quiring health insurance coverage offered in the individual market to provide specific benefits under the terms of such coverage.

(c) Application of part A provisions

(1) In general

The provisions of part A shall apply to health insurance issuers providing health insurance coverage in the individual market in a State as provided for in such part.

(2) Clarification

To the extent that any provision of this part conflicts with a provision of part A with respect to health insurance issuers providing health insurance coverage in the individual market in a State, the provisions of such part A shall apply.

(July 1, 1944, ch. 373, title XXVII, § 2762, formerly § 2746, as added Pub. L. 104–191, title I, § 111(a), Aug. 21, 1996, 110 Stat. 1987; renumbered § 2762 and amended, Pub. L. 104–204, title VI, § 605(a)(2), (b)(3), Sept. 26, 1996, 110 Stat. 2941, 2942; Pub. L. 111–148, title I, § 1563(c)(15), formerly § 1562(c)(15), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 269, 911.)

AMENDMENTS

2010—Pub. L. 111–148, § 1563(c)(15)(A), formerly § 1562(c)(15)(A), as renumbered by Pub. L. 111–148, § 10107(b)(1), inserted ''and application'' after ''Preemption'' in section catchline.

Subsec. (c). Pub. L. 111–148, § 1563(c)(15)(B), formerly § 1562(c)(15)(B), as renumbered by Pub. L. 111–148, § 10107(b)(1), added subsec. (c).

1996—Subsec. (b). Pub. L. 104–204, § 605(b)(3), designated existing provisions as par. (1) and added par. (2).

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–204 applicable to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after Jan. 1, 1998, see section 605(c) of Pub. L. 104–204, set out as a note under section 300gg–44 of this title.

EFFECTIVE DATE

Section applicable with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market after June 30, 1997, regardless of when a period of creditable coverage occurs, see section 111(b) of Pub. L. 104–191, set out as a note under section 300gg–41 of this title.

§ 300gg–63. General exceptions

(a) Exception for certain benefits

The requirements of this part shall not apply to any health insurance coverage in relation to its provision of excepted benefits described in section 300gg–91(c)(1) of this title.

(b) Exception for certain benefits if certain conditions met

The requirements of this part shall not apply to any health insurance coverage in relation to its provision of excepted benefits described in paragraph (2), (3), or (4) of section 300gg–91(c) of this title if the benefits are provided under a separate policy, certificate, or contract of insurance.

(July 1, 1944, ch. 373, title XXVII, § 2763, formerly § 2747, as added Pub. L. 104–191, title I, § 111(a), Aug. 21, 1996, 110 Stat. 1987; renumbered § 2763, Pub. L. 104–204, title VI, § 605(a)(2), Sept. 26, 1996, 110 Stat. 2941.)

EFFECTIVE DATE

Section applicable with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market after June 30, 1997, regardless of when a period of creditable coverage occurs, see section 111(b) of Pub. L. 104–191, set out as a note under section 300gg–41 of this title.

PART C—DEFINITIONS; MISCELLANEOUS PROVISIONS

§ 300gg–91. Definitions

(a) Group health plan

(1) Definition

The term ''group health plan'' means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1002(1)]) to the extent that the plan provides medical care (as defined in paragraph (2)) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(2) Medical care

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

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

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

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

(3) Treatment of certain plans as group health plan for notice provision

A program under which creditable coverage described in subparagraph (C), (D), (E), or (F) of section 2701(c)(1)[1] is provided shall be treated as a group health plan for purposes of applying section 2701(e).[1]

(b) Definitions relating to health insurance

(1) Health insurance coverage

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

(2) Health insurance issuer

The term ''health insurance issuer'' means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is

[1] See References in Text note below.

subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1144(b)(2)]). Such term does not include a group health plan.

(3) Health maintenance organization

The term ''health maintenance organization'' means—

(A) a Federally qualified health maintenance organization (as defined in section 300e(a) of this title),

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

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

(4) Group health insurance coverage

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

(5) Individual health insurance coverage

The term ''individual health insurance coverage'' means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.

(c) Excepted benefits

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

(1) Benefits not subject to requirements

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

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

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

(D) Workers' compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for on-site medical clinics.

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

(2) Benefits not subject to requirements if offered separately

(A) Limited scope dental or vision benefits.

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

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

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

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

(B) Hospital indemnity or other fixed indemnity insurance.

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

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

(d) Other definitions

(1) Applicable State authority

The term ''applicable State authority'' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this subchapter for the State involved with respect to such issuer.

(2) Beneficiary

The term ''beneficiary'' has the meaning given such term under section 3(8) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1002(8)].

