policy pays a percentage of expenses incurred rather than a fixed dollar amount, the benefits under the policy are not excepted benefits under this paragraph (c)(4). This is the result even if, in practice, the policy pays the maximum of $100 for every day of hospitalization.

(5) *Supplemental benefits.* (i) The following benefits are excepted only if they are provided under a separate policy, certificate, or contract of insurance—

(A) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act; also known as Medigap or MedSupp insurance);

(B) Coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code (also known as TRICARE supplemental programs); and

(C) Similar supplemental coverage provided to coverage under a group health plan. To be similar supplemental coverage, the coverage must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles. Similar supplemental coverage does not include coverage that becomes secondary or supplemental only under a coordination-of-benefits provision.

(ii) The rules of this paragraph (c)(5) are illustrated by the following example:

Example. (i) *Facts.* An employer sponsors a group health plan that provides coverage for both active employees and retirees. The coverage for retirees supplements benefits provided by Medicare, but does not meet the requirements for a supplemental policy under section 1882(g)(1) of the Social Security Act.

(ii) *Conclusion.* In this *Example,* the coverage provided to retirees does not meet the definition of supplemental excepted benefits under this paragraph (c)(5) because the coverage is not Medicare supplemental insurance as defined under section 1882(g)(1) of the Social Security Act, is not a TRICARE supplemental program, and is not supplemental to coverage provided under a group health plan.

(d) *Treatment of partnerships.* For purposes of this part:

(1) *Treatment as a group health plan.* Any plan, fund, or program that would not be (but for this paragraph (d)) an employee welfare benefit plan and that is established or maintained by a partnership, to the extent that the plan, fund, or program provides medical care (including items and services paid for as medical care) to present or former partners in the partnership or to their dependents (as defined under the terms of the plan, fund, or program), directly or through insurance, reimbursement, or otherwise, is treated (subject to paragraph (d)(2)) as an employee welfare benefit plan that is a group health plan.

(2) *Employment relationship.* In the case of a group health plan, the term *employer* also includes the partnership in relation to any bona fide partner. In addition, the term *employee* also includes any bona fide partner. Whether or not an individual is a bona fide partner is determined based on all the relevant facts and circumstances, including whether the individual performs services on behalf of the partnership.

(3) *Participants of group health plans.* In the case of a group health plan, the term participant also includes any individual described in paragraph (d)(3)(i) or (ii) of this section if the individual is, or may become, eligible to receive a benefit under the plan or the individual's beneficiaries may be eligible to receive any such benefit.

(i) In connection with a group health plan maintained by a partnership, the individual is a partner in relation to the partnership.

(ii) In connection with a group health plan maintained by a self-employed individual (under which one or more employees are participants), the individual is the self-employed individual.

(e) *Determining the average number of employees.* [Reserved]

§ 2590.736 Applicability dates.

Sections 2590.701–1 through 2590.701–8 and 2590.731 through 2590.736 are applicable for plan years beginning on or after July 1, 2005. Until the applicability date for this regulation, plans and issuers are required to continue to comply with the corresponding sections of 29 CFR part 2590, contained in the 29 CFR, parts 1927 to end, edition revised as of July 1, 2004.

Signed at Washington, DC, this 1st day of December, 2004.

Ann L. Combs,

Assistant Secretary, Employee Benefits Security Administration, U.S. Department of Labor.

Department of Health and Human Services

45 CFR Subtitle A

■ For the reasons set forth in the preamble, the Department of Health and Human Services amends 45 CFR Part 144 and Part 146 as follows:

PART 144—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

■ A. Part 144 is amended as set forth below:

■ 1. The authority citation for Part 144 is revised to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act, 42 U.S.C. 300gg through 300gg-63, 300gg-91, 30gg-92 as amended by HIPAA (Public Law 104–191, 110 Stat. 1936), MHPA (Public Law 104–204, 110 Stat. 2944, as amended by Public Law 107–116, 115 Stat. 2177), NMHPA (Public Law 104–204, 110 Stat. 2935), WHCRA (Public Law 105–277, 112 Stat. 2681–436), and section 103(c)(4) of HIPAA.

■ 2. Section 144.103 is revised to read as follows:

§ 144.103 Definitions.

For purposes of parts 146 (group market), 148 (individual market), and 150 (enforcement) of this subchapter, the following definitions apply unless otherwise provided:

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.

Applicable State authority means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of 45 CFR parts 146 and 148 for the State involved with respect to the issuer.

Beneficiary has the meaning given the term under section 3(8) of the Employee Retirement Income Security Act of 1974 (ERISA), which States, ''a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit'' under the plan.

Bona fide association means, with respect to health insurance coverage offered in a State, an association that meets the following conditions:

(1) Has been actively in existence for at least 5 years.

(2) Has been formed and maintained in good faith for purposes other than obtaining insurance.

(3) Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of any employee).

(4) Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members (or individuals eligible for coverage through a member).

(5) Does not make health insurance coverage offered through the association available other than in connection with a member of the association.

(6) Meets any additional requirements that may be imposed under State law.

Church plan means a Church plan within the meaning of section 3(33) of ERISA.

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 Employee Retirement Income Security Act, section 4980B of the Internal Revenue Code of 1986 (other than paragraph (f)(1) of such section 4980B insofar as it relates to pediatric vaccines), or Title XXII of the PHS Act.

(4) *Continuation coverage* means coverage under a COBRA continuation provision or a similar State program. Coverage provided by a plan that is subject to a COBRA continuation provision or similar State program, but that does not satisfy all the requirements of that provision or program, will be deemed to be continuation coverage if it allows an individual to elect to continue coverage for a period of at least 18 months. Continuation coverage does not include coverage under a conversion policy required to be offered to an individual upon exhaustion of continuation coverage, nor does it include continuation coverage under the Federal Employees Health Benefits Program.

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

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

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

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

(6) *Exhaustion of continuation coverage* means that an individual's 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 continuation coverage if—

(i) Coverage ceases 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 a service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other continuation coverage available to the individual; or

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

Condition means a *medical condition.*

Creditable coverage has the meaning given the term in 45 CFR 146.113(a).

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

Eligible individual, for purposes of—

(1) The group market provisions in 45 CFR part 146, subpart E, is defined in 45 CFR 146.150(b); and

(2) The individual market provisions in 45 CFR part 148, is defined in 45 CFR 148.103.

Employee has the meaning given the term under section 3(6) of ERISA, which States, ''any individual employed by an employer.''

Employer has the meaning given the term under section 3(5) of ERISA, which States, ''any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.''

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

Enrollment date definitions (*enrollment date, first day of coverage,* and *waiting period*) are set forth in 45 CFR 146.111(a)(3)(i) through (iii).

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

Excepted benefits, consistent for purposes of the—

(1) Group market provisions in 45 CFR part 146 subpart D, is defined in 45 CFR 146.145(c); and

(2) Individual market provisions in 45 CFR part 148, is defined in 45 CFR 148.220.

Federal governmental plan means a governmental plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of such Government.

Genetic information means information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

Governmental plan means a governmental plan within the meaning of section 3(32) of ERISA.

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

Group health plan or *plan* means a group health plan within the meaning of 45 CFR 146.145(a).

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

Health insurance coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance.

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

Health maintenance organization or *HMO* means—

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

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

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

Health status-related factor is any factor identified as a health factor in 45 CFR 146.121(a).

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

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

Internal Revenue Code means the Internal Revenue Code of 1986, as amended (Title 26, United States Code).

Issuer means a *health insurance issuer.*

Large employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year, unless otherwise provided under State law.

Large group market means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer, unless otherwise provided under State law.

Late enrollment definitions (*late enrollee* and *late enrollment*) are set forth in 45 CFR 146.111(a)(3)(v) and (vi).

Medical care means amounts paid for—

(1) The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(2) Transportation primarily for and essential to medical care referred to in paragraph (1) of this definition; and

(3) Insurance covering medical care referred to in paragraphs (1) and (2) of this definition.

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

Network plan means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the issuer.

Non-Federal governmental plan means a governmental plan that is not a Federal governmental plan.

Participant has the meaning given the term under section 3(7) of ERISA, which States, ''any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.''

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

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

Plan sponsor has the meaning given the term under section 3(16)(B) of ERISA, which states, ''(i) the employer in the case of an employee benefit plan established or maintained by a single employer, (ii) the employee organization in the case of a plan established or maintained by an employee organization, or (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.''

Plan year means the year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is—

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

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

(3) If the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the

insurance policy is not renewed on an annual basis, then the plan year is the employer's taxable year; or

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

Preexisting condition exclusion has the meaning given the term in 45 CFR 146.111(a)(1), with respect to group health plans and group health insurance coverage. With respect to individual market health insurance issuers or other entities providing coverage to federally eligible individuals pursuant to 45 CFR part 148, preexisting condition exclusion means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the first day of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information that is obtained relating to an individual's health status before the individual's first day of coverage, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

Public health plan has the meaning given the term in 45 CFR 146.113(a)(1)(ix).

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

Significant break in coverage has the meaning given the term in 45 CFR 146.113(b)(2)(iii).

Small employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year, unless otherwise provided under State law.

Small group market means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer.

Special enrollment means enrollment in a group health plan or group health insurance coverage under the rights described in 45 CFR 146.117.

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

State health benefits risk pool has the meaning given the term in 45 CFR § 146.113(a)(1)(vii).

Waiting period has the meaning given the term in 45 CFR 146.111(a)(3)(iii).

PART 146—REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET

■ B. Part 146 is amended as set forth below:

■ 1. The authority citation for Part 146 is revised to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act, 42 U.S.C. 300gg through 300gg–63, 300gg–91, 30gg–92 as amended by HIPAA (Public Law 104–191, 110 Stat. 1936), MHPA (Public Law 104–204, 110 Stat. 2944, as amended by Public Law 107–116, 115 Stat. 2177), NMHPA (Public Law 104–204, 110 Stat. 2935), WHCRA (Public Law 105–277, 112 Stat. 2681–436), and section 103(c)(4) of HIPAA.

