

§ 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.* (1) Subject to paragraph (b)(2) of this section, the requirements of this part 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.

(2) The following requirements apply without regard to paragraph (b)(1) of this section:

(i) Section 2590.702(b) of this Part, as such section applies with respect to genetic information as a health factor.

(ii) Section 2590.702(c) of this Part, as such section applies with respect to genetic information as a health factor.

(iii) Section 2590.702(e) of this Part, as such section applies with respect to genetic information as a health factor.

(iv) Section 2590.702-1(b) of this Part.

(v) Section 2590.702-1(c) of this Part.

(vi) Section 2590.702-1(d) of this Part.

(vii) Section 2590.702-1(e) of this Part.

(viii) Section 2590.711 of this Part.

(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.

(ix) Travel insurance, within the meaning of § 2590.701-2.

(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 (health FSA) are excepted benefits if they satisfy the requirements of paragraph (c)(3)(v) of this section; benefits provided under an employee assistance program are excepted benefits if they satisfy the requirements of paragraph (c)(3)(vi) of this section; benefits provided under limited wraparound coverage are excepted benefits if they satisfy the requirements of paragraph (c)(3)(vii) of this section; and benefits provided under a health reimbursement arrangement or other account-based group health plan, other than a health FSA, are excepted benefits if they satisfy the requirements of paragraph (c)(3)(viii) 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, a separate plan, or as the only plan offered to participants) if either paragraph (c)(3)(ii)(A) or (B) are satisfied.

(A) Participants may decline coverage. For example, a participant may decline coverage if the participant can opt out of the coverage upon request, whether or not there is a participant contribution required for the coverage.

(B) Claims for the benefits are administered under a contract separate from claims administration for any other benefits under the plan.

(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).

(vi) *Employee assistance programs*. Benefits provided under employee assistance programs are excepted if they satisfy all of the requirements of this paragraph (c)(3)(vi).

(A) The program does not provide significant benefits in the nature of medical care. For this purpose, the

amount, scope and duration of covered services are taken into account.

(B) The benefits under the employee assistance program are not coordinated with benefits under another group health plan, as follows:

(1) Participants in the other group health plan must not be required to use and exhaust benefits under the employee assistance program (making the employee assistance program a gatekeeper) before an individual is eligible for benefits under the other group health plan; and

(2) Participant eligibility for benefits under the employee assistance program must not be dependent on participation in another group health plan.

(C) No employee premiums or contributions are required as a condition of participation in the employee assistance program.

(D) There is no cost sharing under the employee assistance program.

(vii) *Limited wraparound coverage*. Limited benefits provided through a group health plan that wrap around eligible individual health insurance (or Basic Health Plan coverage described in section 1331 of the Patient Protection and Affordable Care Act); or that wrap around coverage under a Multi-State Plan described in section 1334 of the Patient Protection and Affordable Care Act, collectively referred to as "limited wraparound coverage," are excepted benefits if all of the following conditions are satisfied. For this purpose, eligible individual health insurance is individual health insurance coverage that is not a grandfathered health plan (as described in section 1251 of the Patient Protection and Affordable Care Act and § 2590.715-1251), not a transitional individual health insurance plan (as described in the March 5, 2014 Insurance Standards Bulletin Series—Extension of Transitional Policy through October 1, 2016), and does not consist solely of excepted benefits (as defined in paragraph (c) of this section).

(A) *Covers additional benefits*. The limited wraparound coverage provides meaningful benefits beyond coverage of cost sharing under either the eligible individual health insurance, Basic Health Program coverage, or Multi-

State Plan coverage. The limited wrap-around coverage must not provide benefits only under a coordination-of-benefits provision and must not consist of an account-based reimbursement arrangement.

(B) *Limited in amount.* The annual cost of coverage per employee (and any covered dependents, as defined in § 2590.701–2) under the limited wrap-around coverage does not exceed the greater of the amount determined under either paragraph (c)(3)(vii)(B)(1) or (2) of this section. Making a determination regarding the annual cost of coverage per employee must occur on an aggregate basis relying on sound actuarial principles.

(1) The maximum permitted annual salary reduction contribution toward health flexible spending arrangements, indexed in the manner prescribed under section 125(i)(2) of the Code. For this purpose, the cost of coverage under the limited wraparound includes both employer and employee contributions towards coverage and is determined in the same manner as the applicable premium is calculated under a COBRA continuation provision.

(2) Fifteen percent of the cost of coverage under the primary plan. For this purpose, the cost of coverage under the primary plan and under the limited wraparound coverage includes both employer and employee contributions towards the coverage and each is determined in the same manner as the applicable premium is calculated under a COBRA continuation provision.

