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

to mental health and substance use disorder benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

(3) Financial requirements and treatment limitations

(A) In general

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, such plan or coverage shall ensure that—

(i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

(ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

(B) Definitions

In this paragraph:

(i) Financial requirement

The term ''financial requirement'' includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit subject to paragraphs (1) and (2).

(ii) Predominant

A financial requirement or treatment limit is considered to be predominant if it is the most common or frequent of such type of limit or requirement.

(iii) Treatment limitation

The term ''treatment limitation'' includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

(4) Availability of plan information

The criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits (or the health insurance coverage offered in connection with the plan with respect to such benefits) shall be made available by the plan administrator (or the health insurance issuer offering such coverage) in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request. The reason for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary shall, on request or as otherwise required, be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary in accordance with regulations.

(5) Out-of-network providers

In the case of a plan or coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, if the plan or coverage provides coverage for medical or surgical benefits provided by out-of-network providers, the plan or coverage shall provide coverage for mental health or substance use disorder benefits provided by out-of-network providers in a manner that is consistent with the requirements of this section.

(b) Construction

Nothing in this section shall be construed—

(1) as requiring a group health plan or a health insurance issuer offering group or individual health insurance coverage to provide any mental health or substance use disorder benefits; or

(2) in the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides mental health or substance use disorder benefits, as affecting the terms and conditions of the plan or coverage relating to such benefits under the plan or coverage, except as provided in subsection (a).

(c) Exemptions

(1) Small employer exemption

This section shall not apply to any group health plan and a health insurance issuer offering group or individual health insurance coverage for any plan year of a small employer (as defined in section 300gg–91(e)(4) of this title, except that for purposes of this paragraph such term shall include employers with 1 employee in the case of an employer residing in a State that permits small groups to include a single individual).

(2) Cost exemption

(A) In general

With respect to a group health plan or a health insurance issuer offering group or individual health insurance coverage, if the application of this section to such plan (or coverage) results in an increase for the plan year involved of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan (as determined and certified under subparagraph (C)) by an amount that exceeds the applicable percentage described in subparagraph (B) of the actual total plan costs, the provisions of this section shall not apply to such plan (or coverage) during the following plan year, and such exemption shall apply to the plan (or coverage) for 1 plan year. An

employer may elect to continue to apply mental health and substance use disorder parity pursuant to this section with respect to the group health plan (or coverage) involved regardless of any increase in total costs.

(B) Applicable percentage

With respect to a plan (or coverage), the applicable percentage described in this subparagraph shall be—

(i) 2 percent in the case of the first plan year in which this section is applied; and

(ii) 1 percent in the case of each subsequent plan year.

(C) Determinations by actuaries

Determinations as to increases in actual costs under a plan (or coverage) for purposes of this section shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. All such determinations shall be in a written report prepared by the actuary. The report, and all underlying documentation relied upon by the actuary, shall be maintained by the group health plan or health insurance issuer for a period of 6 years following the notification made under subparagraph (E).

(D) 6-month determinations

If a group health plan (or a health insurance issuer offering coverage in connection with a group health plan) seeks an exemption under this paragraph, determinations under subparagraph (A) shall be made after such plan (or coverage) has complied with this section for the first 6 months of the plan year involved.

(E) Notification

(i) In general

A group health plan (or a health insurance issuer offering coverage in connection with a group health plan) that, based upon a certification described under subparagraph (C), qualifies for an exemption under this paragraph, and elects to implement the exemption, shall promptly notify the Secretary, the appropriate State agencies, and participants and beneficiaries in the plan of such election.

(ii) Requirement

A notification to the Secretary under clause (i) shall include—

(I) a description of the number of covered lives under the plan (or coverage) involved at the time of the notification, and as applicable, at the time of any prior election of the cost-exemption under this paragraph by such plan (or coverage);

(II) for both the plan year upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan; and

(III) for both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage with respect to mental health and substance use disorder benefits under the plan.

(iii) Confidentiality

A notification to the Secretary under clause (i) shall be confidential. The Secretary shall make available, upon request and on not more than an annual basis, an anonymous itemization of such notifications, that includes—

(I) a breakdown of States by the size and type of employers submitting such notification; and

(II) a summary of the data received under clause (ii).