■ 2. Revise § 146.111 to read as follows:

§ 146.111 Limitations on preexisting condition exclusion period.

(a) *Preexisting condition exclusion*—(1) *Defined.*—(i) A *preexisting condition exclusion* means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage under a group health plan or group health insurance coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage under a group health plan or group health insurance coverage, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

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

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

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

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

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

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

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

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

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

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

(ii) *Conclusion.* In this *Example 5*, the requirement to be covered under the plan for 12 months to be eligible for pregnancy benefits is a subterfuge for a preexisting condition exclusion because it is designed to

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

Example 6. (i) *Facts.* A group health plan provides coverage for medically necessary items and services, generally including treatment of heart conditions. However, the plan does not cover those same items and services when used for treatment of congenital heart conditions.

(ii) *Conclusion.* In this *Example 6*, the exclusion of coverage for treatment of congenital heart conditions is a preexisting condition exclusion because it operates to exclude benefits relating to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 7. (i) *Facts.* A group health plan generally provides coverage for medically necessary items and services. However, the plan excludes coverage for the treatment of cleft palate.

(ii) *Conclusion.* In this *Example 7*, the exclusion of coverage for treatment of cleft palate is not a preexisting condition exclusion because the exclusion applies regardless of when the condition arose relative to the effective date of coverage. The plan provision, therefore, is not subject to the limitations on preexisting condition exclusions in this section.

Example 8. (i) *Facts.* A group health plan provides coverage for treatment of cleft palate, but only if the individual being treated has been continuously covered under the plan from the date of birth.

(ii) *Conclusion.* In this *Example 8*, the exclusion of coverage for treatment of cleft palate for individuals who have not been covered under the plan from the date of birth operates to exclude benefits in relation to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

(2) *General rules.* Subject to paragraph (b) of this section (prohibiting the imposition of a preexisting condition exclusion with respect to certain individuals and conditions), a group health plan, and a health insurance issuer offering group health insurance coverage, may impose, with respect to a participant or beneficiary, a preexisting condition exclusion only if the requirements of this paragraph (a)(2) are satisfied.

(i) *6-month look-back rule.* A preexisting condition exclusion must relate to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period (or such shorter period as applies under the plan) ending on the enrollment date.

(A) For purposes of this paragraph (a)(2)(i), medical advice, diagnosis, care, or treatment is taken into account only if it is recommended by, or received from, an individual licensed or similarly authorized to provide such services under State law and operating within the scope of practice authorized by State law.

(B) For purposes of this paragraph (a)(2)(i), the 6-month period ending on the enrollment date begins on the 6-month anniversary date preceding the enrollment date. For example, for an enrollment date of August 1, 1998, the 6-month period preceding the enrollment date is the period commencing on February 1, 1998 and continuing through July 31, 1998. As another example, for an enrollment date of August 30, 1998, the 6-month period preceding the enrollment date is the period commencing on February 28, 1998 and continuing through August 29, 1998.

(C) The rules of this paragraph (a)(2)(i) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *A* is diagnosed with a medical condition 8 months before *A*'s enrollment date in Employer *R*'s group health plan. *A*'s doctor recommends that *A* take a prescription drug for 3 months, and *A* follows the recommendation.

(ii) *Conclusion.* In this *Example 1,* Employer *R*'s plan may impose a preexisting condition exclusion with respect to *A*'s condition because A received treatment during the 6-month period ending on *A*'s enrollment date in Employer *R*'s plan by taking the prescription medication during that period. However, if *A* did not take the prescription drug during the 6-month period, Employer *R*'s plan would not be able to impose a preexisting condition exclusion with respect to that condition.

Example 2. (i) *Facts.* Individual *B* is treated for a medical condition 7 months before the enrollment date in Employer *S*'s group health plan. As part of such treatment, *B*'s physician recommends that a follow-up examination be given 2 months later. Despite this recommendation, *B* does not receive a follow-up examination, and no other medical advice, diagnosis, care, or treatment for that condition is recommended to *B* or received by *B* during the 6-month period ending on *B*'s enrollment date in Employer *S*'s plan.

(ii) *Conclusion.* In this *Example 2,* Employer *S*'s plan may not impose a preexisting condition exclusion with respect to the condition for which *B* received treatment 7 months prior to the enrollment date.

Example 3. (i) *Facts.* Same facts as *Example 2,* except that Employer *S*'s plan learns of the condition and attaches a rider to *B*'s certificate of coverage excluding coverage for the condition. Three months after enrollment, *B*'s condition recurs, and Employer *S*'s plan denies payment under the rider.

(ii) *Conclusion.* In this *Example 3,* the rider is a preexisting condition exclusion and Employer *S*'s plan may not impose a preexisting condition exclusion with respect to the condition for which *B* received treatment 7 months prior to the enrollment date. (In addition, such a rider would violate the provisions of § 146.121, even if *B* had received treatment for the condition within the 6-month period ending on the enrollment date.)

Example 4. (i) *Facts.* Individual *C* has asthma and is treated for that condition several times during the 6-month period before *C*'s enrollment date in Employer *T*'s plan. Three months after the enrollment date, *C* begins coverage under Employer *T*'s plan. Two months later, *C* is hospitalized for asthma.

(ii) *Conclusion.* In this *Example 4,* Employer *T*'s plan may impose a preexisting condition exclusion with respect to *C*'s asthma because care relating to *C*'s asthma was received during the 6-month period ending on *C*'s enrollment date (which, under the rules of paragraph (a)(3)(i) of this section, is the first day of the waiting period).

Example 5. (i) *Facts.* Individual *D,* who is subject to a preexisting condition exclusion imposed by Employer *U*'s plan, has diabetes, as well as retinal degeneration, a foot condition, and poor circulation (all of which are conditions that may be directly attributed to diabetes). *D* receives treatment for these conditions during the 6-month period ending on *D*'s enrollment date in Employer *U*'s plan. After enrolling in the plan, *D* stumbles and breaks a leg.

(ii) *Conclusion.* In this *Example 5,* the leg fracture is not a condition related to D's diabetes, retinal degeneration, foot condition, or poor circulation, even though they may have contributed to the accident. Therefore, benefits to treat the leg fracture cannot be subject to a preexisting condition exclusion. However, any additional medical services that may be needed because of *D*'s preexisting diabetes, poor circulation, or retinal degeneration that would not be needed by another patient with a broken leg who does not have these conditions may be subject to the preexisting condition exclusion imposed under Employer *U*'s plan.

(ii) *Maximum length of preexisting condition exclusion.* A preexisting condition exclusion is not permitted to extend for more than 12 months (18 months in the case of a late enrollee) after the enrollment date. For example, for an enrollment date of August 1, 1998, the 12-month period after the enrollment date is the period commencing on August 1, 1998 and continuing through July 31, 1999; the

18-month period after the enrollment date is the period commencing on August 1, 1998 and continuing through January 31, 2000.

(iii) *Reducing a preexisting condition exclusion period by creditable coverage*—(A) The period of any preexisting condition exclusion that would otherwise apply to an individual under a group health plan is reduced by the number of days of creditable coverage the individual has as of the enrollment date, as counted under § 146.113. Creditable coverage may be evidenced through a certificate of creditable coverage (required under § 146.115(a)), or through other means in accordance with the rules of § 146.115(c).

(B) The rules of this paragraph (a)(2)(iii) are illustrated by the following example:

Example. (i) *Facts.* Individual *D* works for Employer *X* and has been covered continuously under *X*'s group health plan. *D*'s spouse works for Employer *Y. Y* maintains a group health plan that imposes a 12-month preexisting condition exclusion (reduced by creditable coverage) on all new enrollees. *D* enrolls in *Y*'s plan, but also stays covered under *X*'s plan. *D* presents *Y*'s plan with evidence of creditable coverage under *X*'s plan.

(ii) *Conclusion.* In this *Example, Y*'s plan must reduce the preexisting condition exclusion period that applies to *D* by the number of days of coverage that *D* had under *X*'s plan as of *D*'s enrollment date in *Y*'s plan (even though *D*'s coverage under *X*'s plan was continuing as of that date).

(iv) *Other standards.* See § 146.121 for other standards in this Subpart A that may apply with respect to certain benefit limitations or restrictions under a group health plan. Other laws may also apply, such as the Uniformed Services Employment and Reemployment Rights Act (USERRA), which can affect the application of a preexisting condition exclusion to certain individuals who are reinstated in a group health plan following active military service.

(3) *Enrollment definitions*—(i) *Enrollment date* means the first day of coverage (as described in paragraph (a)(3)(ii) of this section) or, if there is a waiting period, the first day of the waiting period. If an individual receiving benefits under a group health plan changes benefit packages, or if the plan changes group health insurance issuers, the individual's enrollment date does not change.

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

(iii) *Waiting period* means the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective. If an employee or dependent enrolls as a late enrollee or special enrollee, any period before such late or special enrollment is not a waiting period. If an individual seeks coverage in the individual market, a waiting period begins on the date the individual submits a substantially complete application for coverage and ends on—

(A) If the application results in coverage, the date coverage begins;

(B) If the application does not result in coverage, the date on which the application is denied by the issuer or the date on which the offer of coverage lapses.

(iv) The rules of paragraphs (a)(3)(i), (ii), and (iii) of this section are illustrated by the following examples:

Example 1. (i) *Facts.* Employer *V*'s group health plan provides for coverage to begin on the first day of the first payroll period following the date an employee is hired and completes the applicable enrollment forms, or on any subsequent January 1 after completion of the applicable enrollment forms. Employer *V*'s plan imposes a preexisting condition exclusion for 12 months (reduced by the individual's creditable coverage) following an individual's enrollment date. Employee *E* is hired by Employer *V* on October 13, 1998 and on October 14, 1998 *E* completes and files all the forms necessary to enroll in the plan. *E*'s coverage under the plan becomes effective on October 25, 1998 (which is the beginning of the first payroll period after *E*'s date of hire).