(C) *Nondiscrimination.* All of the conditions of this paragraph (c)(3)(vii)(C) are satisfied.

(1) *No preexisting condition exclusion.* The limited wraparound coverage does not impose any preexisting condition exclusion, consistent with the requirements of section 2704 of the PHS Act (incorporated by reference into section 715 of ERISA) and § 2590.715–2704.

(2) *No discrimination based on health status.* The limited wraparound coverage does not discriminate against individuals in eligibility, benefits, or premiums based on any health factor of an individual (or any dependent of the individual, as defined in § 2590.701–2), consistent with the requirements of section 702 of ERISA and section 2705 of

the PHS Act (incorporated by reference into section 715 of ERISA).

(3) *No discrimination in favor of highly compensated individuals.* Neither the limited wraparound coverage, nor any other group health plan coverage offered by the plan sponsor, fails to comply with section 2716 of the PHS Act (incorporated by reference into section 715 of ERISA) or fails to be excludible from income for any individual due to the application of section 105(h) of the Code (as applicable).

(D) *Plan eligibility requirements.* Individuals eligible for the wraparound coverage are not enrolled in excepted benefit coverage under paragraph (c)(3)(v) of this section (relating to health FSAs). In addition, the conditions set forth in either paragraph (c)(3)(vii)(D)(1) or (2) of this section are met.

(1) *Limited wraparound coverage that wraps around eligible individual insurance for persons who are not full-time employees.* Coverage that wraps around eligible individual health insurance (or that wraps around Basic Health Plan coverage) must satisfy all of the conditions of this paragraph (c)(3)(vii)(D)(1).

(i) For each year for which limited wraparound coverage is offered, the employer that is the sponsor of the plan offering limited wraparound coverage, or the employer participating in a plan offering limited wraparound coverage, offers to its full-time employees coverage that is substantially similar to coverage that the employer would need to offer to its full-time employees in order not to be subject to a potential assessable payment under the employer shared responsibility provisions of section 4980H(a) of the Code, if such provisions were applicable; provides minimum value (as defined in section 36B(c)(2)(C)(ii) of the Code); and is reasonably expected to be affordable (applying the safe harbor rules for determining affordability set forth in 26 CFR 54.4980H–5(e)(2)). If a plan or issuer providing limited wraparound coverage takes reasonable steps to ensure that employers disclose to the plan or issuer necessary information regarding their

coverage offered and affordability information, the plan or issuer is permitted to rely on reasonable representations by employers regarding this information, unless the plan or issuer has specific knowledge to the contrary. In the event that the employer that is the sponsor of the plan offering wrap-around coverage, or the employer participating in a plan offering wrap-around coverage, has no full-time employees for any plan year limited wrap-around coverage is offered, the requirement of this paragraph (c)(3)(vii)(D)(I)(i) is considered satisfied.

(ii) Eligibility for the limited wrap-around coverage is limited to employees who are reasonably determined at the time of enrollment to not be full-time employees (and their dependents, as defined in § 2590.701-2), or who are retirees (and their dependents, as defined in § 2590.701-2). For this purpose, full-time employees are employees who are reasonably expected to work at least an average of 30 hours per week.

(iii) Other group health plan coverage, not limited to excepted benefits, is offered to the individuals eligible for the limited wraparound coverage. Only individuals eligible for the other group health plan coverage are eligible for the limited wraparound coverage.

(2) *Limited coverage that wraps around Multi-State Plan coverage.* Coverage that wraps around Multi-State Plan coverage must satisfy all of the conditions of this paragraph (c)(3)(vii)(D)(2). For this purpose, the term “full-time employee” means a “full-time employee” as defined in 26 CFR 54.4980H-1(a)(21) who is not in a limited non-assessment period for certain employees (as defined in 26 CFR 54.4980H-1(a)(26)). Moreover, if a plan or issuer providing limited wraparound coverage takes reasonable steps to ensure that employers disclose to the plan or issuer necessary information regarding their coverage offered and contribution levels for 2013 or 2014 (as applicable), and for any year in which limited wraparound coverage is offered, the plan or issuer is permitted to rely on reasonable representations by employers regarding this information, unless the plan or issuer has specific knowledge to the contrary. Consistent with the reporting and eval-

uation criteria of paragraph (c)(3)(vii)(E) of this section, the Office of Personnel Management may verify that plans and issuers have reasonable mechanisms in place to ensure that contributing employers meet these standards.

