ant to a plan termination occurring before 1986 if such corporation was incorporated in the State of Delaware in March, 1978, and became a parent corporation of the consolidated group on September 19, 1978, pursuant to a merger agreement recorded in the State of Nevada on September 19, 1978.

''(3) TERMINATION DATE.—For purposes of paragraph (2), the term 'termination date' is the date of the termination (within the meaning of section 411(d)(3) of the Internal Revenue Code of 1986) of the plan.

''(4) TRANSITION RULE FOR CERTAIN TERMINATIONS.—

''(A) IN GENERAL.—In the case of a taxpayer to which this paragraph applies, the amendments made by this section shall not apply to any termination occurring before the date which is 1 year after the date of the enactment of this Act [Oct. 22, 1986].

''(B) TAXPAYERS TO WHOM PARAGRAPH APPLIES.—This paragraph shall apply to—

''(i) a corporation incorporated on June 13, 1917, which has its principal place of business in Bartlesville, Oklahoma,

''(ii) a corporation incorporated on January 17, 1917, which is located in Coatesville, Pennsylvania,

''(iii) a corporation incorporated on January 23, 1928, which has its principal place of business in New York, New York,

''(iv) a corporation incorporated on April 23, 1956, which has its principal place of business in Dallas, Texas, and

''(v) a corporation incorporated in the State of Nevada, the principal place of business of which is in Denver, Colorado, and which filed for relief from creditors under the United States Bankruptcy Code on August 28, 1986.

''(5) SPECIAL RULE FOR EMPLOYEE STOCK OWNERSHIP PLANS.—Section 4980(c)(3) of the Internal Revenue Code of 1986 (as added by subsection (a)) shall apply to reversions occurring after March 31, 1985.''

TRANSFER OF EXCESS ASSETS FROM QUALIFIED PENSION PLAN TO WELFARE BENEFIT PLAN

Pub. L. 101–239, title VII, §7861(b), Dec. 19, 1989, 103 Stat. 2430, provided that:

''(1) Notwithstanding any other provision of law, in the case of any qualified pension plan and welfare benefit plan described in paragraph (2), the assets of such pension plan in excess of its liabilities may be transferred to such welfare benefit plan upon the termination of such pension plan if such assets are to be used to provide retiree health benefits.

''(2) For purposes of paragraph (1), a qualified pension plan and welfare benefit plan are described in this paragraph if—

''(A) both such plans are jointly administered pursuant to a collective bargaining agreement between the employer maintaining such plans and one or more employee representatives,

''(B) the welfare benefit plan provides retiree health benefits, and

''(C) the qualified pension plan has assets in excess of liabilities (determined on a termination basis) and the welfare benefit plan has assets which are less than the present value of the benefits to be provided under the plan (determined as of the time of termination of the pension plan).

''(3) For purposes of the Internal Revenue Code of 1986, any transfer of assets to which paragraph (1) applies shall be treated as a reversion of such assets to the employer maintaining the plan which is includible in the gross income of such employer and subject to the tax imposed by section 4980 of such Code.''

PLAN AMENDMENTS NOT REQUIRED UNTIL JANUARY 1, 1989

For provisions directing that if any amendments made by subtitle A or subtitle C of title XI [§§1101–1147 and 1171–1177] or title XVIII [§§1800–1899A] of Pub. L. 99–514 require an amendment to any plan, such plan amendment shall not be required to be made before the first plan year beginning on or after Jan. 1, 1989, see section 1140 of Pub. L. 99–514, as amended, set out as a note under section 401 of this title.

[§ 4980A. Repealed. Pub. L. 105–34, title X, § 1073(a), Aug. 5, 1997, 111 Stat. 948]

Section, added Pub. L. 99–514, title XI, §1133(a), Oct. 22, 1986, 100 Stat. 2481, §4981A; renumbered §4980A and amended Pub. L. 100–647, title I, §1011A(g)(1)(A), (2)–(6), (9), Nov. 10, 1988, 102 Stat. 3479–3482; Pub. L. 102–318, title V, §521(b)(42), July 3, 1992, 106 Stat. 313; Pub. L. 104–188, title I, §§1401(b)(12), 1452(b), Aug. 20, 1996, 110 Stat. 1789, 1816, related to tax on excess distributions from qualified retirement plans.

EFFECTIVE DATE OF REPEAL

Pub. L. 105–34, title X, §1073(c), Aug. 5, 1997, 111 Stat. 948, provided that:

''(1) EXCESS DISTRIBUTION TAX REPEAL.—Except as provided in paragraph (2), the repeal made by subsection (a) [repealing this section] shall apply to excess distributions received after December 31, 1996.

''(2) EXCESS RETIREMENT ACCUMULATION TAX REPEAL.—The repeal made by subsection (a) with respect to section 4980A(d) of the Internal Revenue Code of 1986 and the amendments made by subsection (b) [amending sections 691, 2013, 2053, and 6018 of this title] shall apply to estates of decedents dying after December 31, 1996.''

§ 4980B. Failure to satisfy continuation coverage requirements of group health plans

(a) General rule

There is hereby imposed a tax on the failure of a group health plan to meet the requirements of subsection (f) with respect to any qualified beneficiary.

(b) Amount of tax

(1) In general

The amount of the tax imposed by subsection (a) on any failure with respect to a qualified beneficiary shall be $100 for each day in the noncompliance period with respect to such failure.

(2) Noncompliance period

For purposes of this section, the term ''noncompliance period'' means, with respect to any failure, the period—

(A) beginning on the date such failure first occurs, and

(B) ending on the earlier of—

(i) the date such failure is corrected, or

(ii) the date which is 6 months after the last day in the period applicable to the qualified beneficiary under subsection (f)(2)(B) (determined without regard to clause (iii) thereof).

If a person is liable for tax under subsection (e)(1)(B) by reason of subsection (e)(2)(B) with respect to any failure, the noncompliance period for such person with respect to such failure shall not begin before the 45th day after the written request described in subsection (e)(2)(B) is provided to such person.