(ii) *Conclusion.* In this *Example 1, E*'s enrollment date is October 13, 1998 (which is the first day of the waiting period for *E*'s enrollment and is also *E*'s date of hire). Accordingly, with respect to *E,* the permissible 6-month period in paragraph (a)(2)(i) is the period from April 13, 1998 through October 12, 1998, the maximum permissible period during which Employer *V*'s plan can apply a preexisting condition exclusion under paragraph (a)(2)(ii) is the period from October 13, 1998 through October 12, 1999, and this period must be reduced under paragraph (a)(2)(iii) by *E*'s days of creditable coverage as of October 13, 1998.

Example 2. (i) *Facts.* A group health plan has two benefit package options, Option 1 and Option 2. Under each option a 12-month preexisting condition exclusion is imposed. Individual *B* is enrolled in Option 1 on the first day of employment with the employer maintaining the plan, remains enrolled in Option 1 for more than one year, and then decides to switch to Option 2 at open season.

(ii) *Conclusion.* In this *Example 2, B* cannot be subject to any preexisting condition exclusion under Option 2 because any preexisting condition exclusion period would have to begin on *B*'s enrollment date, which is *B*'s first day of coverage, rather than the date that *B* enrolled in Option 2. Therefore, the preexisting condition exclusion period expired before B switched to Option 2.

Example 3. (i) *Facts.* On May 13, 1997, Individual *E* is hired by an employer and enrolls in the employer's group health plan. The plan provides benefits solely through an insurance policy offered by Issuer *S.* On December 27, 1998, *E*'s leg is injured in an accident and the leg is amputated. On January 1, 1999, the plan switches coverage to a policy offered by Issuer *T.* Issuer *T*'s policy excludes benefits for any prosthesis if the body part was lost before the effective date of coverage under the policy.

(ii) *Conclusion.* In this *Example 3, E*'s enrollment date is May 13, 1997, *E*'s first day of coverage. Therefore, the permissible 6-month look-back period for the preexisting condition exclusion imposed under Issuer *T*'s policy begins on November 13, 1996 and ends on May 12, 1997. In addition, the 12-month maximum permissible preexisting condition exclusion period begins on May 13, 1997 and ends on May 12, 1998. Accordingly, because no medical advice, diagnosis, care, or treatment was recommended to or received by *E* for the leg during the 6-month look-back period (even though medical care was provided within the 6-month period preceding the effective date of *E*'s coverage under Issuer *T*'s policy), Issuer *T* may not impose any preexisting condition exclusion with respect to *E.* Moreover, even if *E* had received treatment during the 6-month look-back period, Issuer *T* still would not be permitted to impose a preexisting condition exclusion because the 12-month maximum permissible preexisting condition exclusion period expired on May 12, 1998 (before the effective date of *E*'s coverage under Issuer *T*'s policy).

Example 4. (i) *Facts.* A group health plan limits eligibility for coverage to full-time employees of Employer *Y.* Coverage becomes effective on the first day of the month following the date the employee becomes eligible. Employee *C* begins working full-time for Employer *Y* on April 11. Prior to this date, *C* worked part-time for *Y. C* enrolls in the plan and coverage is effective May 1.

(ii) *Conclusion.* In this *Example 4, C*'s enrollment date is April 11 and the period from April 11 through April 30 is a waiting period. The period while *C* was working part-time, and therefore not in an eligible class of employees, is not part of the waiting period.

Example 5. (i) *Facts.* To be eligible for coverage under a multiemployer group health plan in the current calendar quarter, the plan requires an individual to have worked 250 hours in covered employment during the previous quarter. If the hours requirement is satisfied, coverage becomes effective on the first day of the current calendar quarter. Employee *D* begins work on January 28 and does not work 250 hours in covered employment during the first quarter (ending March 31). *D* works at least 250 hours in the second quarter (ending June 30) and is enrolled in the plan with coverage effective July 1 (the first day of the third quarter).

(ii) *Conclusion.* In this *Example 5*, *D*'s enrollment date is the first day of the quarter during which *D* satisfies the hours requirement, which is April 1. The period from April 1 through June 30 is a waiting period.

(v) *Late enrollee* means an individual whose enrollment in a plan is a late enrollment.

(vi) (A) *Late enrollment* means enrollment of an individual under a group health plan other than—

(*1*) On the earliest date on which coverage can become effective for the individual under the terms of the plan; or

(*2*) Through special enrollment. (For rules relating to special enrollment, see § 146.117.)

(B) If an individual ceases to be eligible for coverage under the plan, and then subsequently becomes eligible for coverage under the plan, only the individual's most recent period of eligibility is taken into account in determining whether the individual is a late enrollee under the plan with respect to the most recent period of coverage. Similar rules apply if an individual again becomes eligible for coverage following a suspension of coverage that applied generally under the plan.

(vii) *Examples.* The rules of paragraphs (a)(3)(v) and (vi) of this section are illustrated by the following examples:

Example 1. (i) *Facts.* Employee *F* first becomes eligible to be covered by Employer *W*'s group health plan on January 1, 1999 but elects not to enroll in the plan until a later annual open enrollment period, with coverage effective January 1, 2001. *F* has no special enrollment right at that time.

(ii) *Conclusion.* In this *Example 1*, *F* is a late enrollee with respect to *F*'s coverage that became effective under the plan on January 1, 2001.

Example 2. (i) *Facts.* Same facts as *Example 1*, except that *F* terminates employment with Employer *W* on July 1, 1999 without having had any health insurance coverage under the plan. *F* is rehired by Employer *W* on January 1, 2000 and is eligible for and elects coverage under Employer *W*'s plan effective on January 1, 2000.

(ii) *Conclusion.* In this *Example 2*, *F* would not be a late enrollee with respect to *F*'s coverage that became effective on January 1, 2000.

(b) *Exceptions pertaining to preexisting condition exclusions*—(1) *Newborns*—(i) *In general.* Subject to paragraph (b)(3) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion on a child who, within 30 days after birth, is covered under any creditable coverage. Accordingly, if a child is enrolled in a group health plan (or other creditable coverage) within 30 days after birth and subsequently enrolls in another group health plan without a significant break in coverage (as described in § 146.113(b)(2)(iii)), the other plan may not impose any preexisting condition exclusion on the child.

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

Example 1. (i) *Facts.* Individual *E,* who has no prior creditable coverage, begins working for Employer *W* and has accumulated 210 days of creditable coverage under Employer *W*'s group health plan on the date *E* gives birth to a child. Within 30 days after the birth, the child is enrolled in the plan. Ninety days after the birth, both *E* and the child terminate coverage under the plan. Both *E* and the child then experience a break in coverage of 45 days before *E* is hired by Employer *X* and the two are enrolled in Employer *X*'s group health plan.

(ii) *Conclusion.* In this *Example 1,* because *E*'s child is enrolled in Employer *W*'s plan within 30 days after birth, no preexisting condition exclusion may be imposed with respect to the child under Employer *W*'s plan. Likewise, Employer *X*'s plan may not impose any preexisting condition exclusion on *E*'s child because the child was covered under creditable coverage within 30 days after birth and had no significant break in coverage before enrolling in Employer *X*'s plan. On the other hand, because *E* had only 300 days of creditable coverage prior to *E*'s enrollment date in Employer *X*'s plan, Employer *X*'s plan may impose a preexisting condition exclusion on *E* for up to 65 days (66 days if the 12-month period after *E*'s enrollment date in *X*'s plan includes February 29).

Example 2. (i) *Facts.* Individual *F* is enrolled in a group health plan in which coverage is provided through a health insurance issuer. *F* gives birth. Under State law applicable to the health insurance issuer, health care expenses incurred for the child during the 30 days following birth are covered as part of *F*'s coverage. Although *F* may obtain coverage for the child beyond 30 days by timely requesting special enrollment and paying an additional premium, the issuer is prohibited under State law from recouping the cost of any expenses incurred for the child within the 30-day period if the child is not later enrolled.

(ii) *Conclusion.* In this *Example 2,* the child is covered under creditable coverage within 30 days after birth, regardless of whether the child enrolls as a special enrollee under the plan. Therefore, no preexisting condition exclusion may be imposed on the child unless the child has a significant break in coverage.

(2) *Adopted children.* Subject to paragraph (b)(3) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion on a child who is adopted or placed for adoption before attaining 18 years of age and who, within 30 days after the adoption or placement for adoption, is covered under any creditable coverage. Accordingly, if a child is enrolled in a group health plan (or other creditable coverage) within 30 days after adoption or placement for adoption and subsequently enrolls in another group health plan without a significant break in coverage (as described in § 146.113(b)(2)(iii)), the other plan may not impose any preexisting condition exclusion on the child. This rule does not apply to coverage before the date of such adoption or placement for adoption.

(3) *Significant break in coverage.* Paragraphs (b)(1) and (2) of this section no longer apply to a child after a significant break in coverage. (*See* § 146.113(b)(2)(iii) for rules relating to the determination of a significant break in coverage.)

(4) *Special enrollment.* For special enrollment rules relating to new dependents, see § 146.117(b).

(5) *Pregnancy.* A group health plan, and a health insurance issuer offering group health insurance coverage, may not impose a preexisting condition exclusion relating to pregnancy.

(6) *Genetic information*—(i) A group health plan, and a health insurance issuer offering group health insurance coverage, may not impose a preexisting condition exclusion relating to a condition based solely on genetic information. However, if an individual is diagnosed with a condition, even if the condition relates to genetic information, the plan may impose a preexisting condition exclusion with respect to the condition, subject to the other limitations of this section.

