(2) Employer

In the case of a group health plan, the term ''employer'' also includes the partnership in relation to any partner.

(3) Participants of group health plans

In the case of a group health plan, the term ''participant'' also includes—

(A) in connection with a group health plan maintained by a partnership, an individual who is a partner in relation to the partnership, or

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

if such individual is, or may become, eligible to receive a benefit under the plan or such individual's beneficiaries may be eligible to receive any such benefit.

(Pub. L. 93–406, title I, § 732, formerly § 705, as added Pub. L. 104–191, title I, § 101(a), Aug. 21, 1996, 110 Stat. 1948; renumbered § 732 and amended Pub. L. 104–204, title VI, § 603(a)(3), (b)(2), (3)(I)–(L), Sept. 26, 1996, 110 Stat. 2935, 2937, 2938.)

AMENDMENTS

1996—Subsec. (a). Pub. L. 104–204, § 603(b)(2), inserted ''(other than section 1185 of this title)'' after ''part''.

Subsecs. (b), (c)(1) to (3). Pub. L. 104–204, § 603(b)(3)(I)–(L), made technical amendment to references in original act which appear in text as references to section 1191b of this title.

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.

§ 1191b. Definitions

(a) Group health plan

For purposes of this part—

(1) In general

The term ''group health plan'' means an employee welfare benefit plan to the extent that the plan provides medical care (as defined in paragraph (2) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(2) Medical care

The term ''medical care'' means amounts paid for—

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

(B) amounts paid for transportation primarily for and essential to medical care referred to in subparagraph (A), and

(C) amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B).

(b) Definitions relating to health insurance

For purposes of this part—

(1) Health insurance coverage

The term ''health insurance coverage'' means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

(2) Health insurance issuer

The term ''health insurance issuer'' means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 1144(b)(2) of this title). Such term does not include a group health plan.

(3) Health maintenance organization

The term ''health maintenance organization'' means—

(A) a federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act (42 U.S.C. 300e(a))),

(B) an organization recognized under State law as a health maintenance organization, or

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

(4) Group health insurance coverage

The term ''group health insurance coverage'' means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

(c) Excepted benefits

For purposes of this part, the term ''excepted benefits'' means benefits under one or more (or any combination thereof) of the following:

(1) Benefits not subject to requirements

(A) Coverage only for accident, or disability income insurance, or any combination thereof.

(B) Coverage issued as a supplement to liability insurance.

(C) Liability insurance, including general liability insurance and automobile liability insurance.

(D) Workers' compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for on-site medical clinics.

(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(2) Benefits not subject to requirements if offered separately

(A) Limited scope dental or vision benefits.

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(C) Such other similar, limited benefits as are specified in regulations.

(3) Benefits not subject to requirements if offered as independent, noncoordinated benefits

(A) Coverage only for a specified disease or illness.

(B) Hospital indemnity or other fixed indemnity insurance.

(4) Benefits not subject to requirements if offered as separate insurance policy

Medicare supplemental health insurance (as defined under section 1395ss(g)(1) of title 42), coverage supplemental to the coverage provided under chapter 55 of title 10, and similar supplemental coverage provided to coverage under a group health plan.

(d) Other definitions

For purposes of this part—

(1) COBRA continuation provision

The term ''COBRA continuation provision'' means any of the following:

(A) Part 6 of this subtitle.

(B) Section 4980B of title 26, other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines.

(C) Title XXII of the Public Health Service Act [42 U.S.C. 300bb–1 et seq.].

(2) Health status-related factor

The term ''health status-related factor'' means any of the factors described in section 1182(a)(1) of this title.

(3) Network plan

The term ''network plan'' means health insurance coverage offered by 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.

(4) Placed for adoption

The term ''placement'', or being ''placed'', for adoption, has the meaning given such term in section 1169(c)(3)(B) of this title.

(5) Family member

The term ''family member'' means, with respect to an individual—

(A) a dependent (as such term is used for purposes of section 1181(f)(2) of this title) of such individual, and

(B) any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual or of an individual described in subparagraph (A).

(6) Genetic information

(A) In general

The term ''genetic information'' means, with respect to any individual, information about—

(i) such individual's genetic tests,

(ii) the genetic tests of family members of such individual, and

(iii) the manifestation of a disease or disorder in family members of such individual.

(B) Inclusion of genetic services and participation in genetic research

Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual.

(C) Exclusions

The term ''genetic information'' shall not include information about the sex or age of any individual.

(7) Genetic test

(A) In general

The term ''genetic test'' means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detects genotypes, mutations, or chromosomal changes.

(B) Exceptions

The term ''genetic test'' does not mean—

(i) an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or

(ii) an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(8) Genetic services

The term ''genetic services'' means—

(A) a genetic test;

(B) genetic counseling (including obtaining, interpreting, or assessing genetic information); or

(C) genetic education.