(3) Minimum tax for noncompliance period where failure discovered after notice of examination

Notwithstanding paragraphs (1) and (2) of subsection (c)—

(A) In general

In the case of 1 or more failures with respect to a qualified beneficiary—

(i) which are not corrected before the date a notice of examination of income tax liability is sent to the employer, and

(ii) which occurred or continued during the period under examination,

the amount of tax imposed by subsection (a) by reason of such failures with respect to such beneficiary shall not be less than the lesser of $2,500 or the amount of tax which would be imposed by subsection (a) without regard to such paragraphs.

(B) Higher minimum tax where violations are more than de minimis

To the extent violations by the employer (or the plan in the case of a multiemployer plan) for any year are more than de minimis, subparagraph (A) shall be applied by substituting ''$15,000'' for ''$2,500'' with respect to the employer (or such plan).

(c) Limitations on amount of tax

(1) Tax not to apply where failure not discovered exercising reasonable diligence

No tax shall be imposed by subsection (a) on any failure during any period for which it is established to the satisfaction of the Secretary that none of the persons referred to in subsection (e) knew, or exercising reasonable diligence would have known, that such failure existed.

(2) Tax not to apply to failures corrected within 30 days

No tax shall be imposed by subsection (a) on any failure if—

(A) such failure was due to reasonable cause and not to willful neglect, and

(B) such failure is corrected during the 30-day period beginning on the 1st date any of the persons referred to in subsection (e) knew, or exercising reasonable diligence would have known, that such failure existed.

(3) $100 limit on amount of tax for failures on any day with respect to a qualified beneficiary

(A) In general

Except as provided in subparagraph (B), the maximum amount of tax imposed by subsection (a) on failures on any day during the noncompliance period with respect to a qualified beneficiary shall be $100.

(B) Special rule where more than 1 qualified beneficiary

If there is more than 1 qualified beneficiary with respect to the same qualifying event, the maximum amount of tax imposed by subsection (a) on all failures on any day during the noncompliance period with respect to such qualified beneficiaries shall be $200.

(4) Overall limitation for unintentional failures

In the case of failures which are due to reasonable cause and not to willful neglect—

(A) Single employer plans

(i) In general

In the case of failures with respect to plans other than multiemployer plans, the tax imposed by subsection (a) for failures during the taxable year of the employer shall not exceed the amount equal to the lesser of—

(I) 10 percent of the aggregate amount paid or incurred by the employer (or predecessor employer) during the preceding taxable year for group health plans, or

(II) $500,000.

(ii) Taxable years in the case of certain controlled groups

For purposes of this subparagraph, if not all persons who are treated as a single employer for purposes of this section have the same taxable year, the taxable years taken into account shall be determined under principles similar to the principles of section 1561.

(B) Multiemployer plans

(i) In general

In the case of failures with respect to a multiemployer plan, the tax imposed by subsection (a) for failures during the taxable year of the trust forming part of such plan shall not exceed the amount equal to the lesser of—

(I) 10 percent of the amount paid or incurred by such trust during such taxable year to provide medical care (as defined in section 213(d)) directly or through insurance, reimbursement, or otherwise, or

(II) $500,000.

For purposes of the preceding sentence, all plans of which the same trust forms a part shall be treated as 1 plan.

(ii) Special rule for employers required to pay tax

If an employer is assessed a tax imposed by subsection (a) by reason of a failure with respect to a multiemployer plan, the limit shall be determined under subparagraph (A) (and not under this subparagraph) and as if such plan were not a multiemployer plan.

(C) Special rule for persons providing benefits

In the case of a person described in subsection (e)(1)(B) (and not subsection (e)(1)(A)), the aggregate amount of tax imposed by subsection (a) for failures during a taxable year with respect to all plans shall not exceed $2,000,000.

(5) Waiver by Secretary

In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that the payment of such tax would be excessive relative to the failure involved.

(d) Tax not to apply to certain plans

This section shall not apply to—

(1) any failure of a group health plan to meet the requirements of subsection (f) with respect to any qualified beneficiary if the qualifying event with respect to such beneficiary oc-

curred during the calendar year immediately following a calendar year during which all employers maintaining such plan normally employed fewer than 20 employees on a typical business day,

(2) any governmental plan (within the meaning of section 414(d)), or

(3) any church plan (within the meaning of section 414(e)).

(e) Liability for tax

(1) In general

Except as otherwise provided in this subsection, the following shall be liable for the tax imposed by subsection (a) on a failure:

(A)(i) In the case of a plan other than a multiemployer plan, the employer.

(ii) In the case of a multiemployer plan, the plan.

(B) Each person who is responsible (other than in a capacity as an employee) for administering or providing benefits under the plan and whose act or failure to act caused (in whole or in part) the failure.

(2) Special rules for persons described in paragraph (1)(B)

(A) No liability unless written agreement

Except in the case of liability resulting from the application of subparagraph (B) of this paragraph, a person described in subparagraph (B) (and not in subparagraph (A)) of paragraph (1) shall be liable for the tax imposed by subsection (a) on any failure only if such person assumed (under a legally enforceable written agreement) responsibility for the performance of the act to which the failure relates.

(B) Failure to cover qualified beneficiaries where current employees are covered

A person shall be treated as described in paragraph (1)(B) with respect to a qualified beneficiary if—

(i) such person provides coverage under a group health plan for any similarly situated beneficiary under the plan with respect to whom a qualifying event has not occurred, and

(ii) the—

(I) employer or plan administrator, or

(II) in the case of a qualifying event described in subparagraph (C) or (E) of subsection (f)(3) where the person described in clause (i) is the plan administrator, the qualified beneficiary,

submits to such person a written request that such person make available to such qualified beneficiary the same coverage which such person provides to the beneficiary referred to in clause (i).

(f) Continuation coverage requirements of group health plans

(1) In general

A group health plan meets the requirements of this subsection only if the coverage of the costs of pediatric vaccines (as defined under section 2162 of the Public Health Service Act)[1] is not reduced below the coverage provided by the plan as of May 1, 1993, and only if each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled to elect, within the election period, continuation coverage under the plan.