(ii) The rules of this paragraph (b)(6) are illustrated by the following example:

Example. (i) *Facts.* Individual *A* enrolls in a group health plan that imposes a 12-month maximum preexisting condition exclusion. Three months before *A*'s enrollment, *A*'s doctor told *A* that, based on genetic information, *A* has a predisposition towards breast cancer. *A* was not diagnosed with breast cancer at any time prior to *A*'s enrollment date in the plan. Nine months after *A*'s enrollment date in the plan, *A* is diagnosed with breast cancer.

(ii) *Conclusion.* In this *Example,* the plan may not impose a preexisting condition exclusion with respect to *A*'s breast cancer because, prior to *A*'s enrollment date, *A* was not diagnosed with breast cancer.

(c) *General notice of preexisting condition exclusion.* A group health plan imposing a preexisting condition exclusion, and a health insurance issuer offering group health insurance

coverage subject to a preexisting condition exclusion, must provide a written general notice of preexisting condition exclusion to participants under the plan and cannot impose a preexisting condition exclusion with respect to a participant or a dependent of the participant until such a notice is provided.

(1) *Manner and timing.* A plan or issuer must provide the general notice of preexisting condition exclusion as part of any written application materials distributed by the plan or issuer for enrollment. If the plan or issuer does not distribute such materials, the notice must be provided by the earliest date following a request for enrollment that the plan or issuer, acting in a reasonable and prompt fashion, can provide the notice.

(2) *Content.* The general notice of preexisting condition exclusion must notify participants of the following:

(i) The existence and terms of any preexisting condition exclusion under the plan. This description includes the length of the plan's look-back period (which is not to exceed 6 months under paragraph (a)(2)(i) of this section); the maximum preexisting condition exclusion period under the plan (which cannot exceed 12 months (or 18-months for late enrollees) under paragraph (a)(2)(ii) of this section); and how the plan will reduce the maximum preexisting condition exclusion period by creditable coverage (described in paragraph (a)(2)(iii) of this section).

(ii) A description of the rights of individuals to demonstrate creditable coverage, and any applicable waiting periods, through a certificate of creditable coverage (as required by § 146.115(a)) or through other means (as described in § 146.115(c)). This must include a description of the right of the individual to request a certificate from a prior plan or issuer, if necessary, and a statement that the current plan or issuer will assist in obtaining a certificate from any prior plan or issuer, if necessary.

(iii) A person to contact (including an address or telephone number) for obtaining additional information or assistance regarding the preexisting condition exclusion.

(3) *Duplicate notices not required.* If a notice satisfying the requirements of this paragraph (c) is provided to an individual, the obligation to provide a general notice of preexisting condition exclusion with respect to that individual is satisfied for both the plan and the issuer.

(4) *Example with sample language.* The rules of this paragraph (c) are illustrated by the following example, which includes sample language that plans and issuers can use as a basis for preparing their own notices to satisfy the requirements of this paragraph (c):

Example. (i) *Facts.* A group health plan makes coverage effective on the first day of the first calendar month after hire and on each January 1 following an open season. The plan imposes a 12-month maximum preexisting condition exclusion (18 months for late enrollees) and uses a 6-month look-back period. As part of the enrollment application materials, the plan provides the following statement:

This plan imposes a preexisting condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior ''creditable coverage.'' Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the preexisting condition exclusion and creditable coverage should be directed to Individual *B* at Address *M* or Telephone Number *N*.

(ii) *Conclusion.* In this *Example,* the plan satisfies the general notice requirement of this paragraph (c), and thus also satisfies this requirement for any issuer providing the coverage.

(d) *Determination of creditable coverage*—(1) *Determination within reasonable time.* If a group health plan or health insurance issuer offering group health insurance coverage receives creditable coverage information under § 146.115, the plan or issuer is required, within a reasonable time following receipt of the information, to make a determination regarding the amount of the individual's creditable coverage and the length of any exclusion that remains. Whether this determination is made within a reasonable time depends on the relevant facts and circumstances. Relevant facts and circumstances include whether a plan's application of a preexisting condition exclusion would prevent an individual from having access to urgent medical care.

(2) *No time limit on presenting evidence of creditable coverage.* A plan or issuer may not impose any limit on the amount of time that an individual has to present a certificate or other evidence of creditable coverage.

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

Example. (i) *Facts.* A group health plan imposes a preexisting condition exclusion period of 12 months. After receiving the general notice of preexisting condition exclusion, Individual *H* develops an urgent health condition before receiving a certificate of creditable coverage from *H*'s prior group health plan. *H* attests to the period of prior coverage, presents corroborating documentation of the coverage period, and authorizes the plan to request a certificate on *H*'s behalf in accordance with the rules of § 146.115.

(ii) *Conclusion.* In this *Example,* the plan must review the evidence presented by *H* and make a determination of creditable coverage within a reasonable time that is consistent with the urgency of *H*'s health condition. (This determination may be modified as permitted under paragraph (f) of this section.)

(e) *Individual notice of period of preexisting condition exclusion.* After an individual has presented evidence of creditable coverage and after the plan or issuer has made a determination of creditable coverage under paragraph (d) of this section, the plan or issuer must provide the individual a written notice of the length of preexisting condition exclusion that remains after offsetting for prior creditable coverage. This individual notice is not required to identify any medical conditions specific to the individual that could be subject to the exclusion. A plan or issuer is not required to provide this notice if the plan or issuer does not impose any preexisting condition exclusion on the individual or if the plan's preexisting condition exclusion is completely offset by the individual's prior creditable coverage.

(1) *Manner and timing.* The individual notice must be provided by the earliest date following a determination that the plan or issuer, acting in a reasonable and prompt fashion, can provide the notice.

(2) *Content.* A plan or issuer must disclose—

(i) Its determination of any preexisting condition exclusion period that applies to the individual (including the last day on which the preexisting condition exclusion applies);

(ii) The basis for such determination, including the source and substance of any information on which the plan or issuer relied;

(iii) An explanation of the individual's right to submit additional evidence of creditable coverage; and

(iv) A description of any applicable appeal procedures established by the plan or issuer.

(3) *Duplicate notices not required.* If a notice satisfying the requirements of this paragraph (e) is provided to an individual, the obligation to provide this individual notice of preexisting condition exclusion with respect to that individual is satisfied for both the plan and the issuer.

(4) *Examples.* The rules of this paragraph (e) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan imposes a preexisting condition exclusion period of 12 months. After receiving the general notice of preexisting condition exclusion, Individual *G* presents a certificate of creditable coverage indicating 240 days of creditable coverage. Within seven days of receipt of the certificate, the plan determines that *G* is subject to a preexisting condition exclusion of 125 days, the last day of which is March 5. Five days later, the plan notifies *G* that, based on the certificate *G* submitted, *G* is subject to a preexisting condition exclusion period of 125 days, ending on March 5. The notice also explains the opportunity to submit additional evidence of creditable coverage and the plan's appeal procedures. The notice does not identify any of *G*'s medical conditions that could be subject to the exclusion.

(ii) *Conclusion.* In this *Example 1,* the plan satisfies the requirements of this paragraph (e).

Example 2. (i) *Facts.* Same facts as in *Example 1*, except that the plan determines that *G* has 430 days of creditable coverage based on *G*'s certificate indicating 430 days of creditable coverage under *G*'s prior plan.

(ii) *Conclusion.* In this *Example 2,* the plan is not required to notify *G* that *G* will not be subject to a preexisting condition exclusion.

(f) *Reconsideration.* Nothing in this section prevents a plan or issuer from modifying an initial determination of creditable coverage if it determines that the individual did not have the claimed creditable coverage, provided that —

(1) A notice of the new determination (consistent with the requirements of paragraph (e) of this section) is provided to the individual; and

(2) Until the notice of the new determination is provided, the plan or issuer, for purposes of approving access to medical services (such as a pre-surgery authorization), acts in a manner consistent with the initial determination.

■ 3. Revise § 146.113 to read as follows:

§ 146.113 Rules relating to creditable coverage.

(a) *General rules*—(1) *Creditable coverage.* For purposes of this section, except as provided in paragraph (a)(2) of this section, the term *creditable coverage* means coverage of an individual under any of the following:

(i) A group health plan as defined in § 146.145(a).

(ii) Health insurance coverage as defined in § 144.103 of this chapter (whether or not the entity offering the coverage is subject to the requirements of this part and 45 CFR part 148 and without regard to whether the coverage is offered in the group market, the individual market, or otherwise).

(iii) Part A or B of Title XVIII of the Social Security Act (Medicare).

(iv) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).

(v) Title 10 U.S.C. Chapter 55 (medical and dental care for members and certain former members of the uniformed services, and for their dependents; for purposes of Title 10 U.S.C. Chapter 55, *uniformed services* means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service).

(vi) A medical care program of the Indian Health Service or of a tribal organization.

(vii) A State health benefits risk pool. For purposes of this section, a *State health benefits risk pool* means—

(A) An organization qualifying under section 501(c)(26) of the Internal Revenue Code;

(B) A qualified high risk pool described in section 2744(c)(2) of the PHS Act; or

(C) Any other arrangement sponsored by a State, the membership composition of which is specified by the State and which is established and maintained primarily to provide health coverage for individuals who are residents of such State and who, by reason of the existence or history of a medical condition—

(*1*) Are unable to acquire medical care coverage for such condition through insurance or from an HMO, or

(*2*) Are able to acquire such coverage only at a rate which is substantially in excess of the rate for such coverage through the membership organization.

(viii) A health plan offered under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program).

(ix) A public health plan. For purposes of this section, a *public health plan* means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

(x) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(xi) Title XXI of the Social Security Act (State Children's Health Insurance Program).