(F) Audits by appropriate agencies

To determine compliance with this paragraph, the Secretary may audit the books and records of a group health plan or health insurance issuer relating to an exemption, including any actuarial reports prepared pursuant to subparagraph (C), during the 6 year period following the notification of such exemption under subparagraph (E). A State agency receiving a notification under subparagraph (E) may also conduct such an audit with respect to an exemption covered by such notification.

(d) Separate application to each option offered

In the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, the requirements of this section shall be applied separately with respect to each such option.

(e) Definitions

For purposes of this section—

(1) Aggregate lifetime limit

The term ''aggregate lifetime limit'' means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit.

(2) Annual limit

The term ''annual limit'' means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount of benefits that may be paid with respect to such benefits in a 12-month period under the plan or health insurance coverage with respect to an individual or other coverage unit.

(3) Medical or surgical benefits

The term ''medical or surgical benefits'' means benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage (as the case may be), but does not include mental health or substance use disorder benefits.

(4) Mental health benefits

The term ''mental health benefits'' means benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law.

(5) Substance use disorder benefits

The term ''substance use disorder benefits'' means benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law.

(July 1, 1944, ch. 373, title XXVII, § 2726, formerly § 2705, as added Pub. L. 104–204, title VII, § 703(a), Sept. 26, 1996, 110 Stat. 2947; amended Pub. L. 107–116, title VII, § 701(b), Jan. 10, 2002, 115 Stat. 2228; Pub. L. 107–313, § 2(b), Dec. 2, 2002, 116 Stat. 2457; Pub. L. 108–197, § 2(b), Dec. 19, 2003, 117 Stat. 2898; Pub. L. 108–311, title III, § 302(c), Oct. 4, 2004, 118 Stat. 1179; Pub. L. 109–151, § 1(b), Dec. 30, 2005, 119 Stat. 2886; Pub. L. 109–432, div. A, title I, § 115(c), Dec. 20, 2006, 120 Stat. 2941; Pub. L. 110–245, title IV, § 401(c), June 17, 2008, 122 Stat. 1650; Pub. L. 110–343, div. C, title V, § 512(b), (g)(2), Oct. 3, 2008, 122 Stat. 3885, 3892; renumbered § 2726 and amended Pub. L. 111–148, title I, §§ 1001(2), 1563(c)(4), formerly § 1562(c)(4), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 265, 911.)

CODIFICATION

Section was formerly classified to section 300gg–5 of this title prior to renumbering by Pub. L. 111–148.

AMENDMENTS

2010—Subsecs. (a), (b). Pub. L. 111–148, § 1563(c)(4)(A), (B), formerly § 1562(c)(4)(A), (B), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''or a health insurance issuer offering group or individual health insurance coverage'' for ''(or health insurance coverage offered in connection with such a plan)'' wherever appearing.

Subsec. (c)(1). Pub. L. 111–148, § 1563(c)(4)(C)(i), formerly § 1562(c)(4)(C)(i), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''and a health insurance issuer offering group or individual health insurance coverage'' for ''(and group health insurance coverage offered in connection with a group health plan)''.

Subsec. (c)(2)(A). Pub. L. 111–148, § 1563(c)(4)(C)(ii), formerly § 1562(c)(4)(C)(ii), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''or a health insurance issuer offering group or individual health insurance coverage'' for ''(or health insurance coverage offered in connection with such a plan)''.

2008—Pub. L. 110–343, § 512(g)(2), amended section catchline generally. Prior to amendment, catchline read as follows: ''Parity in application of certain limits to mental health benefits''.

Subsec. (a)(1), (2). Pub. L. 110–343, § 512(b)(7), substituted ''mental health or substance use disorder benefits'' for ''mental health benefits'' wherever appearing in pars. (1)(introductory provisions), (A), and (B)(ii) and (2)(introductory provisions), (A), and (B)(ii).

Pub. L. 110–343, § 512(b)(6), substituted ''mental health and substance use disorder benefits'' for ''mental health benefits'' wherever appearing in pars. (1)(B)(i) and (C) and (2)(B)(i) and (C).

Subsec. (a)(3) to (5). Pub. L. 110–343, § 512(b)(1), added pars. (3) to (5).