(2) Continuation coverage

For purposes of paragraph (1), the term ''continuation coverage'' means coverage under the plan which meets the following requirements:

(A) Type of benefit coverage

The coverage must consist of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred. If coverage under the plan is modified for any group of similarly situated beneficiaries, the coverage shall also be modified in the same manner for all individuals who are qualified beneficiaries under the plan pursuant to this subsection in connection with such group.

(B) Period of coverage

The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:

(i) Maximum required period

(I) General rule for terminations and reduced hours

In the case of a qualifying event described in paragraph (3)(B), except as provided in subclause (II), the date which is 18 months after the date of the qualifying event.

(II) Special rule for multiple qualifying events

If a qualifying event (other than a qualifying event described in paragraph (3)(F)) occurs during the 18 months after the date of a qualifying event described in paragraph (3)(B), the date which is 36 months after the date of the qualifying event described in paragraph (3)(B).

(III) Special rule for certain bankruptcy proceedings

In the case of a qualifying event described in paragraph (3)(F) (relating to bankruptcy proceedings), the date of the death of the covered employee or qualified beneficiary (described in subsection (g)(1)(D)(iii)), or in the case of the surviving spouse or dependent children of the covered employee, 36 months after the date of the death of the covered employee.

(IV) General rule for other qualifying events

In the case of a qualifying event not described in paragraph (3)(B) or (3)(F), the date which is 36 months after the date of the qualifying event.

(V) Special rule for PBGC recipients

In the case of a qualifying event described in paragraph (3)(B) with respect

[1] See References in Text note below.

to a covered employee who (as of such qualifying event) has a nonforfeitable right to a benefit any portion of which is to be paid by the Pension Benefit Guaranty Corporation under title IV of the Employee Retirement Income Security Act of 1974, notwithstanding subclause (I) or (II), the date of the death of the covered employee, or in the case of the surviving spouse or dependent children of the covered employee, 24 months after the date of the death of the covered employee. The preceding sentence shall not require any period of coverage to extend beyond January 1, 2014.

(VI) Special rule for TAA-eligible individuals

In the case of a qualifying event described in paragraph (3)(B) with respect to a covered employee who is (as of the date that the period of coverage would, but for this subclause or subclause (VII), otherwise terminate under subclause (I) or (II)) a TAA-eligible individual (as defined in paragraph (5)(C)(iv)(II)), the period of coverage shall not terminate by reason of subclause (I) or (II), as the case may be, before the later of the date specified in such subclause or the date on which such individual ceases to be such a TAA-eligible individual. The preceding sentence shall not require any period of coverage to extend beyond January 1, 2014.

(VII) Medicare entitlement followed by qualifying event

In the case of a qualifying event described in paragraph (3)(B) that occurs less than 18 months after the date the covered employee became entitled to benefits under title XVIII of the Social Security Act, the period of coverage for qualified beneficiaries other than the covered employee shall not terminate under this clause before the close of the 36-month period beginning on the date the covered employee became so entitled.

(VIII) Special rule for disability

In the case of a qualified beneficiary who is determined, under title II or XVI of the Social Security Act, to have been disabled at any time during the first 60 days of continuation coverage under this section, any reference in subclause (I) or (II) to 18 months is deemed a reference to 29 months (with respect to all qualified beneficiaries), but only if the qualified beneficiary has provided notice of such determination under paragraph (6)(C) before the end of such 18 months.

(ii) End of plan

The date on which the employer ceases to provide any group health plan to any employee.

(iii) Failure to pay premium

The date on which coverage ceases under the plan by reason of a failure to make timely payment of any premium required under the plan with respect to the qualified beneficiary. The payment of any premium (other than any payment referred to in the last sentence of subparagraph (C)) shall be considered to be timely if made within 30 days after the date due or within such longer period as applies to or under the plan.

(iv) Group health plan coverage or medicare entitlement

The date on which the qualified beneficiary first becomes, after the date of the election—

(I) covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary (other than such an exclusion or limitation which does not apply to (or is satisfied by) such beneficiary by reason of chapter 100 of this title, part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, or title XXVII of the Public Health Service Act), or

(II) in the case of a qualified beneficiary other than a qualified beneficiary described in subsection (g)(1)(D) entitled to benefits under title XVIII of the Social Security Act.

(v) Termination of extended coverage for disability

In the case of a qualified beneficiary who is disabled at any time during the first 60 days of continuation coverage under this section, the month that begins more than 30 days after the date of the final determination under title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled.

(C) Premium requirements

The plan may require payment of a premium for any period of continuation coverage, except that such premium—

(i) shall not exceed 102 percent of the applicable premium for such period, and

(ii) may, at the election of the payor, be made in monthly installments.

In no event may the plan require the payment of any premium before the day which is 45 days after the day on which the qualified beneficiary made the initial election for continuation coverage. In the case of an individual described in the last sentence of subparagraph (B)(i), any reference in clause (i) of this subparagraph to ''102 percent'' is deemed a reference to ''150 percent'' for any month after the 18th month of continuation coverage described in subclause (I) or (II) of subparagraph (B)(i).

(D) No requirement of insurability

The coverage may not be conditioned upon, or discriminate on the basis of lack of, evidence of insurability.

(E) Conversion option

In the case of a qualified beneficiary whose period of continuation coverage expires

under subparagraph (B)(i), the plan must, during the 180-day period ending on such expiration date, provide to the qualified beneficiary the option of enrollment under a conversion health plan otherwise generally available under the plan.

(3) Qualifying event

For purposes of this subsection, the term ''qualifying event'' means, with respect to any covered employee, any of the following events which, but for the continuation coverage required under this subsection, would result in the loss of coverage of a qualified beneficiary—

(A) The death of the covered employee.

(B) The termination (other than by reason of such employee's gross misconduct), or reduction of hours, of the covered employee's employment.

(C) The divorce or legal separation of the covered employee from the employee's spouse.

(D) The covered employee becoming entitled to benefits under title XVIII of the Social Security Act.

(E) A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.

(F) A proceeding in a case under title 11, United States Code, commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time.

In the case of an event described in subparagraph (F), a loss of coverage includes a substantial elimination of coverage with respect to a qualified beneficiary described in subsection (g)(1)(D) within one year before or after the date of commencement of the proceeding.