(2) *Excluded coverage.* Creditable coverage does not include coverage of solely excepted benefits (described in § 146.145).

(3) *Methods of counting creditable coverage.* For purposes of reducing any preexisting condition exclusion period, as provided under § 146.111(a)(2)(iii), the amount of an individual's creditable coverage generally is determined by using the standard method described in paragraph (b) of this section. A plan or issuer may use the alternative method under paragraph (c) of this section with respect to any or all of the categories of benefits described under paragraph (c)(3) of this section.

(b) *Standard method*—(1) *Specific benefits not considered.* Under the standard method, the amount of creditable coverage is determined without regard to the specific benefits included in the coverage.

(2) *Counting creditable coverage*—(i) *Based on days.* For purposes of reducing the preexisting condition exclusion period that applies to an individual, the amount of creditable coverage is determined by counting all the days on which the individual has one or more types of creditable coverage. Accordingly, if on a particular day an individual has creditable coverage from more than one source, all the creditable coverage on that day is counted as one day. Any days in a waiting period for coverage are not creditable coverage.

(ii) *Days not counted before significant break in coverage.* Days of creditable coverage that occur before a significant break in coverage are not required to be counted.

(iii) *Significant break in coverage defined*—A significant break in coverage means a period of 63 consecutive days during each of which an individual does not have any creditable coverage. (See also § 146.143(c)(2)(iii) regarding the applicability to issuers of State insurance laws that require a break of more than 63 days before an individual

has a significant break in coverage for purposes of State insurance law.)

(iv) *Periods that toll a significant break.* Days in a waiting period and days in an affiliation period are not taken into account in determining whether a significant break in coverage has occurred. In addition, for an individual who elects COBRA continuation coverage during the second election period provided under the Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period are not taken into account in determining whether a significant break in coverage has occurred.

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

Example 1. (i) *Facts.* Individual *A* has creditable coverage under Employer *P*'s plan for 18 months before coverage ceases. *A* is provided a certificate of creditable coverage on *A*'s last day of coverage. Sixty-four days after the last date of coverage under *P*'s plan, *A* is hired by Employer *Q* and enrolls in *Q*'s group health plan. *Q*'s plan has a 12-month preexisting condition exclusion.

(ii) *Conclusion.* In this *Example 1, A* has a break in coverage of 63 days. Because *A*'s break in coverage is a significant break in coverage, *Q*'s plan may disregard *A*'s prior coverage and *A* may be subject to a 12-month preexisting condition exclusion.

Example 2. (i) *Facts.* Same facts as *Example 1,* except that *A* is hired by *Q* and enrolls in *Q*'s plan on the 63rd day after the last date of coverage under *P*'s plan.

(ii) *Conclusion.* In this *Example 2, A* has a break in coverage of 62 days. Because *A*'s break in coverage is not a significant break in coverage, *Q*'s plan must count *A*'s prior creditable coverage for purposes of reducing the plan's preexisting condition exclusion period that applies to *A*.

Example 3. (i) *Facts.* Same facts as *Example 1,* except that *Q*'s plan provides benefits through an insurance policy that, as required by applicable State insurance laws, defines a significant break in coverage as 90 days.

(ii) *Conclusion.* In this *Example 3,* under State law, the issuer that provides group health insurance coverage to *Q*'s plan must count *A*'s period of creditable coverage prior to the 63-day break. (However, if *Q*'s plan was a self-insured plan, the coverage would not be subject to State law. Therefore, the health coverage would not be governed by the longer break rules and *A*'s previous health coverage could be disregarded.)

Example 4. —[Reserved]

Example 5. (i) *Facts.* Individual *C* has creditable coverage under Employer *S*'s plan for 200 days before coverage ceases. *C* is provided a certificate of creditable coverage on *C*'s last day of coverage. *C* then does not have any creditable coverage for 51 days before being hired by Employer *T*. *T*'s plan has a 3-month waiting period. *C* works for *T* for 2 months and then terminates employment. Eleven days after terminating employment with *T, C* begins working for Employer *U*. *U*'s plan has no waiting period, but has a 6-month preexisting condition exclusion.

(ii) *Conclusion.* In this *Example 5, C* does not have a significant break in coverage because, after disregarding the waiting period under *T*'s plan, *C* had only a 62-day break in coverage (51 days plus 11 days). Accordingly, *C* has 200 days of creditable coverage, and *U*'s plan may not apply its 6-month preexisting condition exclusion with respect to *C*.

Example 6. —[Reserved]

Example 7. (i) *Facts.* Individual *E* has creditable coverage under Employer *X*'s plan. *E* is provided a certificate of creditable coverage on *E*'s last day of coverage. On the 63rd day without coverage, *E* submits a substantially complete application for a health insurance policy in the individual market. *E*'s application is accepted and coverage is made effective 10 days later.

(ii) *Conclusion.* In this *Example 7,* because *E* applied for the policy before the end of the 63rd day, the period between the date of application and the first day of coverage is a waiting period and no significant break in coverage occurred even though the actual period without coverage was 73 days.

Example 8. (i) *Facts.* Same facts as *Example 7,* except that *E*'s application for a policy in the individual market is denied.

(ii) *Conclusion.* In this *Example 8,* even though *E* did not obtain coverage following application, the period between the date of application and the date the coverage was denied is a waiting period. However, to avoid a significant break in coverage, no later than the day after the application for the policy is denied *E* would need to do one of the following: submit a substantially complete application for a different individual market policy; obtain coverage in the group market; or be in a waiting period for coverage in the group market.

(vi) *Other permissible counting methods*—(A) *Rule.* Notwithstanding any other provisions of this paragraph (b)(2), for purposes of reducing a preexisting condition exclusion period (but not for purposes of issuing a certificate under § 146.115), a group health plan, and a health insurance issuer offering group health insurance coverage, may determine the amount of creditable coverage in any other manner that is at least as favorable to the individual as the method set forth in this paragraph (b)(2), subject to the requirements of other applicable law.

(B) *Example.* The rule of this paragraph (b)(2)(vi) is illustrated by the following example:

Example. (i) *Facts.* Individual *F* has coverage under Group Health Plan *Y* from January 3, 1997 through March 25, 1997. *F* then becomes covered by Group Health Plan *Z*. *F*'s enrollment date in Plan *Z* is May 1, 1997. Plan *Z* has a 12-month preexisting condition exclusion.

(ii) *Conclusion.* In this *Example,* Plan *Z* may determine, in accordance with the rules prescribed in paragraphs (b)(2)(i), (ii), and (iii) of this section, that *F* has 82 days of creditable coverage (29 days in January, 28 days in February, and 25 days in March). Thus, the preexisting condition exclusion will no longer apply to *F* on February 8, 1998 (82 days before the 12-month anniversary of *F*'s enrollment (May 1)). For administrative convenience, however, Plan *Z* may consider that the preexisting condition exclusion will no longer apply to *F* on the first day of the month (February 1).

(c) *Alternative method*—(1) *Specific benefits considered.* Under the alternative method, a group health plan, or a health insurance issuer offering group health insurance coverage, determines the amount of creditable coverage based on coverage within any category of benefits described in paragraph (c)(3) of this section and not based on coverage for any other benefits. The plan or issuer may use the alternative method for any or all of the categories. The plan or issuer may apply a different preexisting condition exclusion period with respect to each category (and may apply a different preexisting condition exclusion period for benefits that are not within any category). The creditable coverage determined for a category of benefits applies only for purposes of reducing the preexisting condition exclusion period with respect to that category. An individual's creditable coverage for benefits that are not within any category for which the alternative method is being used is determined under the standard method of paragraph (b) of this section.

(2) *Uniform application.* A plan or issuer using the alternative method is required to apply it uniformly to all participants and beneficiaries under the plan or health insurance coverage. The use of the alternative method is required to be set forth in the plan.

(3) *Categories of benefits.* The alternative method for counting creditable coverage may be used for coverage for the following categories of benefits—

(i) Mental health;

(ii) Substance abuse treatment;

(iii) Prescription drugs;

(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) *Issuer notice.* With respect to health insurance coverage offered by an issuer in the small or large group market, if the insurance coverage uses the alternative method, the issuer states prominently in any disclosure statement concerning the coverage, that the issuer is using the alternative method, and includes in such statements a description of the effect of using the alternative method. This applies separately to each type of coverage offered by the health insurance issuer.

(6) *Disclosure of information on previous benefits.* See § 146.115(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).

(7) *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)(7) 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.

■ 4. Revise § 146.115 to read as follows:

§ 146.115 Certification and disclosure of previous 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 ERISA, section 4980(B)(g)(1) of the Internal Revenue Code, or section 2208 of the PHS 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 ERISA, section 4980(B)(f)(6) of the Internal Revenue Code, and section 2206 of the PHS 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 paragraph (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 § 146.145(c). In addition, the information in the certificate regarding coverage is not required to specify categories of benefits described in § 146.113(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. 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 § 146.111(b), under which such a child cannot be subject to a preexisting condition exclusion.

(6) *Special certification rules*—(i) *Issuers.* Issuers of group and individual health insurance are required to provide certificates of any creditable coverage they provide in the group or individual health insurance market, even if the coverage is provided in connection with an entity or program that is not itself required to provide a certificate because it is not subject to the group market provisions of this part, part 7 of subtitle B of title I of ERISA, or chapter 100 of subtitle K of the Internal Revenue Code. This would include coverage provided in connection with any of the following:

(A) Creditable coverage described in sections 2701(c)(1)(G), (I) and (J) of the PHS 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).

(B) Coverage subject to section 2721(b)(1)(B) of the PHS Act (requiring certificates by issuers offering health insurance coverage in connection with any group health plan, including a church plan or a governmental plan (including the Federal Employees Health Benefits Program).