(9) Underwriting purposes

The term ''underwriting purposes'' means, with respect to any group health plan, or health insurance coverage offered in connection with a group health plan—

(A) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the plan or coverage;

(B) the computation of premium or contribution amounts under the plan or coverage;

(C) the application of any pre-existing condition exclusion under the plan or coverage; and

(D) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

(Pub. L. 93–406, title I, §733, formerly §706, as added Pub. L. 104–191, title I, §101(a), Aug. 21, 1996, 110 Stat. 1949; renumbered §733, Pub. L. 104–204, title VI, §603(a)(3), Sept. 26, 1996, 110 Stat. 2935; amended Pub. L. 110–233, title I, §101(d), May 21, 2008, 122 Stat. 885.)

REFERENCES IN TEXT

The Public Health Service Act, referred to in subsec. (d)(1)(C), is act July 1, 1944, ch. 373, 58 Stat. 682, as

amended. Title XXII of the Act is classified generally to subchapter XX (§ 300bb–1 et seq.) 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 Title 42 and Tables.

AMENDMENTS

2008—Subsec. (d)(5) to (9). Pub. L. 110–233 added pars. (5) to (9).

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by Pub. L. 110–233 applicable with respect to group health plans for plan years beginning after the date that is one year after May 21, 2008, see section 101(f)(2) of Pub. L. 110–233, set out as a note under section 1132 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.

§ 1191c. Regulations

The Secretary, consistent with section 104 of the Health Care Portability and Accountability Act of 1996, may promulgate such regulations as may be necessary or appropriate to carry out the provisions of this part. The Secretary may promulgate any interim final rules as the Secretary determines are appropriate to carry out this part.

(Pub. L. 93–406, title I, § 734, formerly § 707, as added Pub. L. 104–191, title I, § 101(a), Aug. 21, 1996, 110 Stat. 1951; renumbered § 734, Pub. L. 104–204, title VI, § 603(a)(3), Sept. 26, 1996, 110 Stat. 2935.)

REFERENCES IN TEXT

Section 104 of the Health Care Portability and Accountability Act of 1996, referred to in text, probably means section 104 of the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191, which is set out as a note under section 300gg–92 of Title 42, The Public Health and Welfare.

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.

SUBCHAPTER II—JURISDICTION, ADMINISTRATION, ENFORCEMENT; JOINT PENSION TASK FORCE, ETC.

SUBTITLE A—JURISDICTION, ADMINISTRATION, AND ENFORCEMENT

§ 1201. Procedures in connection with the issuance of certain determination letters by the Secretary of the Treasury covering qualifications under Internal Revenue Code

(a) Additional material required of applicants

Before issuing an advance determination of whether a pension, profit-sharing, or stock bonus plan, a trust which is a part of such a plan, or an annuity or bond purchase plan meets the requirements of part I of subchapter D of chapter 1 of title 26, the Secretary of the Treasury shall require the person applying for the determination to provide, in addition to any material and information necessary for such determination, such other material and information as may reasonably be made available at the time such application is made as the Secretary of Labor may require under subchapter I of this chapter for the administration of that subchapter. The Secretary of the Treasury shall also require that the applicant provide evidence satisfactory to the Secretary that the applicant has notified each employee who qualifies as an interested party (within the meaning of regulations prescribed under section 7476(b)(1) of title 26 (relating to declaratory judgments in connection with the qualification of certain retirement plans)) of the application for a determination.

(b) Opportunity to comment on application

(1) Whenever an application is made to the Secretary of the Treasury for a determination of whether a pension, profit-sharing, or stock bonus plan, a trust which is a part of such a plan, or an annuity or bond purchase plan meets the requirements of part I of subchapter D of chapter 1 of title 26, the Secretary shall upon request afford an opportunity to comment on the application at any time within 45 days after receipt thereof to—

(A) any employee or class of employee qualifying as an interested party within the meaning of the regulations referred to in subsection (a) of this section.[1]

(B) the Secretary of Labor, and

(C) the Pension Benefit Guaranty Corporation.

(2) The Secretary of Labor may not request an opportunity to comment upon such an application unless he has been requested in writing to do so by the Pension Benefit Guaranty Corporation or by the lesser of—

(A) 10 employees, or

(B) 10 percent of the employees

who qualify as interested parties within the meaning of the regulations referred to in subsection (a) of this section. Upon receiving such a request, the Secretary of Labor shall furnish a copy of the request to the Secretary of the Treasury within 5 days (excluding Saturdays, Sundays, and legal public holidays (as set forth in section 6103 of title 5)).

(3) Upon receiving such a request from the Secretary of Labor, the Secretary of the Treasury shall furnish to the Secretary of Labor such information held by the Secretary of the Treasury relating to the application as the Secretary of Labor may request.

(4) The Secretary of Labor shall, within 30 days after receiving a request from the Pension Benefit Guaranty Corporation or from the necessary number of employees who qualify as interested parties, notify the Secretary of the Treasury, the Pension Benefit Guaranty Corporation, and such employees with respect to whether he is going to comment on the application to which the request relates and with respect to any matters raised in such request on which he is not going to comment. If the Secretary of Labor indicates in the notice required under the preceding sentence that he is not going to comment on all or part of the matters

[1] So in original. The period probably should be a comma.