Subsec. (b)(1). Pub. L. 110–343, § 512(b)(7), substituted ''mental health or substance use disorder benefits'' for ''mental health benefits''.

Subsec. (b)(2). Pub. L. 110–343, § 512(b)(2), amended par. (2) generally. Prior to amendment, par. (2) read as follows: ''in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides mental health benefits, as affecting the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under the plan or coverage, except as specifically provided in subsection (a) of this section (in regard to parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits).''

Subsec. (c)(1). Pub. L. 110–343, § 512(b)(3)(A), inserted ''(as defined in section 300gg–91(e)(4) of this title, except that for purposes of this paragraph such term shall include employers with 1 employee in the case of an employer residing in a State that permits small groups to include a single individual)'' before period at end.

Subsec. (c)(2). Pub. L. 110–343, § 512(b)(3)(B), added par. (2) and struck out former par. (2). Prior to amendment, text read as follows: ''This section shall not apply with respect to a group health plan (or health insurance coverage offered in connection with a group health plan) if the application of this section to such plan (or to such coverage) results in an increase in the cost under the plan (or for such coverage) of at least 1 percent.''

Subsec. (e)(3). Pub. L. 110–343, § 512(b)(7), substituted ''mental health or substance use disorder benefits'' for ''mental health benefits''.

Subsec. (e)(4). Pub. L. 110–343, § 512(b)(7), which directed substitution of ''mental health or substance use disorder benefits'' for ''mental health benefits'' wherever appearing in this section (other than in any provision amended by section 512(b)(6) of Pub. L. 110–343), was not executed to par. (4) as added by Pub. L. 110–343, § 512(b)(4), to reflect the probable intent of Congress. See below.

Pub. L. 110–343, § 512(b)(4), added par. (4) and struck out former par. (4). Prior to amendment, text read as follows: ''The term 'mental health benefits' means benefits with respect to mental health services, as defined under the terms of the plan or coverage (as the case may be), but does not include benefits with respect to treatment of substance abuse or chemical dependency.''

Subsec. (e)(5). Pub. L. 110–343, § 512(b)(4), added par. (5).

Subsec. (f). Pub. L. 110–343, § 512(b)(5), struck out subsec. (f). Text read as follows: ''This section shall not apply to benefits for services furnished—

''(1) on or after January 1, 2008, and before June 17, 2008, and

''(2) after December 31, 2008..''

Pub. L. 110–245 substituted ''services furnished—'' for ''services furnished after December 31, 2007'' and added pars. (1) and (2).

2006—Subsec. (f). Pub. L. 109–432 substituted ''2007'' for ''2006''.

2005—Subsec. (f). Pub. L. 109–151 substituted ''December 31, 2006'' for ''December 31, 2005''.

2004—Subsec. (f). Pub. L. 108–311 substituted ''after December 31, 2005'' for ''on or after December 31, 2004''.

2003—Subsec. (f). Pub. L. 108–197 substituted ''December 31, 2004'' for ''December 31, 2003''.

2002—Subsec. (f). Pub. L. 107–313 substituted ''December 31, 2003'' for ''December 31, 2002''.

Pub. L. 107–116 substituted ''December 31, 2002'' for ''September 30, 2001''.

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–343, div. C, title V, § 512(e), Oct. 3, 2008, 122 Stat. 3891, as amended by Pub. L. 110–460, § 1, Dec. 23, 2008, 122 Stat. 5123, provided that:

''(1) IN GENERAL.—The amendments made by this section [amending this section, section 9812 of Title 26, Internal Revenue Code, and section 1185a of Title 29, Labor] shall apply with respect to group health plans for plan years beginning after the date that is 1 year after the date of enactment of this Act [Oct. 3, 2008], regardless of whether regulations have been issued to carry out such amendments by such effective date, except that the amendments made by subsections (a)(5), (b)(5), and (c)(5) [amending this section, section 9812 of Title 26, and section 1185a of Title 29], relating to striking of certain sunset provisions, shall take effect on January 1, 2009.

''(2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enact-

ment of this Act [Oct. 3, 2008], the amendments made by this section shall not apply to plan years beginning before the later of—

''(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

''(B) January 1, 2010.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.''