(4) Applicable premium

For purposes of this subsection—

(A) In general

The term ''applicable premium'' means, with respect to any period of continuation coverage of qualified beneficiaries, the cost to the plan for such period of the coverage for similarly situated beneficiaries with respect to whom a qualifying event has not occurred (without regard to whether such cost is paid by the employer or employee).

(B) Special rule for self-insured plans

To the extent that a plan is a self-insured plan—

(i) In general

Except as provided in clause (ii), the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to a reasonable estimate of the cost of providing coverage for such period for similarly situated beneficiaries which—

(I) is determined on an actuarial basis, and

(II) takes into account such factors as the Secretary may prescribe in regulations.

(ii) Determination on basis of past cost

If a plan administrator elects to have this clause apply, the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to—

(I) the cost to the plan for similarly situated beneficiaries for the same period occurring during the preceding determination period under subparagraph (C), adjusted by

(II) the percentage increase or decrease in the implicit price deflator of the gross national product (calculated by the Department of Commerce and published in the Survey of Current Business) for the 12-month period ending on the last day of the sixth month of such preceding determination period.

(iii) Clause (ii) not to apply where significant change

A plan administrator may not elect to have clause (ii) apply in any case in which there is any significant difference between the determination period and the preceding determination period, in coverage under, or in employees covered by, the plan. The determination under the preceding sentence for any determination period shall be made at the same time as the determination under subparagraph (C).

(C) Determination period

The determination of any applicable premium shall be made for a period of 12 months and shall be made before the beginning of such period.

(5) Election

For purposes of this subsection—

(A) Election period

The term ''election period'' means the period which—

(i) begins not later than the date on which coverage terminates under the plan by reason of a qualifying event,

(ii) is of at least 60 days' duration, and

(iii) ends not earlier than 60 days after the later of—

(I) the date described in clause (i), or

(II) in the case of any qualified beneficiary who receives notice under paragraph (6)(D), the date of such notice.

(B) Effect of election on other beneficiaries

Except as otherwise specified in an election, any election of continuation coverage by a qualified beneficiary described in subparagraph (A)(i) or (B) of subsection (g)(1) shall be deemed to include an election of continuation coverage on behalf of any other qualified beneficiary who would lose coverage under the plan by reason of the qualifying event. If there is a choice among types of coverage under the plan, each qualified beneficiary is entitled to make a separate selection among such types of coverage.

(C) Temporary extension of COBRA election period for certain individuals

(i) In general

In the case of a nonelecting TAA-eligible individual and notwithstanding subpara-

graph (A), such individual may elect continuation coverage under this subsection during the 60-day period that begins on the first day of the month in which the individual becomes a TAA-eligible individual, but only if such election is made not later than 6 months after the date of the TAA-related loss of coverage.

(ii) Commencement of coverage; no reach-back

Any continuation coverage elected by a TAA-eligible individual under clause (i) shall commence at the beginning of the 60-day election period described in such paragraph and shall not include any period prior to such 60-day election period.

(iii) Preexisting conditions

With respect to an individual who elects continuation coverage pursuant to clause (i), the period—

(I) beginning on the date of the TAA-related loss of coverage, and

(II) ending on the first day of the 60-day election period described in clause (i),

shall be disregarded for purposes of determining the 63-day periods referred to in section 9801(c)(2), section 701(c)(2) of the Employee Retirement Income Security Act of 1974, and section 2701(c)(2)[1] of the Public Health Service Act.

(iv) Definitions

For purposes of this subsection:

(I) Nonelecting TAA-eligible individual

The term ''nonelecting TAA-eligible individual'' means a TAA-eligible individual who has a TAA-related loss of coverage and did not elect continuation coverage under this subsection during the TAA-related election period.

(II) TAA-eligible individual

The term ''TAA-eligible individual'' means an eligible TAA recipient (as defined in paragraph (2) of section 35(c)) and an eligible alternative TAA recipient (as defined in paragraph (3) of such section).

(III) TAA-related election period

The term ''TAA-related election period'' means, with respect to a TAA-related loss of coverage, the 60-day election period under this subsection which is a direct consequence of such loss.

(IV) TAA-related loss of coverage

The term ''TAA-related loss of coverage'' means, with respect to an individual whose separation from employment gives rise to being an TAA-eligible individual, the loss of health benefits coverage associated with such separation.

(6) Notice requirement

In accordance with regulations prescribed by the Secretary—

(A) The group health plan shall provide, at the time of commencement of coverage under the plan, written notice to each covered employee and spouse of the employee (if any) of the rights provided under this subsection.

(B) The employer of an employee under a plan must notify the plan administrator of a qualifying event described in subparagraph (A), (B), (D), or (F) of paragraph (3) with respect to such employee within 30 days (or, in the case of a group health plan which is a multiemployer plan, such longer period of time as may be provided in the terms of the plan) of the date of the qualifying event.

(C) Each covered employee or qualified beneficiary is responsible for notifying the plan administrator of the occurrence of any qualifying event described in subparagraph (C) or (E) of paragraph (3) within 60 days after the date of the qualifying event and each qualified beneficiary who is determined, under title II or XVI of the Social Security Act, to have been disabled at any time during the first 60 days of continuation coverage under this section is responsible for notifying the plan administrator of such determination within 60 days after the date of the determination and for notifying the plan administrator within 30 days of the date of any final determination under such title or titles that the qualified beneficiary is no longer disabled.

(D) The plan administrator shall notify—

(i) in the case of a qualifying event described in subparagraph (A), (B), (D), or (F) of paragraph (3), any qualified beneficiary with respect to such event, and

(ii) in the case of a qualifying event described in subparagraph (C) or (E) of paragraph (3) where the covered employee notifies the plan administrator under subparagraph (C), any qualified beneficiary with respect to such event,

of such beneficiary's rights under this subsection.