(i) The limited wraparound coverage is reviewed and approved by the Office of Personnel Management, consistent with the reporting and evaluation criteria of paragraph (c)(3)(vii)(E) of this section, to provide benefits in conjunction with coverage under a Multi-State Plan authorized under section 1334 of the Patient Protection and Affordable Care Act. The Office of Personnel Management may revoke approval if it determines that continued approval is inconsistent with the reporting and evaluation criteria of paragraph (c)(3)(vii)(E) of this section.

(ii) The employer offered coverage in the plan year that began in either 2013 or 2014 that is substantially similar to coverage that the employer would need to have offered to its full-time employees in order to not be subject to an assessable payment under the employer shared responsibility provisions of section 4980H(a) of the Code, if such provisions had been applicable. In the event that a plan that offered coverage in 2013 or 2014 has no full-time employees for any plan year limited wraparound coverage is offered, the requirement of this paragraph (c)(3)(vii)(D)(2)(ii) is considered satisfied.

(iii) In the plan year that began in either 2013 or 2014, the employer offered coverage to a substantial portion of full-time employees that provided minimum value (as defined in section 36B(c)(2)(C)(ii) of the Code) and was affordable (applying the safe harbor rules for determining affordability set forth in 26 CFR 54.4980H-5(e)(2)). In the event that the plan that offered coverage in 2013 or 2014 has no full-time employees for any plan year limited wraparound coverage is offered, the requirement of this paragraph (c)(3)(vii)(D)(2)(iii) is considered satisfied.

(iv) For the duration of the pilot program, as described in paragraph (c)(3)(vii)(F) of this section, the employer’s annual aggregate contributions for both primary and limited wraparound coverage are substantially

the same as the employer's total contributions for coverage offered to full-time employees in 2013 or 2014.

(E) *Reporting—(1) Reporting by group health plans and group health insurance issuers.* A self-insured group health plan, or a health insurance issuer, offering or proposing to offer limited wraparound coverage in connection with Multi-State Plan coverage pursuant to paragraph (c)(3)(vii)(D)(2) of this section reports to the Office of Personnel Management (OPM), in a form and manner specified in guidance, information OPM reasonably requires to determine whether the plan or issuer qualifies to offer such coverage or complies with the applicable requirements of this section.

(2) *Reporting by group health plan sponsors.* The plan sponsor of a group health plan offering limited wraparound coverage under paragraph (c)(3)(vii) of this section, must report to the Department of Health and Human Services (HHS), in a form and manner specified in guidance, information HHS reasonably requires.

(F) *Pilot program with sunset.* The provisions of paragraph (c)(3)(vii) of this section apply to limited wraparound coverage that is first offered no earlier than January 1, 2016 and no later than December 31, 2018 and that ends no later than on the later of:

(1) The date that is three years after the date limited wraparound coverage is first offered; or

(2) The date on which the last collective bargaining agreement relating to the plan terminates after the date limited wraparound coverage is first offered (determined without regard to any extension agreed to after the date limited wraparound coverage is first offered).

(viii) *Health reimbursement arrangements (HRAs) and other account-based group health plans.* Benefits provided under an HRA or other account-based group health plan, other than a health FSA, are excepted if they satisfy all of the requirements of this paragraph (c)(3)(viii). See paragraph (c)(3)(v) of this section for the circumstances in which benefits provided under a health FSA are excepted benefits. For purposes of this paragraph (c)(3)(viii), the term “HRA or other account-based

group health plan” has the same meaning as “account-based group health plan” set forth in § 2590.715–2711(d)(6)(i) of this part, except that the term does not include health FSAs. For ease of reference, an HRA or other account-based group health plan that satisfies the requirements of this paragraph (c)(3)(viii) is referred to as an excepted benefit HRA.

(A) *Otherwise not an integral part of the plan.* Other group health plan coverage that is not limited to excepted benefits and that is not an HRA or other account-based group health plan must be made available by the same plan sponsor for the plan year to the participant.

(B) *Benefits are limited in amount—(1) Limit on annual amounts made available.* The amounts newly made available for each plan year under the HRA or other account-based group health plan do not exceed \$1,800. In the case of any plan year beginning after December 31, 2020, the dollar amount in the preceding sentence shall be increased by an amount equal to such dollar amount multiplied by the cost-of-living adjustment. The cost of living adjustment is the percentage (if any) by which the C–CPI–U for the preceding calendar year exceeds the C–CPI–U for calendar year 2019. The term “C–CPI–U” means the Chained Consumer Price Index for All Urban Consumers as published by the Bureau of Labor Statistics of the Department of Labor. The C–CPI–U for any calendar year is the average of the C–CPI–U as of the close of the 12-month period ending on March 31 of such calendar year. The values of the C–CPI–U used for any calendar year shall be the latest values so published as of the date on which the Bureau publishes the initial value of the C–CPI–U for the month of March for the preceding calendar year. Any such increase that is not a multiple of \$50 shall be rounded down to the next lowest multiple of \$50. The Department of the Treasury and the Internal Revenue Service will publish the adjusted amount for plan years beginning in any calendar year no later than June 1 of the preceding calendar year.