EFFECTIVE DATE

Pub. L. 104–204, title VII, §703(b), Sept. 26, 1996, 110 Stat. 2950, provided that: ''The amendments made by this section [enacting this section] shall apply with respect to group health plans for plan years beginning on or after January 1, 1998.''

REGULATIONS

Pub. L. 110–343, div. C, title V, §512(d), Oct. 3, 2008, 122 Stat. 3891, provided that: ''Not later than 1 year after the date of enactment of this Act [Oct. 3, 2008], the Secretaries of Labor, Health and Human Services, and the Treasury shall issue regulations to carry out the amendments made by subsections (a), (b), and (c) [amending this section, section 9812 of Title 26, Internal Revenue Code, and section 1185a of Title 29, Labor], respectively.''

ASSURING COORDINATION

Pub. L. 110–343, div. C, title V, §512(f), Oct. 3, 2008, 122 Stat. 3892, provided that: ''The Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury may ensure, through the execution or revision of an interagency memorandum of understanding among such Secretaries, that—

''(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under this section [amending this section, section 9812 of Title 26, Internal Revenue Code, and section 1185a of Title 29, Labor, and enacting provisions set out as notes under this section] (and the amendments made by this section) are administered so as to have the same effect at all times; and

''(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.''

§ 300gg–27. Required coverage for reconstructive surgery following mastectomies

The provisions of section 1185b of title 29 shall apply to group health plans, and and[1] health insurance issuers offering group or individual health insurance coverage, as if included in this subpart.

(July 1, 1944, ch. 373, title XXVII, §2727, formerly §2706, as added Pub. L. 105–277, div. A, §101(f) [title IX, §903(a)], Oct. 21, 1998, 112 Stat. 2681–337, 2681–438; renumbered §2727 and amended Pub. L. 111–148, title I, §§1001(2), 1563(c)(5), formerly §1562(c)(5), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 266, 911.)

CODIFICATION

Section was formerly classified to section 300gg–6 of this title prior to renumbering by Pub. L. 111–148.

[1] So in original.

AMENDMENTS

2010—Pub. L. 111–148, §1563(c)(5), formerly §1562(c)(5), as renumbered by Pub. L. 111–148, §10107(b)(1), substituted ''and health insurance issuers offering group or individual health insurance coverage'' for ''health insurance issuers providing health insurance coverage in connection with group health plans''.

EFFECTIVE DATE

Pub. L. 105–277, div. A, §101(f) [title IX, §903(c)(1)], Oct. 21, 1998, 112 Stat. 2681–337, 2681–438, provided that:

''(A) IN GENERAL.—The amendment made by subsection (a) [enacting this section] shall apply to group health plans for plan years beginning on or after the date of enactment of this Act [Oct. 21, 1998].

''(B) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by the amendment made by subsection (a) shall not be treated as a termination of such collective bargaining agreement.''

§ 300gg–28. Coverage of dependent students on medically necessary leave of absence

(a) Medically necessary leave of absence

In this section, the term ''medically necessary leave of absence'' means, with respect to a dependent child described in subsection (b)(2) in connection with a group health plan or individual health insurance coverage, a leave of absence of such child from a postsecondary educational institution (including an institution of higher education as defined in section 1002 of title 20), or any other change in enrollment of such child at such an institution, that—

(1) commences while such child is suffering from a serious illness or injury;

(2) is medically necessary; and

(3) causes such child to lose student status for purposes of coverage under the terms of the plan or coverage.

(b) Requirement to continue coverage

(1) In general

In the case of a dependent child described in paragraph (2), a group health plan, or a health insurance issuer that offers group or individual health insurance coverage, shall not terminate coverage of such child under such plan or health insurance coverage due to a medically necessary leave of absence before the date that is the earlier of—

(A) the date that is 1 year after the first day of the medically necessary leave of absence; or

(B) the date on which such coverage would otherwise terminate under the terms of the plan or health insurance coverage.

(2) Dependent child described

A dependent child described in this paragraph is, with respect to a group health plan or individual health insurance coverage, a beneficiary under the plan who—

(A) is a dependent child, under the terms of the plan or coverage, of a participant or beneficiary under the plan or coverage; and

(B) was enrolled in the plan or coverage, on the basis of being a student at a post-