The requirements of subparagraph (B) shall be considered satisfied in the case of a multiemployer plan in connection with a qualifying event described in paragraph (3)(B) if the plan provides that the determination of the occurrence of such qualifying event will be made by the plan administrator. For purposes of subparagraph (D), any notification shall be made within 14 days (or, in the case of a group health plan which is a multiemployer plan, such longer period of time as may be provided in the terms of the plan) of the date on which the plan administrator is notified under subparagraph (B) or (C), whichever is applicable, and any such notification to an individual who is a qualified beneficiary as the spouse of the covered employee shall be treated as notification to all other qualified beneficiaries residing with such spouse at the time such notification is made.

(7) Covered employee

For purposes of this subsection, the term ''covered employee'' means an individual who is (or was) provided coverage under a group health plan by virtue of the performance of

services by the individual for 1 or more persons maintaining the plan (including as an employee defined in section 401(c)(1)).

(8) Optional extension of required periods

A group health plan shall not be treated as failing to meet the requirements of this subsection solely because the plan provides both—

(A) that the period of extended coverage referred to in paragraph (2)(B) commences with the date of the loss of coverage, and

(B) that the applicable notice period provided under paragraph (6)(B) commences with the date of the loss of coverage.

(g) Definitions

For purposes of this section—

(1) Qualified beneficiary

(A) In general

The term ''qualified beneficiary'' means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan—

(i) as the spouse of the covered employee, or

(ii) as the dependent child of the employee.

Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continuation coverage under this section.

(B) Special rule for terminations and reduced employment

In the case of a qualifying event described in subsection (f)(3)(B), the term ''qualified beneficiary'' includes the covered employee.

(C) Exception for nonresident aliens

Notwithstanding subparagraphs (A) and (B), the term ''qualified beneficiary'' does not include an individual whose status as a covered employee is attributable to a period in which such individual was a nonresident alien who received no earned income (within the meaning of section 911(d)(2)) from the employer which constituted income from sources within the United States (within the meaning of section 861(a)(3)). If an individual is not a qualified beneficiary pursuant to the previous sentence, a spouse or dependent child of such individual shall not be considered a qualified beneficiary by virtue of the relationship of the individual.

(D) Special rule for retirees and widows

In the case of a qualifying event described in subsection (f)(3)(F), the term ''qualified beneficiary'' includes a covered employee who had retired on or before the date of substantial elimination of coverage and any other individual who, on the day before such qualifying event, is a beneficiary under the plan—

(i) as the spouse of the covered employee,

(ii) as the dependent child of the covered employee, or

(iii) as the surviving spouse of the covered employee.

(2) Group health plan

The term ''group health plan'' has the meaning given such term by section 5000(b)(1). Such term shall not include any plan substantially all of the coverage under which is for qualified long-term care services (as defined in section 7702B(c)).

(3) Plan administrator

The term ''plan administrator'' has the meaning given the term ''administrator'' by section 3(16)(A) of the Employee Retirement Income Security Act of 1974.

(4) Correction

A failure of a group health plan to meet the requirements of subsection (f) with respect to any qualified beneficiary shall be treated as corrected if—

(A) such failure is retroactively undone to the extent possible, and

(B) the qualified beneficiary is placed in a financial position which is as good as such beneficiary would have been in had such failure not occurred.

For purposes of applying subparagraph (B), the qualified beneficiary shall be treated as if he had elected the most favorable coverage in light of the expenses he incurred since the failure first occurred.

(Added Pub. L. 100–647, title III, §3011(a), Nov. 10, 1988, 102 Stat. 3616; amended Pub. L. 101–239, title VI, §§6202(b)(3)(B), 6701(a)–(c), title VII, §§7862(c)(2)(B), (3)(C), (4)(B), (5)(A), 7891(d)(1)(B), (2)(A), Dec. 19, 1989, 103 Stat. 2233, 2294, 2295, 2432, 2433, 2446; Pub. L. 101–508, title XI, §11702(f), Nov. 5, 1990, 104 Stat. 1388–515; Pub. L. 103–66, title XIII, §13422(a), Aug. 10, 1993, 107 Stat. 566; Pub. L. 104–188, title I, §1704(g)(1)(A), (t)(21), Aug. 20, 1996, 110 Stat. 1880, 1888; Pub. L. 104–191, title III, §321(d)(1), title IV, §421(c), Aug. 21, 1996, 110 Stat. 2058, 2088; Pub. L. 107–210, div. A, title II, §203(e)(3), Aug. 6, 2002, 116 Stat. 971; Pub. L. 111–5, div. B, title I, §1899F(b), Feb. 17, 2009, 123 Stat. 429; Pub. L. 111–344, title I, §116(b), Dec. 29, 2010, 124 Stat. 3616; Pub. L. 112–40, title II, §243(a)(3), (4), Oct. 21, 2011, 125 Stat. 420.)

REFERENCES IN TEXT

The Public Health Service Act, referred to in subsec. (f)(1), does not contain a section 2162. The reference probably should be to section 1928 of the Social Security Act, which is classified to section 1396s of Title 42, The Public Health and Welfare, and which relates to pediatric vaccines.

The Social Security Act, referred to in subsec. (f)(2)(B)(i)(IV), (VII), (VIII), (iv)(II), (v), (3)(D), (6)(C), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Titles II, XVI, and XVIII of the Social Security Act are classified generally to subchapters II (§401 et seq.), XVI (§1381 et seq.), and XVIII (§1395 et seq.), respectively, of chapter 7 of Title 42, The Public Health and Welfare. For complete classification of this Act to the Code, see section 1305 of Title 42 and Tables.

The Employee Retirement Income Security Act of 1974, referred to in subsecs. (f)(2)(B)(i)(V), (iv)(I), (5)(C)(iii), and (g)(3), is Pub. L. 93–406, Sept. 2, 1974, 88 Stat. 832. Part 7 of subtitle B of title I of the Act is classified generally to part 7 (§1181 et seq.) of subtitle B of subchapter I of chapter 18 of Title 29, Labor. Sections 3(16)(A) and 701(c)(2) of the Act are classified to sections 1002(16)(A) and 1181(c)(2), respectively, of Title 29. Title IV of the Act is classified principally to sub-

chapter III (§ 1301 et seq.) of chapter 18 of Title 29. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

The Public Health Service Act, referred to in subsec. (f)(2)(B)(iv)(I), is act July 1, 1944, ch. 373, 58 Stat. 682. Title XXVII of the Act is classified generally to subchapter XXV (§ 300gg 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.