(3) Bona fide association

The term ''bona fide association'' means, with respect to health insurance coverage offered in a State, an association which—

(A) has been actively in existence for at least 5 years;

(B) has been formed and maintained in good faith for purposes other than obtaining insurance;

(C) does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

(D) makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member);

(E) does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

(F) meets such additional requirements as may be imposed under State law.

(4) COBRA continuation provision

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

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

(B) Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1161 et seq.], other than section 609 of such Act [29 U.S.C. 1169].

(C) Subchapter XX of this chapter.

(5) Employee

The term ''employee'' has the meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1002(6)].

(6) Employer

The term ''employer'' has the meaning given such term under section 3(5) of the Employee

Retirement Income Security Act of 1974 [29 U.S.C. 1002(5)], except that such term shall include only employers of two or more employees.

(7) Church plan

The term ''church plan'' has the meaning given such term under section 3(33) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1002(33)].

(8) Governmental plan

(A) The term ''governmental plan'' has the meaning given such term under section 3(32) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1002(32)] and any Federal governmental plan.

(B) FEDERAL GOVERNMENTAL PLAN.—The term ''Federal governmental plan'' means a governmental plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of such Government.

(C) NON-FEDERAL GOVERNMENTAL PLAN.—The term ''non-Federal governmental plan'' means a governmental plan that is not a Federal governmental plan.

(9) Health status-related factor

The term ''health status-related factor'' means any of the factors described in section 2702(a)(1).[1]

(10) Network plan

The term ''network plan'' means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the issuer.

(11) Participant

The term ''participant'' has the meaning given such term under section 3(7) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1002(7)].

(12) Placed for adoption defined

The term ''placement'', or being ''placed'', for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

(13) Plan sponsor

The term ''plan sponsor'' has the meaning given such term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1002(16)(B)].

(14) State

The term ''State'' means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

(15) Family member

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

(A) a dependent (as such term is used for purposes of section 2701(f)(2))[1] of such individual; and

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

(16) Genetic information

(A) In general

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

(i) such individual's genetic tests,

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

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

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

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

(C) Exclusions

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

(17) Genetic test

(A) In general

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

(B) Exceptions

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

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

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

(18) Genetic services

The term ''genetic services'' means—

(A) a genetic test;

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

(C) genetic education.

(19) Underwriting purposes

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

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

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

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

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

(20) Qualified health plan

The term ''qualified health plan'' has the meaning given such term in section 18021(a) of this title.

(21) Exchange

The term ''Exchange'' means an American Health Benefit Exchange established under section 18031 of this title.

(e) Definitions relating to markets and small employers

For purposes of this subchapter:

(1) Individual market

(A) In general

The term ''individual market'' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(B) Treatment of very small groups

(i) In general

Subject to clause (ii), such terms[2] includes coverage offered in connection with a group health plan that has fewer than two participants as current employees on the first day of the plan year.

(ii) State exception

Clause (i) shall not apply in the case of a State that elects to regulate the coverage described in such clause as coverage in the small group market.

(2) Large employer

The term ''large employer'' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

(3) Large group market

The term ''large group market'' means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer.

(4) Small employer

The term ''small employer'' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employees[3] on the first day of the plan year.

(5) Small group market

The term ''small group market'' means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer.

(6) Application of certain rules in determination of employer size

For purposes of this subsection—

(A) Application of aggregation rule for employers

all[4] persons treated as a single employer under subsection (b), (c), (m), or (*o*) of section 414 of title 26 shall be treated as 1 employer.

(B) Employers not in existence in preceding year

In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(C) Predecessors

Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

(7) State option to extend definition of small employer

Notwithstanding paragraphs (2) and (4), nothing in this section shall prevent a State from applying this subsection by treating as a small employer, with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

(July 1, 1944, ch. 373, title XXVII, §2791, as added Pub. L. 104–191, title I, §102(a), Aug. 21, 1996, 110 Stat. 1972; amended Pub. L. 110–233, title I, §102(a)(4), May 21, 2008, 122 Stat. 890; Pub. L. 111–148, title I, §1563(b), (c)(16), formerly §1562(b), (c)(16), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 264, 269, 911; Pub. L. 114–60, §2(b), Oct. 7, 2015, 129 Stat. 543.)

REFERENCES IN TEXT

Section 2701, referred to in subsecs. (a)(3) and (d)(15)(A), 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.

The Employee Retirement Income Security Act of 1974, referred to in subsec. (d)(4)(B), is Pub. L. 93–406,

[2] So in original. Probably should be ''term''.

[3] So in original.

[4] So in original. Probably should be capitalized.

