

a selection after the Notice is qualified, and, if the Issuing Agency does not respond within 20 days, the child will be enrolled under the plan's default option (if any).

(4) Section 609(a)(3)(C) of ERISA is satisfied because the Notice specifies that the period of coverage may only end for the alternate recipient(s) when similarly situated dependents are no longer eligible for coverage under the terms of the plan, or upon the occurrence of certain specified events.

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

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

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

[65 FR 82142, Dec. 27, 2000]

**Subpart B—Requirements Relating to Access and Renewability of Coverage, and Limitations on Preexisting Condition Exclusion Periods**

SOURCE: 62 FR 16941, Apr. 8, 1997. Redesignated at 65 FR 82142, Dec. 27, 2000, unless otherwise noted.

**§ 2590.701-1 Basis and scope.**

(a) *Statutory basis.* This subpart 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. This subpart A 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) 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 Code (other than paragraph (f)(1) of such section 4980B insofar as it relates to pediatric vaccines), and title XXII of the PHSA.

(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; or