Section 2701 of the Public Health Service Act, referred to in subsec. (f)(5)(C)(iii), was classified to section 300gg of Title 42, The Public Health and Welfare, 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 Title 42. A new section 2701, related to fair health insurance premiums, was added 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 Title 42.

AMENDMENTS

2011—Subsec. (f)(2)(B)(i)(V), (VI). Pub. L. 112–40 substituted ''January 1, 2014'' for ''February 12, 2011''.

2010—Subsec. (f)(2)(B)(i)(V), (VI). Pub. L. 111–344 substituted ''February 12, 2011'' for ''December 31, 2010''.

2009—Subsec. (f)(2)(B)(i)(V). Pub. L. 111–5, § 1899F(b)(2), added subcl. (V). Former subcl. (V) redesignated (VII).

Subsec. (f)(2)(B)(i)(VI). Pub. L. 111–5, § 1899F(b)(2), added subcl. (VI). Former subcl. (VI) redesignated (VIII).

Pub. L. 111–5, § 1899F(b)(1), designated concluding provisions as subcl. (VI) and inserted heading.

Subsec. (f)(2)(B)(i)(VII), (VIII). Pub. L. 111–5, § 1899F(b)(2), designated subcls. (V) and (VI) as (VII) and (VIII), respectively.

2002—Subsec. (f)(5)(C). Pub. L. 107–210 added subpar. (C).

1996—Subsec. (f)(2)(B)(i). Pub. L. 104–191, § 421(c)(1)(A), in concluding provisions, substituted ''at any time during the first 60 days of continuation coverage under this section'' for ''at the time of a qualifying event described in paragraph (3)(B)'', struck out ''with respect to such event'' after ''(II) to 18 months'', and inserted ''(with respect to all qualified beneficiaries)'' after ''29 months''.

Pub. L. 104–188, § 1704(t)(21), made technical amendment to directory language of Pub. L. 101–239, § 6701(a)(1). See 1989 Amendment note below.

Subsec. (f)(2)(B)(i)(V). Pub. L. 104–188, § 1704(g)(1)(A), substituted ''Medicare entitlement followed by qualifying event'' for ''Qualifying event involving medicare entitlement'' in heading and amended text generally. Prior to amendment, text read as follows: ''In the case of an event described in paragraph (3)(D) (without regard to whether such event is a qualifying event), the period of coverage for qualified beneficiaries other than the covered employee for such event or any subsequent qualifying event shall not terminate before the close of the 36-month period beginning on the date the covered employee becomes entitled to benefits under title XVIII of the Social Security Act.''

Subsec. (f)(2)(B)(iv)(I). Pub. L. 104–191, § 421(c)(1)(B), inserted ''(other than such an exclusion or limitation which does not apply to (or is satisfied by) such beneficiary by reason of chapter 100 of this title, part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, or title XXVII of the Public Health Service Act)'' before '', or''.

Subsec. (f)(2)(B)(v). Pub. L. 104–191, § 421(c)(1)(C), substituted ''at any time during the first 60 days of continuation coverage under this section'' for ''at the time of a qualifying event described in paragraph (3)(B)''.

Subsec. (f)(6)(C). Pub. L. 104–191, § 421(c)(2), substituted ''at any time during the first 60 days of continuation coverage under this section'' for ''at the time of a qualifying event described in paragraph (3)(B)''.

Subsec. (g)(1)(A). Pub. L. 104–191, § 421(c)(3), inserted at end ''Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continuation coverage under this section.''

Subsec. (g)(2). Pub. L. 104–191, § 321(d)(1), inserted at end ''Such term shall not include any plan substantially all of the coverage under which is for qualified long-term care services (as defined in section 7702B(c)).''

1993—Subsec. (f)(1). Pub. L. 103–66 inserted ''the coverage of the costs of pediatric vaccines (as defined under section 2162 of the Public Health Service Act) is not reduced below the coverage provided by the plan as of May 1, 1993, and only if'' after ''only if''.

1990—Subsec. (d)(1). Pub. L. 101–508 amended par. (1) generally. Prior to amendment, par. (1) read as follows: ''any failure of a group health plan to meet the requirements of subsection (f) if all employers maintaining such plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year,''.

1989—Subsec. (f)(2)(B)(i). Pub. L. 101–239, § 6701(a)(1), as amended by Pub. L. 104–188, § 1704(t)(21), inserted at end ''In the case of a qualified beneficiary who is determined, under title II or XVI of the Social Security Act, to have been disabled at the time of a qualifying event described in paragraph (3)(B), any reference in subclause (I) or (II) to 18 months with respect to such event is deemed a reference to 29 months, but only if the qualified beneficiary has provided notice of such determination under paragraph (6)(C) before the end of such 18 months.''

Subsec. (f)(2)(B)(i)(V). Pub. L. 101–239, § 7862(c)(5)(A), added subcl. (V).

Subsec. (f)(2)(B)(iv). Pub. L. 101–239, § 7862(c)(3)(C), substituted ''entitlement'' for ''eligibility'' in heading and inserted ''which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary'' after ''or otherwise)'' in subcl. (I).

Subsec. (f)(2)(B)(v). Pub. L. 101–239, § 6701(a)(2), added cl. (v).

Subsec. (f)(2)(C). Pub. L. 101–239, § 7862(c)(4)(B), amended last sentence generally. Prior to amendment, last sentence read as follows: ''If an election is made after the qualifying event, the plan shall permit payment for continuation coverage during the period preceding the election to be made within 45 days of the date of the election.''

Pub. L. 101–239, § 6701(b), inserted at end ''In the case of an individual described in the last sentence of subparagraph (B)(i), any reference in clause (i) of this subparagraph to '102 percent' is deemed a reference to '150 percent' for any month after the 18th month of continuation coverage described in subclause (I) or (II) of subparagraph (B)(i).''

