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[1] 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) substitutes for the reference to ''6-month period'' in section 2701(a)(1)[1] a reference to any shorter period of time;

(ii) substitutes for the reference to ''12 months'' and ''18 months'' in section 2701(a)(2)[1] a reference to any shorter period of time;

(iii) substitutes for the references to ''63'' days in sections 2701(c)(2)(A)[1] and 2701(d)(4)(A)[1] a reference to any greater number of days;

(iv) substitutes for the reference to ''30-day period'' in sections 2701(b)(2)[1] and 2701(d)(1)[1] a reference to any greater period;

(v) prohibits the imposition of any preexisting condition exclusion in cases not described in section 2701(d)[1] or expands the exceptions described in such section;

(vi) requires special enrollment periods in addition to those required under section 2701(f)[1]; or

(vii) reduces the maximum period permitted in an affiliation period under section 2701(g)(1)(B)[1].

(c) Rules of construction

Nothing in this part (other than section 2704)[1] 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 (including the Northern Mariana Islands), any political subdivisions of a State or such Islands, or any agency or instrumentality of either.

(July 1, 1944, ch. 373, title XXVII, § 2724, formerly § 2723, as added Pub. L. 104–191, title I, § 102(a), Aug. 21, 1996, 110 Stat. 1971; amended Pub. L. 104–204, title VI, § 604(b)(2), Sept. 26, 1996, 110 Stat. 2941; renumbered § 2737, renumbered § 2724, and amended Pub. L. 111–148, title I, §§ 1001(4), 1563(c)(14), formerly § 1562(c)(14), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 269, 911.)

[1] See References in Text note below.

REFERENCES IN TEXT

Section 2701, referred to in subsec. (b), is a reference to section 2701 of act July 1, 1944. Section 2701, which was classified to section 300gg of this title, was renumbered section 2704, effective for plan years beginning on or after Jan. 1, 2014, with certain exceptions, and amended, by Pub. L. 111–148, title I, §§ 1201(2), 1563(c)(1), formerly § 1562(c)(1), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911, and was transferred to section 300gg–3 of this title. A new section 2701 of act July 1, 1944, related to fair health insurance premiums, was added, effective for plan years beginning on or after Jan. 1, 2014, and amended, by Pub. L. 111–148, title I, § 1201(4), title X, § 10103(a), Mar. 23, 2010, 124 Stat. 155, 892, and is classified to section 300gg of this title.

Section 701, referred to in subsec. (b)(1), probably means ''section 2701'' of act July 1, 1944. See note above.

Section 2704, referred to in subsec. (c), is a reference to section 2704 of act July 1, 1944. Section 2704, which was classified to section 300gg–4 of this title, was renumbered section 2725, and amended by Pub. L. 111–148, title I, §§ 1001(2), 1563(c)(3), formerly § 1562(c)(3), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 265, 911, and was transferred to section 300gg–25 of this title. A new section 2704 of act July 1, 1944, related to prohibition of preexisting condition exclusions or other discrimination based on health status, was added, effective for plan years beginning on or after Jan. 1, 2014, with certain exceptions, and amended, by Pub. L. 111–148, title I, §§ 1201(2), 1563(c)(1), formerly § 1562(c)(1), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911, and is classified to section 300gg–3 of this title.

AMENDMENTS

2010—Subsec. (a)(1). Pub. L. 111–148, § 1563(c)(14)(A), formerly § 1562(c)(14)(A), as renumbered by Pub. L. 111–148, § 10107(b)(1), inserted ''individual or'' before ''group health insurance''.

1996—Subsec. (c). Pub. L. 104–204 inserted ''(other than section 2704)'' after ''part''.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–204 applicable with respect to group health plans for plan years beginning on or after Jan. 1, 1998, see section 604(c) of Pub. L. 104–204 set out as an Effective Date note under section 300gg–25 of this title.