(2) *Carryover amounts.* If the terms of the HRA or other account-based group health plan allow unused amounts to be made available to participants and

dependents in later plan years, such carryover amounts are disregarded for purposes of determining whether benefits are limited in amount.

(3) *Multiple HRAs or other account-based group health plans.* If the plan sponsor provides more than one HRA or other account-based group health plan to the participant for the same time period, the amounts made available under all such plans are aggregated to determine whether the benefits are limited in amount, except that HRAs or other account-based group health plans that reimburse only excepted benefits are not included in determining whether the benefits are limited in amount.

(C) *Prohibition on reimbursement of certain health insurance premiums.* The HRA or other account-based group health plan must not reimburse premiums for individual health insurance coverage, group health plan coverage (other than COBRA continuation coverage or other continuation coverage), or Medicare Part A, B, C, or D, except that the HRA or other account-based group health plan may reimburse premiums for such coverage that consists solely of excepted benefits. See also, paragraph (c)(3)(viii)(F) of this section.

(D) *Uniform availability.* The HRA or other account-based group health plan is made available under the same terms to all similarly situated individuals, as defined in § 2590.702(d) of this part, regardless of any health factor (as described in § 2590.702(a)).

(E) *Notice requirement.* See sections 2520.102-3(j)(2) and (3) and 2520.104b-2(a) of this chapter regarding the time, manner, and content for summary plan descriptions (including a description of conditions pertaining to eligibility to receive benefits; annual or lifetime caps or other limits on benefits under the plan; and a description or summary of the benefits).

(F) *Special rule.* The HRA or other account-based group health plan must not reimburse premiums for short-term, limited-duration insurance (as defined in § 2590.701-2 of this part) if the conditions of this paragraph (c)(3)(viii)(F) are satisfied.

(I) The HRA or other account-based group health plan is offered by a small

employer (as defined in PHS Act section 2791(e)(4)).

(2) The other group health plan coverage offered by the employer pursuant to paragraph (c)(3)(viii)(A) of this section is either fully-insured or partially-insured.

(3) The Secretary of Health and Human Services (HHS) makes a finding, in consultation with the Secretaries of Labor and the Treasury, that the reimbursement of premiums for short-term, limited-duration insurance by excepted benefit HRAs has caused significant harm to the small group market in the state that is the principal place of business of the small employer.

(4) The finding by the Secretary of HHS is made after submission of a written recommendation by the applicable state authority of such state, in a form and manner specified by HHS. The written recommendation must include evidence that the reimbursement of premiums for short-term, limited-duration insurance by excepted benefit HRAs established by insured or partially-insured small employers in the state has caused significant harm to the state's small group market, including with respect to premiums.

(5) The restriction shall be imposed or discontinued by publication by the Secretary of HHS of a notice in the FEDERAL REGISTER and shall apply only prospectively and with a reasonable time for plan sponsors to comply.

(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 the primary coverage. The preceding sentence is satisfied if the coverage is designed to fill gaps in cost sharing in the primary coverage, such as coinsurance or deductibles, or the coverage is designed to provide benefits for items and services not covered by the primary coverage and that are not essential health benefits (as defined under section 1302(b) of the Patient Protection and Affordable Care Act) in the State

where the coverage is issued, or the coverage is designed to both fill such gaps in cost sharing under, and cover such benefits not covered by, the primary coverage. 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.

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(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]

[69 FR 78778, Dec. 30, 2004, as amended at 74 FR 51687, Oct. 7, 2009; 79 FR 10312, Feb. 24, 2014; 79 FR 59136, Oct. 1, 2014; 80 FR 14005, Mar. 18, 2015; 81 FR 75325, Oct. 31, 2016; 84 FR 29013, June 20, 2019]

§ 2590.734 Enforcement. [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. Notwithstanding the previous sentence, the definition of "short-term, limited-duration insurance" in § 2590.701-2 applies October 2, 2018.

[69 FR 78778, Dec. 30, 2004, as amended at 81 FR 75326, Oct. 31, 2016; 83 FR 38243, Aug. 3, 2018]

PARTS 2591-2599 [RESERVED]