Subsec. (f)(6). Pub. L. 101–239, § 7891(d)(1)(B)(ii), inserted after and below subpar. (D) the following new flush sentence ''The requirements of subparagraph (B) shall be considered satisfied in the case of a multiemployer plan in connection with a qualifying event described in paragraph (3)(B) if the plan provides that the determination of the occurrence of such qualifying event will be made by the plan administrator.''

Pub. L. 101–239, § 7891(d)(1)(B)(i)(II), inserted ''(or, in the case of a group health plan which is a multiemployer plan, such longer period of time as may be provided in the terms of the plan)'' after ''14 days'' in last sentence.

Subsec. (f)(6)(B). Pub. L. 101–239, § 7891(d)(1)(B)(i)(I), inserted ''(or, in the case of a group health plan which is a multiemployer plan, such longer period of time as may be provided in the terms of the plan)'' after ''30 days''.

Subsec. (f)(6)(C). Pub. L. 101–239, § 6701(c), inserted before period at end ''and each qualified beneficiary who is determined, under title II or XVI of the Social Security Act, to have been disabled at the time of a qualify-

ing event described in paragraph (3)(B) is responsible for notifying the plan administrator of such determination within 60 days after the date of the determination and for notifying the plan administrator within 30 days of the date of any final determination under such title or titles that the qualified beneficiary is no longer disabled''.

Subsec. (f)(7). Pub. L. 101–239, §7862(c)(2)(B), substituted ''the performance of services by the individual for 1 or more persons maintaining the plan (including as an employee defined in section 401(c)(1))'' for ''the individual's employment or previous employment with an employer''.

Subsec. (f)(8). Pub. L. 101–239, §7891(d)(2)(A), added par. (8).

Subsec. (g)(2). Pub. L. 101–239, §6202(b)(3)(B), substituted ''section 5000(b)(1)'' for ''section 162(i)''.

EFFECTIVE DATE OF 2011 AMENDMENT

Pub. L. 112–40, title II, §243(b), Oct. 21, 2011, 125 Stat. 420, provided that: ''The amendments made by this section [amending this section, section 1162 of Title 29, Labor, and section 300bb–2 of Title 42, The Public Health and Welfare] shall apply to periods of coverage which would (without regard to the amendments made by this section) end on or after the date which is 30 days after the date of the enactment of this Act [Oct. 21, 2011].''

EFFECTIVE DATE OF 2010 AMENDMENT

Pub. L. 111–344, title I, §116(d), Dec. 29, 2010, 124 Stat. 3616, provided that: ''The amendments made by this section [amending this section, section 1162 of Title 29, Labor, and section 300bb–2 of Title 42, The Public Health and Welfare] shall apply to periods of coverage which would (without regard to the amendments made by this section) end on or after December 31, 2010.''

EFFECTIVE DATE OF 2009 AMENDMENT

Except as otherwise provided and subject to certain applicability provisions, amendment by Pub. L. 111–5 effective upon the expiration of the 90-day period beginning on Feb. 17, 2009, see section 1891 of Pub. L. 111–5, set out as an Effective and Termination Dates of 2009 Amendment note under section 2271 of Title 19, Customs Duties.

Pub. L. 111–5, div. B, title I, §1899F(d), Feb. 17, 2009, 123 Stat. 430, provided that: ''The amendments made by this section [amending this section, section 1162 of Title 29, Labor, and section 300bb–2 of Title 42, The Public Health and Welfare] shall apply to periods of coverage which would (without regard to the amendments made by this section) end on or after the date of the enactment of this Act [Feb. 17, 2009].''

EFFECTIVE DATE OF 2002 AMENDMENT

Amendment by Pub. L. 107–210 applicable to petitions for certification filed under part 2 or 3 of subchapter II of chapter 12 of Title 19, Customs Duties, on or after the date that is 90 days after Aug. 6, 2002, except as otherwise provided, see section 151 of Pub. L. 107–210, set out as a note preceding section 2271 of Title 19.

EFFECTIVE DATE OF 1996 AMENDMENTS

Amendment by section 321(d)(1) of Pub. L. 104–191 applicable to contracts issued after Dec. 31, 1996, see section 321(f) of Pub. L. 104–191, set out as an Effective Date note under section 7702B of this title.

Pub. L. 104–191, title IV, §421(d), Aug. 21, 1996, 110 Stat. 2089, provided that: ''The amendments made by this section [amending this section, sections 1162, 1166, and 1167 of Title 29, Labor, and sections 300bb–2, 300bb–6, and 300bb–8 of Title 42, The Public Health and Welfare] shall become effective on January 1, 1997, regardless of whether the qualifying event occurred before, on, or after such date.''

Pub. L. 104–188, title I, §1704(g)(2), Aug. 20, 1996, 110 Stat. 1881, provided that: ''The amendments made by this subsection [amending this section, section 1162 of Title 29, Labor, and section 300bb–2 of Title 42, The Public Health and Welfare] shall apply to plan years beginning after December 31, 1989.''

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XIII, §13422(b), Aug. 10, 1993, 107 Stat. 566, provided that: ''The amendment made by subsection (a) [amending this section] shall apply with respect to plan years beginning after the date of the enactment of this Act [Aug. 10, 1993].''

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by Pub. L. 101–508 effective as if included in the provision of the Technical and Miscellaneous Revenue Act of 1988, Pub. L. 100–647, to which such amendment relates, see section 11702(j) of Pub. L. 101–508, set out as a note under section 59 of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 6202(b)(3)(B) of Pub. L. 101–239 applicable to items and services furnished after Dec. 19, 1989, see section 6202(b)(5) of Pub. L. 101–239, set out as a note under section 162 of this title.

Pub. L. 101–239, title VI, §6701(d), Dec. 19, 1989, 103 Stat. 2295, provided that: ''The amendments made by this section [amending this section] shall apply to plan years beginning on or after the date of the enactment of this Act [Dec. 19, 1989], regardless of whether the qualifying event occurred before, on, or after such date.''

Pub. L. 101–239, title VII, §7862(c)(2)(C), Dec. 19, 1989, 103 Stat. 2432, provided that: ''The amendments made by this paragraph [amending this section and section 1167 of Title 29, Labor] shall apply to plan years beginning after December 31, 1989.''

Amendment by section 7862(c)(3)(C) of Pub. L. 101–239 applicable to (i) qualifying events occurring after Dec. 31, 1989, and (ii) in the case of qualified beneficiaries who elected continuation coverage after Dec. 31, 1988, the period for which the required premium was paid (or was attempted to be paid but was rejected as such), see section 7862(c)(3)(D) of Pub. L. 101–239, set out as a note under section 162 of this title.

Pub. L. 101–239, title VII, §7862(c)(4)(C), Dec. 19, 1989, 103 Stat. 2433, provided that: ''The amendments made by this paragraph [amending this section and section 1162 of Title 29, Labor] shall apply to plan years beginning after December 31, 1989.''

Pub. L. 101–239, title VII, §7862(c)(5)(C), Dec. 19, 1989, 103 Stat. 2433, provided that: ''The amendments made by this paragraph [amending this section and section 1162 of Title 29] shall apply to plan years beginning after December 31, 1989.''

Pub. L. 101–239, title VII, §7891(d)(1)(C), Dec. 19, 1989, 103 Stat. 2446, provided that: ''The amendments made by this paragraph [amending this section and section 1166 of Title 29] shall apply with respect to plan years beginning on or after January 1, 1990.''

Pub. L. 101–239, title VII, §7891(d)(2)(C), Dec. 19, 1989, 103 Stat. 2447, provided that: ''The amendments made by this paragraph [amending this section and section 1167 of Title 29] shall apply with respect to plan years beginning on or after January 1, 1990.''

EFFECTIVE DATE

Section applicable to taxable years beginning after Dec. 31, 1988, but not applicable to any plan for any plan year to which section 162(k) of this title (as in effect on the day before Nov. 10, 1988) did not apply by reason of section 10001(e)(2) of Pub. L. 99–272, see section 3011(d) of Pub. L. 100–647, set out as an Effective Date of 1988 Amendment note under section 162 of this title.

CONSTRUCTION OF 2002 AMENDMENT

Nothing in amendment by Pub. L. 107–210, other than provisions relating to COBRA continuation coverage and reporting requirements, to be construed as creating new mandate on any party regarding health insurance

coverage, see section 203(f) of Pub. L. 107–210, set out as a Construction note under section 35 of this title.

NOTIFICATION OF CHANGES IN CONTINUATION COVERAGE

Pub. L. 104–191, title IV, §421(e), Aug. 21, 1996, 110 Stat. 2089, provided that: ''Not later than November 1, 1996, each group health plan (covered under title XXII of the Public Health Service Act [42 U.S.C. 300bb–1 et seq.], part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1161 et seq.], and section 4980B(f) of the Internal Revenue Code of 1986) shall notify each qualified beneficiary who has elected continuation coverage under such title, part or section of the amendments made by this section [amending this section, sections 1162, 1166, and 1167 of Title 29, Labor, and sections 300bb–2, 300bb–6, and 300bb–8 of Title 42, The Public Health and Welfare].''

§ 4980C. Requirements for issuers of qualified long-term care insurance contracts

(a) General rule

There is hereby imposed on any person failing to meet the requirements of subsection (c) or (d) a tax in the amount determined under subsection (b).

(b) Amount

(1) In general

The amount of the tax imposed by subsection (a) shall be $100 per insured for each day any requirement of subsection (c) or (d) is not met with respect to each qualified long-term care insurance contract.

(2) Waiver

In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that payment of the tax would be excessive relative to the failure involved.

(c) Responsibilities

The requirements of this subsection are as follows:

(1) Requirements of model provisions

(A) Model regulation

The following requirements of the model regulation must be met:

(i) Section 13 (relating to application forms and replacement coverage).

(ii) Section 14 (relating to reporting requirements), except that the issuer shall also report at least annually the number of claims denied during the reporting period for each class of business (expressed as a percentage of claims denied), other than claims denied for failure to meet the waiting period or because of any applicable preexisting condition.

(iii) Section 20 (relating to filing requirements for marketing).

(iv) Section 21 (relating to standards for marketing), including inaccurate completion of medical histories, other than sections 21C(1) and 21C(6) thereof, except that—

(I) in addition to such requirements, no person shall, in selling or offering to sell a qualified long-term care insurance contract, misrepresent a material fact; and

(II) no such requirements shall include a requirement to inquire or identify whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance.

(v) Section 22 (relating to appropriateness of recommended purchase).

(vi) Section 24 (relating to standard format outline of coverage).

(vii) Section 25 (relating to requirement to deliver shopper's guide).

(B) Model Act

The following requirements of the model Act must be met:

(i) Section 6F (relating to right to return), except that such section shall also apply to denials of applications and any refund shall be made within 30 days of the return or denial.

(ii) Section 6G (relating to outline of coverage).

(iii) Section 6H (relating to requirements for certificates under group plans).

(iv) Section 6I (relating to policy summary).

(v) Section 6J (relating to monthly reports on accelerated death benefits).

(vi) Section 7 (relating to incontestability period).

(C) Definitions

For purposes of this paragraph, the terms ''model regulation'' and ''model Act'' have the meanings given such terms by section 7702B(g)(2)(B).

(2) Delivery of policy

If an application for a qualified long-term care insurance contract (or for a certificate under such a contract for a group) is approved, the issuer shall deliver to the applicant (or policyholder or certificateholder) the contract (or certificate) of insurance not later than 30 days after the date of the approval.

(3) Information on denials of claims

If a claim under a qualified long-term care insurance contract is denied, the issuer shall, within 60 days of the date of a written request by the policyholder or certificateholder (or representative)—

(A) provide a written explanation of the reasons for the denial, and

(B) make available all information directly relating to such denial.

(d) Disclosure

The requirements of this subsection are met if the issuer of a long-term care insurance policy discloses in such policy and in the outline of coverage required under subsection (c)(1)(B)(ii) that the policy is intended to be a qualified long-term care insurance contract under section 7702B(b).

(e) Qualified long-term care insurance contract defined

For purposes of this section, the term ''qualified long-term care insurance contract'' has the meaning given such term by section 7702B.

(f) Coordination with State requirements

If a State imposes any requirement which is more stringent than the analogous requirement