EFFECTIVE DATE

Section applicable with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning after June 30, 1997, except as otherwise provided, see section 102(c) of Pub. L. 104–191, set out as a note under section 300gg of this title.

§ 300gg–25. Standards relating to benefits for mothers and newborns

(a) Requirements for minimum hospital stay following birth

(1) In general

A group health plan, and a health insurance issuer offering group or individual health insurance coverage, may not—

(A) except as provided in paragraph (2)—

(i) restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a normal vaginal delivery, to less than 48 hours, or

(ii) restrict benefits for any hospital length of stay in connection with child-

birth for the mother or newborn child, following a cesarean section, to less than 96 hours, or

(B) require that a provider obtain authorization from the plan or the issuer for prescribing any length of stay required under subparagraph (A) (without regard to paragraph (2)).

(2) Exception

Paragraph (1)(A) shall not apply in connection with any group health plan or health insurance issuer in any case in which the decision to discharge the mother or her newborn child prior to the expiration of the minimum length of stay otherwise required under paragraph (1)(A) is made by an attending provider in consultation with the mother.

(b) Prohibitions

A group health plan, and a health insurance issuer offering group or individual health insurance coverage, may not—

(1) deny to the mother or her newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan or coverage, solely for the purpose of avoiding the requirements of this section;

(2) provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum protections available under this section;

(3) penalize or otherwise reduce or limit the reimbursement of an attending provider because such provider provided care to an individual participant or beneficiary in accordance with this section;

(4) provide incentives (monetary or otherwise) to an attending provider to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section; or

(5) subject to subsection (c)(3) of this section, restrict benefits for any portion of a period within a hospital length of stay required under subsection (a) of this section in a manner which is less favorable than the benefits provided for any preceding portion of such stay.

(c) Rules of construction

(1) Nothing in this section shall be construed to require a mother who is a participant or beneficiary—

(A) to give birth in a hospital; or

(B) to stay in the hospital for a fixed period of time following the birth of her child.

(2) This section shall not apply with respect to any group health plan, or any health insurance issuer offering group or individual health insurance coverage, which does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn child.

(3) Nothing in this section shall be construed as preventing a group health plan or health insurance issuer from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or newborn child under the plan (or under health insurance coverage offered in connection with a group health plan), except that such coinsurance or other cost-sharing for any portion of a period within a hospital length of stay required under subsection (a) of this section may not be greater than such coinsurance or cost-sharing for any preceding portion of such stay.

(d) Notice

A group health plan under this part shall comply with the notice requirement under section 1185(d) of title 29 with respect to the requirements of this section as if such section applied to such plan.

(e) Level and type of reimbursements

Nothing in this section shall be construed to prevent a group health plan or a health insurance issuer offering group or individual health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

(f) Preemption; exception for health insurance coverage in certain States

(1) In general

The requirements of this section shall not apply with respect to health insurance coverage if there is a State law (as defined in section 300gg–23(d)(1)[1] of this title) for a State that regulates such coverage that is described in any of the following subparagraphs:

(A) Such State law requires such coverage to provide for at least a 48-hour hospital length of stay following a normal vaginal delivery and at least a 96-hour hospital length of stay following a cesarean section.

(B) Such State law requires such coverage to provide for maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or other established professional medical associations.

(C) Such State law requires, in connection with such coverage for maternity care, that the hospital length of stay for such care is left to the decision of (or required to be made by) the attending provider in consultation with the mother.

(2) Construction

Section 300gg–23(a)(1)[1] of this title shall not be construed as superseding a State law described in paragraph (1).

(July 1, 1944, ch. 373, title XXVII, § 2725, formerly § 2704, as added Pub. L. 104–204, title VI, § 604(a)(3), Sept. 26, 1996, 110 Stat. 2939; renumbered § 2725 and amended Pub. L. 111–148, title I, §§ 1001(2), 1563(c)(3), formerly § 1562(c)(3), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 265, 911.)