Sept. 2, 1974, 88 Stat. 829, as amended. Part 6 of subtitle B of title I of the Act is classified generally to part 6 (§ 1161 et seq.) of subtitle B of subchapter I of chapter 18 of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

Section 2702, referred to in subsec. (d)(9), is a reference to section 2702 of act July 1, 1944. Section 2702, which was classified to section 300gg–1 of this title, was amended by Pub. L. 111–148, title I, § 1201(3), Mar. 23, 2010, 124 Stat. 154, and was transferred to subsecs. (b) to (f) of section 300gg–4 of this title, effective for plan years beginning on or after Jan. 1, 2014. A new section 2702, related to guaranteed availability of coverage, was added by Pub. L. 111–148, title I, § 1201(4), Mar. 23, 2010, 124 Stat. 156, effective for plan years beginning on or after Jan. 1, 2014, and is classified to section 300gg–1 of this title.

AMENDMENTS

2015—Subsec. (e)(2). Pub. L. 114–60, § 2(b)(1), substituted ''51'' for ''101''.

Subsec. (e)(4). Pub. L. 114–60, § 2(b)(2), substituted ''50'' for ''100''.

Subsec. (e)(7). Pub. L. 114–60, § 2(b)(3), added par. (7).

2010—Subsec. (d)(20), (21). Pub. L. 111–148, § 1563(b), formerly § 1562(b), as renumbered by Pub. L. 111–148, § 10107(b)(1), added pars. (20) and (21).

Subsec. (e)(2). Pub. L. 111–148, § 1563(c)(16)(A), formerly § 1562(c)(16)(A), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''101'' for ''51''.

Subsec. (e)(4). Pub. L. 111–148, § 1563(c)(16)(B), formerly § 1562(c)(16)(B), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''100'' for ''50'' and ''at least 1'' for ''at least 2'' in two places.

2008—Subsec. (d)(15) to (19). Pub. L. 110–233 added pars. (15) to (19).

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by Pub. L. 110–233 applicable, with respect to group health plans and health insurance coverage offered in connection with group health plans, for plan years beginning after the date that is one year after May 21, 2008, and, with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market, after the date that is one year after May 21, 2008, see section 102(d)(2) of Pub. L. 110–233, set out as a note under section 300gg–21 of this title.

§ 300gg–92. Regulations

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

(July 1, 1944, ch. 373, title XXVII, § 2792, as added Pub. L. 104–191, title I, § 102(a), Aug. 21, 1996, 110 Stat. 1976.)

REFERENCES IN TEXT

Section 104 of the Health Care Portability and Accountability Act of 1996, referred to in text, probably means section 104 of the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191, set out below.

ASSURING COORDINATION AMONG DEPARTMENTS OF TREASURY, HEALTH AND HUMAN SERVICES, AND LABOR

Pub. L. 104–191, title I, § 104, Aug. 21, 1996, 110 Stat. 1978, provided that: ''The Secretary of the Treasury, the Secretary of Health and Human Services, and the Secretary of Labor shall ensure, through the execution 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 subtitle [subtitle A (§§ 101–104) of title I of Pub. L. 104–191, enacting this section, sections 300gg, 300gg–1, 300gg–11 to 300gg–13, 300gg–21 to 300gg–23, and 300gg–91 of this title, and sections 1181 to 1183 and 1191 to 1191c of Title 29, Labor, amending sections 300e and 300bb–8 of this title and sections 1003, 1021, 1022, 1024, 1132, 1136, and 1144 of Title 29, and enacting provisions set out as notes under section 300gg of this title and section 1181 of Title 29] (and the amendments made by this subtitle and section 401 [enacting sections 9801 to 9806 of Title 26, Internal Revenue Code]) 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–93. Health insurance consumer information

(a) In general

The Secretary shall award grants to States to enable such States (or the Exchanges operating in such States) to establish, expand, or provide support for—

(1) offices of health insurance consumer assistance; or

(2) health insurance ombudsman programs.

(b) Eligibility

(1) In general

To be eligible to receive a grant, a State shall designate an independent office of health insurance consumer assistance, or an ombudsman, that, directly or in coordination with State health insurance regulators and consumer assistance organizations, receives and responds to inquiries and complaints concerning health insurance coverage with respect to Federal health insurance requirements and under State law.

(2) Criteria

A State that receives a grant under this section shall comply with criteria established by the Secretary for carrying out activities under such grant.

(c) Duties

The office of health insurance consumer assistance or health insurance ombudsman shall—

(1) assist with the filing of complaints and appeals, including filing appeals with the internal appeal or grievance process of the group health plan or health insurance issuer involved and providing information about the external appeal process;

(2) collect, track, and quantify problems and inquiries encountered by consumers;

(3) educate consumers on their rights and responsibilities with respect to group health plans and health insurance coverage;

(4) assist consumers with enrollment in a group health plan or health insurance coverage by providing information, referral, and assistance; and

(5) resolve problems with obtaining premium tax credits under section 36B of title 26.