(C) Coverage subject to section 2743 of the PHS Act applicable to health insurance issuers in the individual market. (However, this section does not require a certificate to be provided with respect to short-term limited duration insurance, which is excluded from the definition of ''individual health insurance coverage'' in 45 CFR 144.103 that is not provided in connection with a group health plan, as described in paragraph (a)(6)(i)(B) of this section.)

(ii) *Other entities.* For special rules requiring that certain other entities, not subject to this part, provide certificates consistent with the rules of 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 non-Federal governmental plans generally, section 2721(b)(2)(C)(ii) of the PHS Act applicable to non-Federal 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 9805(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 § 146.113(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 2701(c)(4) of the PHS Act, which permits individuals to demonstrate the duration of creditable coverage through means other than certificates, and section 2701(e)(3) of the PHS 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 received 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.

■ 5. Revise § 146.117 to read as follows:

§ 146.117 Special enrollment periods.

(a) *Special enrollment for certain individuals who lose coverage*—(1) *In General.* A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, is required to permit current employees and dependents (as defined in § 144.103 of this chapter) 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 employee satisfies the criteria of paragraph (a)(2)(i) of this section.

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

Example 1. (i) *Facts.* Individual *A* works for Employer *X. A, A*'s spouse, and *A*'s dependent children are eligible but not enrolled for coverage under *X*'s group health plan. *A*'s spouse works for Employer *Y* and at the time coverage was offered under *X*'s plan, *A* was enrolled in coverage under *Y*'s plan. Then, *A* loses eligibility for coverage under *Y*'s plan.

(ii) *Conclusion.* In this *Example 1,* because *A* satisfies the conditions for special enrollment under paragraph (a)(2)(i) of this section, *A, A*'s spouse, and *A*'s dependent children are eligible for special enrollment under *X*'s plan.

Example 2. (i) *Facts.* Individual *A* and *A*'s spouse are eligible but not enrolled for coverage under Group Health Plan *P* maintained by *A*'s employer. When *A* was first presented with an opportunity to enroll *A* and *A*'s spouse, they did not have other coverage. Later, *A* and *A*'s spouse enroll in Group Health Plan *Q* maintained by the employer of *A*'s spouse. During a subsequent open enrollment period in *P, A* and *A*'s spouse did not enroll because of their coverage under *Q*. They then lose eligibility for coverage under *Q*.

(ii) *Conclusion.* In this *Example 2,* because *A* and *A*'s spouse were covered under *Q* when they did not enroll in *P* during open enrollment, they satisfy the conditions for special enrollment under paragraphs (a)(2)(i) and (ii) of this section. Consequently, *A* and *A*'s spouse are eligible for special enrollment under *P*.

Example 3. (i) *Facts.* Individual *B* works for Employer *X. B* and *B*'s spouse are eligible but not enrolled for coverage under *X*'s group health plan. *B*'s spouse works for Employer *Y* and at the time coverage was offered under *X*'s plan, *B*'s spouse was enrolled in self-only coverage under *Y*'s group health plan. Then, *B*'s spouse loses eligibility for coverage under *Y*'s plan.

(ii) *Conclusion.* In this *Example 3,* because *B*'s spouse satisfies the conditions for special enrollment under paragraph (a)(2)(ii) of this section, both *B* and *B*'s spouse are eligible for special enrollment under *X*'s plan.

Example 4. (i) *Facts.* Individual *A* works for Employer *X. X* maintains a group health plan with two benefit packages—an HMO option and an indemnity option. Self-only and family coverage are available under both options. *A* enrolls for self-only coverage in the HMO option. *A*'s spouse works for Employer *Y* and was enrolled for self-only coverage under *Y*'s plan at the time coverage was offered under *X*'s plan. Then, *A*'s spouse loses coverage under *Y*'s plan. *A* requests special enrollment for *A* and *A*'s spouse under the plan's indemnity option.

(ii) *Conclusion.* In this *Example 4,* because *A*'s spouse satisfies the conditions for special enrollment under paragraph (a)(2)(ii) of this section, both *A* and *A*'s spouse can enroll in either benefit package under *X*'s plan. Therefore, if *A* requests enrollment in accordance with the requirements of this section, the plan must allow *A* and *A*'s spouse to enroll in the indemnity option.

(3) *Conditions for special enrollment*—(i) *Loss of eligibility for coverage.* In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph (a)(3)(i) are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). Loss of eligibility under this paragraph (a)(3)(i) does not include a loss due to the failure

of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Loss of eligibility for coverage under this paragraph (a)(3)(i) includes (but is not limited to)—

(A) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;

(B) In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);

(C) In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;

(D) A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and

(E) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in § 146.121(d)) that includes the individual.

(ii) *Termination of employer contributions.* In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph (a)(3)(ii) are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent.

(iii) *Exhaustion of COBRA continuation coverage.* In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions of this paragraph (a)(3)(iii) are satisfied at the time the COBRA continuation coverage is exhausted. For purposes of this paragraph (a)(3)(iii), an individual who satisfies the conditions for special enrollment of paragraph (a)(3)(i) of this section, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions of this paragraph (a)(3)(iii). (*Exhaustion of COBRA continuation coverage* is defined in § 144.103 of this chapter.)

(iv) *Written statement.* A plan may require an employee declining coverage (for the employee or any dependent of the employee) to state in writing whether the coverage is being declined due to other health coverage only if, at or before the time the employee declines coverage, the employee is provided with notice of the requirement to provide the statement (and the consequences of the employee's failure to provide the statement). If a plan requires such a statement, and an employee does not provide it, the plan is not required to provide special enrollment to the employee or any dependent of the employee under this paragraph (a)(3). A plan must treat an employee as having satisfied the plan requirement permitted under this paragraph (a)(3)(iv) if the employee provides a written statement that coverage was being declined because the employee or dependent had other coverage; a plan cannot require anything more for the employee to satisfy the plan's requirement to provide a written statement. (For example, the plan cannot require that the statement be notarized.)

(v) The rules of this paragraph (a)(3) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *D* enrolls in a group health plan maintained by Employer *Y*. At the time *D* enrolls, *Y* pays 70 percent of the cost of employee coverage and *D* pays the rest. *Y* announces that beginning January 1, *Y* will no longer make employer contributions towards the coverage. Employees may maintain coverage, however, if they pay the total cost of the coverage.

(ii) *Conclusion.* In this *Example 1*, employer contributions towards *D*'s coverage ceased on January 1 and the conditions of paragraph (a)(3)(ii) of this section are satisfied on this date (regardless of whether *D* elects to pay the total cost and continue coverage under *Y*'s plan).

Example 2. (i) *Facts.* A group health plan provides coverage through two options—Option 1 and Option 2. Employees can enroll in either option only within 30 days of hire or on January 1 of each year. Employee *A* is eligible for both options and enrolls in Option 1. Effective July 1 the plan terminates coverage under Option 1 and the plan does not create an immediate open enrollment opportunity into Option 2.

(ii) *Conclusion.* In this *Example 2*, A has experienced a loss of eligibility for coverage that satisfies paragraph (a)(3)(i) of this section, and has satisfied the other conditions for special enrollment under paragraph (a)(2)(i) of this section. Therefore, if *A* satisfies the other conditions of this paragraph (a), the plan must permit *A* to enroll in Option 2 as a special enrollee. (*A* may also be eligible to enroll in another group health plan, such as a plan maintained by the employer of *A*'s spouse, as a special enrollee.) The outcome would be the same if Option 1 was terminated by an issuer and the plan made no other coverage available to *A*.

Example 3. (i) *Facts.* Individual *C* is covered under a group health plan maintained by Employer *X*. While covered under *X*'s plan, *C* was eligible for but did not enroll in a plan maintained by Employer Z, the employer of *C*'s spouse. *C* terminates employment with *X* and loses eligibility for coverage under *X*'s plan. *C* has a special enrollment right to enroll in *Z*'s plan, but *C* instead elects COBRA continuation coverage under *X*'s plan. *C* exhausts COBRA continuation coverage under *X*'s plan and requests special enrollment in *Z*'s plan.

(ii) *Conclusion.* In this *Example 3*, *C* has satisfied the conditions for special enrollment under paragraph (a)(3)(iii) of this section, and has satisfied the other conditions for special enrollment under paragraph (a)(2)(i) of this section. The special enrollment right that *C* had into *Z*'s plan immediately after the loss of eligibility for coverage under *X*'s plan was an offer of coverage under *Z*'s plan. When *C* later exhausts COBRA coverage under *X*'s plan, *C* has a second special enrollment right in *Z*'s plan.

(4) *Applying for special enrollment and effective date of coverage*—(i) A plan or issuer must allow an employee a period of at least 30 days after an event described in paragraph (a)(3) of this section (other than an event described in paragraph (a)(3)(i)(D)) to request enrollment (for the employee or the employee's dependent). In the case of an event described in paragraph (a)(3)(i)(D) of this section (relating to loss of eligibility for coverage due to the operation of a lifetime limit on all benefits), a plan or issuer must allow an employee a period of at least 30 days after a claim is denied due to the operation of a lifetime limit on all benefits.

(ii) Coverage must begin no later than the first day of the first calendar month beginning after the date the plan or issuer receives the request for special enrollment.

(b) *Special enrollment with respect to certain dependent beneficiaries*—(1) *General.* A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, that makes coverage available with respect to dependents is required to permit individuals described in paragraph (b)(2) of this section to be enrolled for coverage in a benefit

package under the terms of the plan. Paragraph (b)(3) of this section describes the required special enrollment period and the date by which coverage must begin. The special enrollment rights under this paragraph (b) 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.* An individual is described in this paragraph (b)(2) if the individual is otherwise eligible for coverage in a benefit package under the plan and if the individual is described in paragraph (b)(2)(i), (ii), (iii), (iv), (v), or (vi) of this section.