REFERENCES IN TEXT

Section 300gg–23 of this title, referred to in subsec. (f), was in the original section ''2723'', and was translated as meaning section 2724 of act July 1, 1944, to reflect the probable intent of Congress and the renumbering of section 2723 as 2724 by Pub. L. 111–148, title I, §§ 1001(4), 1563(c)(14)(B), formerly § 1562(c)(14)(B), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 269, 911.

CODIFICATION

Section was formerly classified to section 300gg–4 of this title prior to renumbering by Pub. L. 111–148.

[1] See References in Text note below.

AMENDMENTS

2010—Subsec. (a)(1). Pub. L. 111–148, § 1563(c)(3)(A), formerly § 1562(c)(3)(A), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''group or individual health insurance coverage'' for ''group health insurance coverage'' in introductory provisions.

Subsec. (b). Pub. L. 111–148, § 1563(c)(3)(B)(i), formerly § 1562(c)(3)(B)(i), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''group or individual health insurance coverage'' for ''group health insurance coverage in connection with a group health plan'' in introductory provisions.

Subsec. (b)(1). Pub. L. 111–148, § 1563(c)(3)(B)(ii), formerly § 1562(c)(3)(B)(ii), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''plan or coverage'' for ''plan''.

Subsec. (c)(2). Pub. L. 111–148, § 1563(c)(3)(C)(i), formerly § 1562(c)(3)(C)(i), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''health insurance issuer offering group or individual health insurance coverage'' for ''group health insurance coverage offered by a health insurance issuer''.

Subsec. (c)(3). Pub. L. 111–148, § 1563(c)(3)(C)(ii), formerly § 1562(c)(3)(C)(ii), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''health insurance issuer'' for ''issuer''.

Subsec. (e). Pub. L. 111–148, § 1563(c)(3)(D), formerly § 1562(c)(3)(D), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''group or individual health insurance coverage'' for ''group health insurance coverage''.

EFFECTIVE DATE

Pub. L. 104–204, title VI, § 604(c), Sept. 26, 1996, 110 Stat. 2941, provided that: ''The amendments made by this section [enacting this section and amending sections 300gg–21 and 300gg–23 of this title] shall apply with respect to group health plans for plan years beginning on or after January 1, 1998.''

CONGRESSIONAL FINDINGS

Pub. L. 104–204, title VI, § 602, Sept. 26, 1996, 110 Stat. 2935, provided that: ''Congress finds that—

''(1) the length of post-delivery hospital stay should be based on the unique characteristics of each mother and her newborn child, taking into consideration the health of the mother, the health and stability of the newborn, the ability and confidence of the mother and the father to care for their newborn, the adequacy of support systems at home, and the access of the mother and her newborn to appropriate follow-up health care; and

''(2) the timing of the discharge of a mother and her newborn child from the hospital should be made by the attending provider in consultation with the mother.''

§ 300gg–26. Parity in mental health and substance use disorder benefits

(a) In general

(1) Aggregate lifetime limits

In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits—

(A) No lifetime limit

If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health or substance use disorder benefits.

(B) Lifetime limit

If the plan or coverage includes an aggregate lifetime limit on substantially all medical and surgical benefits (in this paragraph referred to as the ''applicable lifetime limit''), the plan or coverage shall either—

(i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or

(ii) not include any aggregate lifetime limit on mental health or substance use disorder benefits that is less than the applicable lifetime limit.

(C) Rule in case of different limits

In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different aggregate lifetime limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health and substance use disorder benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

(2) Annual limits

In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits—

(A) No annual limit

If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health or substance use disorder benefits.

(B) Annual limit

If the plan or coverage includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the ''applicable annual limit''), the plan or coverage shall either—

(i) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or

(ii) not include any annual limit on mental health or substance use disorder benefits that is less than the applicable annual limit.

(C) Rule in case of different limits

In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different annual limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect