

be a covered student at the institution of higher education and was not on a medically necessary leave of absence.

(e) Continued application in case of changed coverage

If—

(1) a dependent child of a participant or beneficiary is in a period of coverage under a group health plan or health insurance coverage offered in connection with such a plan, pursuant to a medically necessary leave of absence of the child described in subsection (b);

(2) the manner in which the participant or beneficiary is covered under the plan changes, whether through a change in health insurance coverage or health insurance issuer, a change between health insurance coverage and self-insured coverage, or otherwise; and

(3) the coverage as so changed continues to provide coverage of beneficiaries as dependent children,

this section shall apply to coverage of the child under the changed coverage for the remainder of the period of the medically necessary leave of absence of the dependent child under the plan in the same manner as it would have applied if the changed coverage had been the previous coverage.

(Pub. L. 93-406, title I, §714, as added Pub. L. 110-381, §2(a)(1), Oct. 9, 2008, 122 Stat. 4081.)

EFFECTIVE DATE

Section applicable with respect to plan years beginning on or after the date that is one year after Oct. 9, 2008, and to medically necessary leaves of absence beginning during such plan years, see section 2(d) of Pub. L. 110-381, set out as a note under section 9813 of Title 26, Internal Revenue Code.

§ 1185d. Additional market reforms

(a) General rule

Except as provided in subsection (b)—

(1) the provisions of part A of title XXVII of the Public Health Service Act [42 U.S.C. 300gg et seq.] (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart; and

(2) to the extent that any provision of this part conflicts with a provision of such part A with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.

(b) Exception

Notwithstanding subsection (a), the provisions of sections 2716 and 2718 of title XXVII of the Public Health Service Act [42 U.S.C. 300gg-16, 300gg-18] (as amended by the Patient Protection and Affordable Care Act) shall not apply with respect to self-insured group health plans, and the provisions of this part shall continue to apply to such plans as if such sections of the Public Health Service Act (as so amended) had not been enacted.

(Pub. L. 93-406, title I, §715, as added Pub. L. 111-148, title I, §1563(e), formerly §1562(e), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 270, 911.)

REFERENCES IN TEXT

The Public Health Service Act, referred to in text, is act July 1, 1944, ch. 373, 58 Stat. 682. Part A of title XXVII of the Act is classified generally to part A (§300gg et seq.) of subchapter XXV of chapter 6A of Title 42, The Public Health and Welfare. For complete classification of this Act to the Code, see Short Title note set out under section 201 of this Title 42 and Tables.

The Patient Protection and Affordable Care Act, referred to in text, is Pub. L. 111-148, Mar. 23, 2010, 124 Stat. 119. For complete classification of this Act to the Code, see Short Title note set out under section 18001 of Title 42, The Public Health and Welfare, and Tables.

Subpart C—General Provisions

§ 1191. Preemption; State flexibility; construction

(a) Continued applicability of State law with respect to health insurance issuers

(1) In general

Subject to paragraph (2) and except as provided in subsection (b) of this section, this part shall not 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.

(2) Continued preemption with respect to group health plans

Nothing in this part shall be construed to affect or modify the provisions of section 1144 of this title with respect to group health plans.

(b) Special rules in case of portability requirements

(1) In general

Subject to paragraph (2), the provisions of this part 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 1181 of this title 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—

(A) substitutes for the reference to “6-month period” in section 1181(a)(1) of this title a reference to any shorter period of time;

(B) substitutes for the reference to “12 months” and “18 months” in section 1181(a)(2) of this title a reference to any shorter period of time;

(C) substitutes for the references to “63 days” in sections 1181(c)(2)(A) and (d)(4)(A)

of this title a reference to any greater number of days;

(D) substitutes for the reference to “30-day period” in sections 1181(b)(2) and (d)(1) of this title a reference to any greater period;

(E) prohibits the imposition of any pre-existing condition exclusion in cases not described in section 1181(d) of this title or expands the exceptions described in such section;

(F) requires special enrollment periods in addition to those required under section 1181(f) of this title; or

(G) reduces the maximum period permitted in an affiliation period under section 1181(g)(1)(B) of this title.

(c) Rules of construction

Except as provided in section 1185 of this title, nothing in this part shall be construed as requiring a group health plan or health insurance coverage to provide specific benefits under the terms of such plan or coverage.

(d) Definitions

For purposes of this section—

(1) State law

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 shall be treated as a State law rather than a law of the United States.

(2) State

The term “State” includes a State, the Northern Mariana Islands, any political subdivisions of a State or such Islands, or any agency or instrumentality of either.

(Pub. L. 93-406, title I, § 731, formerly § 704, as added Pub. L. 104-191, title I, § 101(a), Aug. 21, 1996, 110 Stat. 1946; renumbered § 731 and amended Pub. L. 104-204, title VI, § 603(a)(3), (b)(1), Sept. 26, 1996, 110 Stat. 2935, 2937.)

AMENDMENTS

1996—Subsec. (c). Pub. L. 104-204, § 603(b)(1), substituted “Except as provided in section 1185 of this title, nothing” for “Nothing”.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104-204 applicable with respect to group health plans for plan years beginning on and after Jan. 1, 1998, see section 603(c) of Pub. L. 104-204, set out as a note under section 1003 of this title.

EFFECTIVE DATE

Section applicable with respect to group health plans for plan years beginning after June 30, 1997, except as otherwise provided, see section 101(g) of Pub. L. 104-191, set out as a note under section 1181 of this title.

§ 1191a. Special rules relating to group health plans

(a) General exception for certain small group health plans

The requirements of this part (other than section 1185 of this title) shall not apply to any group health plan (and group health insurance coverage offered in connection with a group

health plan) for any plan year if, on the first day of such plan year, such plan has less than 2 participants who are current employees.

(b) Exception for certain benefits

The requirements of this part shall not apply to any group health plan (and group health insurance coverage) in relation to its provision of excepted benefits described in section 1191b(c)(1) of this title.

(c) Exception for certain benefits if certain conditions met

(1) Limited, excepted benefits

The requirements of this part shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 1191b(c)(2) of this title if the benefits—

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

(B) are otherwise not an integral part of the plan.

(2) Noncoordinated, excepted benefits

The requirements of this part shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 1191b(c)(3) of this title if all of the following conditions are met:

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

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

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

(3) Supplemental excepted benefits

The requirements of this part shall not apply to any group health plan (and group health insurance coverage) in relation to its provision of excepted benefits described in section 1191b(c)(4) of this title if the benefits are provided under a separate policy, certificate, or contract of insurance.

(d) Treatment of partnerships

For purposes of this part—

(1) Treatment as a group health plan

Any plan, fund, or program which would not be (but for this subsection) an employee welfare benefit plan and which is established or maintained by a partnership, to the extent that such 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, shall be treated (subject to paragraph (2)) as an employee welfare benefit plan which is a group health plan.