(i) *Current employee only.* A current employee is described in this paragraph (b)(2)(i) if a person becomes a dependent of the individual through marriage, birth, adoption, or placement for adoption.

(ii) *Spouse of a participant only.* An individual is described in this paragraph (b)(2)(ii) if either—

(A) The individual becomes the spouse of a participant; or

(B) The individual is a spouse of a participant and a child becomes a dependent of the participant through birth, adoption, or placement for adoption.

(iii) *Current employee and spouse.* A current employee and an individual who is or becomes a spouse of such an employee, are described in this paragraph (b)(2)(iii) if either—

(A) The employee and the spouse become married; or

(B) The employee and spouse are married and a child becomes a dependent of the employee through birth, adoption, or placement for adoption.

(iv) *Dependent of a participant only.* An individual is described in this paragraph (b)(2)(iv) if the individual is a dependent (as defined in § 144.103 of this chapter) of a participant and the individual has become a dependent of the participant through marriage, birth, adoption, or placement for adoption.

(v) *Current employee and a new dependent.* A current employee and an individual who is a dependent of the employee, are described in this paragraph (b)(2)(v) if the individual becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.

(vi) *Current employee, spouse, and a new dependent.* A current employee, the employee's spouse, and the employee's dependent are described in this paragraph (b)(2)(vi) if the dependent becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.

(3) *Applying for special enrollment and effective date of coverage*—(i) *Request.* A plan or issuer must allow an individual a period of at least 30 days after the date of the marriage, birth, adoption, or placement for adoption (or, if dependent coverage is not generally made available at the time of the marriage, birth, adoption, or placement for adoption, a period of at least 30 days after the date the plan makes dependent coverage generally available) to request enrollment (for the individual or the individual's dependent).

(ii) *Reasonable procedures for special enrollment.* [Reserved]

(iii) *Date coverage must begin*—(A) *Marriage.* In the case of marriage, coverage must begin no later than the first day of the first calendar month beginning after the date the plan or issuer receives the request for special enrollment.

(B) *Birth, adoption, or placement for adoption.* Coverage must begin in the case of a dependent's birth on the date of birth and in the case of a dependent's adoption or placement for adoption no later than the date of such adoption or placement for adoption (or, if dependent coverage is not made generally available at the time of the birth, adoption, or placement for adoption, the date the plan makes dependent coverage available).

(4) *Examples.* The rules of this paragraph (b) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer maintains a group health plan that offers all employees employee-only coverage, employee-plus-spouse coverage, or family coverage. Under the terms of the plan, any employee may elect to enroll when first hired (with coverage beginning on the date of hire) or during an annual open enrollment period held each December (with coverage beginning the following January 1). Employee *A* is hired on September 3. *A* is married to *B*, and they have no children. On March 15 in the following year a child *C* is born to *A* and *B*. Before that date, *A* and *B* have not been enrolled in the plan.

(ii) *Conclusion.* In this *Example 1*, the conditions for special enrollment of an employee with a spouse and new dependent under paragraph (b)(2)(vi) of this section are satisfied. If *A* satisfies the conditions of paragraph (b)(3) of this section for requesting enrollment timely, the plan will satisfy this paragraph (b) if it allows *A* to enroll either with employee-only coverage, with employee-plus-spouse coverage (for *A* and *B*), or with family coverage (for *A*, *B*, and *C*). The plan must allow whatever coverage is chosen to begin on March 15, the date of *C*'s birth.

Example 2. (i) *Facts.* Individual *D* works for Employer *X*. *X* maintains a group health plan with two benefit packages—an HMO option and an indemnity option. Self-only and family coverage are available under both options. *D* enrolls for self-only coverage in the HMO option. Then, a child, *E*, is placed for adoption with *D*. Within 30 days of the placement of *E* for adoption, *D* requests enrollment for *D* and *E* under the plan's indemnity option.

(ii) *Conclusion.* In this *Example 2*, *D* and *E* satisfy the conditions for special enrollment under paragraphs (b)(2)(v) and (b)(3) of this section. Therefore, the plan must allow *D* and *E* to enroll in the indemnity coverage, effective as of the date of the placement for adoption.

(c) *Notice of special enrollment.* At or before the time an employee is initially offered the opportunity to enroll in a group health plan, the plan must furnish the employee with a notice of special enrollment that complies with the requirements of this paragraph (c).

(1) *Description of special enrollment rights.* The notice of special enrollment must include a description of special enrollment rights. The following model language may be used to satisfy this requirement:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within [insert ''30 days'' or any longer period that applies under the plan] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within [insert ''30 days'' or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact [insert the name, title, telephone number, and any additional contact information of the appropriate plan representative].

(2) *Additional information that may be required.* The notice of special enrollment must also include, if applicable, the notice described in paragraph (a)(3)(iv) of this section (the notice required to be furnished to an individual declining coverage if the plan requires the reason for declining coverage to be in writing).

(d) *Treatment of special enrollees*—(1) If an individual requests enrollment while the individual is entitled to special enrollment under either paragraph (a) or (b) of this section, the individual is a special enrollee, even if the request for enrollment coincides with a late enrollment opportunity under the plan. Therefore, the

individual cannot be treated as a late enrollee.

(2) Special enrollees must be offered all the benefit packages available to similarly situated individuals who enroll when first eligible. For this purpose, any difference in benefits or cost-sharing requirements for different individuals constitutes a different benefit package. In addition, a special enrollee cannot be required to pay more for coverage than a similarly situated individual who enrolls in the same coverage when first eligible. The length of any preexisting condition exclusion that may be applied to a special enrollee cannot exceed the length of any preexisting condition exclusion that is applied to similarly situated individuals who enroll when first eligible. For rules prohibiting the application of a preexisting condition exclusion to certain newborns, adopted children, and children placed for adoption, see § 146.111(b).

(3) The rules of this section are illustrated by the following example:

Example. (i) *Facts.* Employer *Y* maintains a group health plan that has an enrollment period for late enrollees every November 1 through November 30 with coverage effective the following January 1. On October 18, Individual *B* loses coverage under another group health plan and satisfies the requirements of paragraphs (a)(2), (3), and (4) of this section. *B* submits a completed application for coverage on November 2.

(ii) *Conclusion.* In this *Example*, *B* is a special enrollee. Therefore, even though *B*'s request for enrollment coincides with an open enrollment period, *B*'s coverage is required to be made effective no later than December 1 (rather than the plan's January 1 effective date for late enrollees).

■ 6. Revise § 146.119 to read as follows:

§ 146.119 HMO affiliation period as an alternative to a preexisting condition exclusion.

(a) *In general.* A group health plan offering health insurance coverage through an HMO, or an HMO that offers health insurance coverage in connection with a group health plan, may impose an affiliation period only if each of the following requirements is satisfied—

(1) No preexisting condition exclusion is imposed with respect to any coverage offered by the HMO in connection with the particular group health plan.

(2) No premium is charged to a participant or beneficiary for the affiliation period.

(3) The affiliation period for the HMO coverage is imposed consistent with the requirements of § 146.121 (prohibiting discrimination based on a health factor).

(4) The affiliation period does not exceed 2 months (or 3 months in the case of a late enrollee).

(5) The affiliation period begins on the enrollment date, or in the case of a late enrollee, the affiliation period begins on the day that would be the first day of coverage but for the affiliation period.

(6) The affiliation period for enrollment in the HMO under a plan runs concurrently with any waiting period.

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

Example 1. (i) *Facts.* An employer sponsors a group health plan. Benefits under the plan are provided through an HMO, which imposes a two-month affiliation period. In order to be eligible under the plan, employees must have worked for the employer for six months. Individual *A* begins working for the employer on February 1.

(ii) *Conclusion.* In this *Example 1,* Individual *A*'s enrollment date is February 1 (see § 146.111(a)(2)), and both the waiting period and the affiliation period begin on this date and run concurrently. Therefore, the affiliation period ends on March 31, the waiting period ends on July 31, and *A* is eligible to have coverage begin on August 1.

Example 2. (i) *Facts.* A group health plan has two benefit package options, a fee-for-service option and an HMO option. The HMO imposes a 1-month affiliation period. Individual *B* is enrolled in the fee-for-service option for more than one month and then decides to switch to the HMO option at open season.

(ii) *Conclusion.* In this *Example 2,* the HMO may not impose the affiliation period with respect to *B* because any affiliation period would have to begin on *B*'s enrollment date in the plan rather than the date that *B* enrolled in the HMO option. Therefore, the affiliation period would have expired before *B* switched to the HMO option.

Example 3. (i) *Facts.* An employer sponsors a group health plan that provides benefits through an HMO. The plan imposes a two-month affiliation period with respect to salaried employees, but it does not impose an affiliation period with respect to hourly employees.

(ii) *Conclusion.* In this *Example 3,* the plan may impose the affiliation period with respect to salaried employees without imposing any affiliation period with respect to hourly employees (unless, under the circumstances, treating salaried and hourly employees differently does not comply with the requirements of § 146.121).

(c) *Alternatives to affiliation period.* An HMO may use alternative methods in lieu of an affiliation period to address adverse selection, as approved by the State insurance commissioner or other official designated to regulate HMOs. However, an arrangement that is in the nature of a preexisting condition exclusion cannot be an alternative to an affiliation period. Nothing in this part requires a State to receive proposals for or approve alternatives to affiliation periods.

■ 7. Add and reserve § 146.120 to read as follows:

§ 146.120 Interaction with the Family and Medical Leave Act [Reserved]

■ 8. Revise § 146.125 to read as follows:

§ 146.125 Applicability dates.

Sections 146.111 through 146.119, § 146.143, and § 146.145 are applicable for plan years beginning on or after July 1, 2005. Until the applicability date for this regulation, plans and issuers are required to continue to comply with the corresponding sections of 45 CFR parts 144 and 146, contained in the 45 CFR, parts 1 to 199, edition revised as of October 1, 2004.

■ 9. Revise § 146.143 to read as follows:

§ 146.143 Preemption; State flexibility; construction.

(a) *Continued applicability of State law with respect to health insurance issuers.* Subject to paragraph (b) of this section and except as provided in paragraph (c) of this section, part A of title XXVII of the PHS Act is not to be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part.

(b) *Continued preemption with respect to group health plans.* Nothing in part A of title XXVII of the PHS Act affects or modifies the provisions of section 514 of the Act with respect to group health plans.

(c) *Special rules*—(1) *In general.* Subject to paragraph (c)(2) of this section, the provisions of part A of title XXVII of the PHS Act relating to health insurance coverage offered by a health insurance issuer supersede any provision of State law which establishes, implements, or continues in effect a standard or requirement applicable to imposition of a preexisting condition exclusion specifically governed by section 2701 of the PHS Act which differs from the standards or requirements specified in section 2701 of the PHS Act.

(2) *Exceptions.* Only in relation to health insurance coverage offered by a health insurance issuer, the provisions of this part do not supersede any provision of State law to the extent that such provision—

(i) Shortens the period of time from the ''6-month period'' described in section 2701(a)(1) of the PHS Act and

§ 146.111(a)(1)(i) (for purposes of identifying a preexisting condition);

(ii) Shortens the period of time from the ''12 months'' and ''18 months'' described in section 2701(a)(2) of the PHS Act and § 146.111(a)(1)(ii) (for purposes of applying a preexisting condition exclusion period);

(iii) Provides for a greater number of days than the ''63-day period'' described in sections 2701(c)(2)(A) and (d)(4)(A) of the PHS Act and §§ 146.111(a)(1)(iii) and 146.113 (for purposes of applying the break in coverage rules);

(iv) Provides for a greater number of days than the ''30-day period'' described in sections 2701(b)(2) and (d)(1) of the PHS Act and § 146.111(b) (for purposes of the enrollment period and preexisting condition exclusion periods for certain newborns and children that are adopted or placed for adoption);

(v) Prohibits the imposition of any preexisting condition exclusion in cases not described in section 2701(d) of the PHS Act or expands the exceptions described therein;

(vi) Requires special enrollment periods in addition to those required under section 2701(f) of the PHS Act; or

(vii) Reduces the maximum period permitted in an affiliation period under section 2701(g)(1)(B) of the PHS Act.

(d) *Definitions*—(1) *State law.* For purposes of this section the term *State law* includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia is treated as a State law rather than a law of the United States.

(2) *State.* For purposes of this section the term *State* includes a State (as defined in § 144.103), any political subdivisions of a State, or any agency or instrumentality of either.

■ 10. Revise § 146.145 to read as follows:

§ 146.145 Special rules relating to group health plans.

(a) *Group health plan*—(1) *Definition.* A group health plan means an employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees (including both current and former employees) or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(2) *Determination of number of plans.* [Reserved]

(b) *General exception for certain small group health plans.* The requirements of this part, other than § 146.130, do not apply to any group health plan (and group health insurance coverage) for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees.

(c) *Excepted benefits*—(1) *In general.* The requirements of subparts B and C of this part do not apply to any group health plan (or any group health insurance coverage) in relation to its provision of the benefits described in paragraph (c)(2), (3), (4), or (5) of this section (or any combination of these benefits).

(2) *Benefits excepted in all circumstances.* The following benefits are excepted in all circumstances—

(i) Coverage only for accident (including accidental death and dismemberment);

(ii) Disability income coverage;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Coverage issued as a supplement to liability insurance;

(v) Workers' compensation or similar coverage;

(vi) Automobile medical payment insurance;

(vii) Credit-only insurance (for example, mortgage insurance); and

(viii) Coverage for on-site medical clinics.

(3) *Limited excepted benefits*—(i) *In general.* Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan as described in paragraph (c)(3)(ii) of this section. In addition, benefits provided under a health flexible spending arrangement are excepted benefits if they satisfy the requirements of paragraph (c)(3)(v) of this section.

(ii) *Not an integral part of a group health plan.* For purposes of this paragraph (c)(3), benefits are not an integral part of a group health plan (whether the benefits are provided through the same plan or a separate plan) only if the following two requirements are satisfied—

(A) Participants must have the right to elect not to receive coverage for the benefits; and

(B) If a participant elects to receive coverage for the benefits, the participant must pay an additional premium or contribution for that coverage.

(iii) *Limited scope*—(A) *Dental benefits.* Limited scope dental benefits are benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth).

(B) *Vision benefits.* Limited scope vision benefits are benefits substantially all of which are for treatment of the eye.

(iv) *Long-term care.* Long-term care benefits are benefits that are either—

(A) Subject to State long-term care insurance laws;

(B) For qualified long-term care services, as defined in section 7702B(c)(1) of the Internal Revenue Code, or provided under a qualified long-term care insurance contract, as defined in section 7702B(b) of the Internal Revenue Code; or

(C) Based on cognitive impairment or a loss of functional capacity that is expected to be chronic.

(v) *Health flexible spending arrangements.* Benefits provided under a health flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code) are excepted for a class of participants only if they satisfy the following two requirements—

(A) Other group health plan coverage, not limited to excepted benefits, is made available for the year to the class of participants by reason of their employment; and

(B) The arrangement is structured so that the maximum benefit payable to any participant in the class for a year cannot exceed two times the participant's salary reduction election under the arrangement for the year (or, if greater, cannot exceed $500 plus the amount of the participant's salary reduction election). For this purpose, any amount that an employee can elect to receive as taxable income but elects to apply to the health flexible spending arrangement is considered a salary reduction election (regardless of whether the amount is characterized as salary or as a credit under the arrangement).

(4) *Noncoordinated benefits*—(i) *Excepted benefits that are not coordinated.* Coverage for only a specified disease or illness (for example, cancer-only policies) or hospital indemnity or other fixed indemnity insurance is excepted only if it meets each of the conditions specified in paragraph (c)(4)(ii) of this section. To be hospital indemnity or other fixed indemnity insurance, the insurance must pay a fixed dollar amount per day (or per other period) of hospitalization or illness (for example, $100/day) regardless of the amount of expenses incurred.

(ii) *Conditions.* Benefits are described in paragraph (c)(4)(i) of this section only if—

(A) The benefits are provided under a separate policy, certificate, or contract of insurance;

(B) There is no coordination between the provision of the benefits and an exclusion of benefits under any group

health plan maintained by the same plan sponsor; and

(C) The benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor.

(iii) *Example.* The rules of this paragraph (c)(4) are illustrated by the following example:

Example. (i) *Facts.* An employer sponsors a group health plan that provides coverage through an insurance policy. The policy provides benefits only for hospital stays at a fixed percentage of hospital expenses up to a maximum of $100 a day.

(ii) *Conclusion.* In this *Example,* even though the benefits under the policy satisfy the conditions in paragraph (c)(4)(ii) of this section, because the policy pays a percentage of expenses incurred rather than a fixed dollar amount, the benefits under the policy are not excepted benefits under this paragraph (c)(4). This is the result even if, in practice, the policy pays the maximum of $100 for every day of hospitalization.

(5) *Supplemental benefits.* (i) The following benefits are excepted only if they are provided under a separate policy, certificate, or contract of insurance—

(A) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act; also known as Medigap or MedSupp insurance);

(B) Coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code (also known as TRICARE supplemental programs); and

(C) Similar supplemental coverage provided to coverage under a group health plan. To be similar supplemental coverage, the coverage must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles. Similar supplemental coverage does not include coverage that becomes secondary or supplemental only under a coordination-of-benefits provision.

(ii) The rules of this paragraph (c)(5) are illustrated by the following example:

Example. (i) *Facts.* An employer sponsors a group health plan that provides coverage for both active employees and retirees. The coverage for retirees supplements benefits provided by Medicare, but does not meet the requirements for a supplemental policy under section 1882(g)(1) of the Social Security Act.

(ii) *Conclusion.* In this *Example,* the coverage provided to retirees does not meet the definition of supplemental excepted benefits under this paragraph (c)(5) because the coverage is not Medicare supplemental insurance as defined under section 1882(g)(1) of the Social Security Act, is not a TRICARE supplemental program, and is not supplemental to coverage provided under a group health plan.

(d) *Treatment of partnerships.* For purposes of this part:

(1) *Treatment as a group health plan.* Any plan, fund, or program that would not be (but for this paragraph (d)) an employee welfare benefit plan and that is established or maintained by a partnership, to the extent that the plan, fund, or program provides medical care (including items and services paid for as medical care) to present or former partners in the partnership or to their dependents (as defined under the terms of the plan, fund, or program), directly or through insurance, reimbursement, or otherwise, is treated (subject to paragraph (d)(2) of this section) as an employee welfare benefit plan that is a group health plan.

(2) *Employment relationship.* In the case of a group health plan, the term *employer* also includes the partnership in relation to any bona fide partner. In addition, the term *employee* also includes any bona fide partner. Whether or not an individual is a bona fide partner is determined based on all the relevant facts and circumstances, including whether the individual performs services on behalf of the partnership.

(3) *Participants of group health plans.* In the case of a group health plan, the term *participant* also includes any individual described in paragraph (d)(3)(i) or (ii) of this section if the individual is, or may become, eligible to receive a benefit under the plan or the individual's beneficiaries may be eligible to receive any such benefit.

(i) In connection with a group health plan maintained by a partnership, the individual is a partner in relation to the partnership.

(ii) In connection with a group health plan maintained by a self-employed individual (under which one or more employees are participants), the individual is the self-employed individual.

(e) *Determining the average number of employees.* [Reserved]

Dated: November 24, 2004.

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Administrator, Centers for Medicare & Medicaid Services.

Dated: December 2, 2004.

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