child, and the Notice meets the requirements of paragraphs (3) and (4) of this subsection, the Notice shall be deemed to be a qualified medical child support order in the case of such child.

''(ii) ENROLLMENT OF CHILD IN PLAN.—In any case in which an appropriately completed National Medical Support Notice is issued in the case of a child of a participant under a church group health plan who is a parent of the child, and the Notice is deemed under clause (i) to be a qualified medical child support order, the plan administrator, within 40 business days after the date of the Notice, shall—

''(I) notify the State agency issuing the Notice with respect to such child whether coverage of the child is available under the terms of the plan and, if so, whether such child is covered under the plan and either the effective date of the coverage or any steps necessary to be taken by the custodial parent (or by the official of a State or political subdivision thereof substituted for the name of such child pursuant to paragraph (3)(A)) to effectuate the coverage; and

''(II) provide to the custodial parent (or such substituted official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

''(iii) RULE OF CONSTRUCTION.—Nothing in this subparagraph shall be construed as requiring a church group health plan, upon receipt of a National Medical Support Notice, to provide benefits under the plan (or eligibility for such benefits) in addition to benefits (or eligibility for benefits) provided under the terms of the plan as of immediately before receipt of such Notice.

''(6) DIRECT PROVISION OF BENEFITS PROVIDED TO ALTERNATE RECIPIENTS.—Any payment for benefits made by a church group health plan pursuant to a medical child support order in reimbursement for expenses paid by an alternate recipient or an alternate recipient's custodial parent or legal guardian shall be made to the alternate recipient or the alternate recipient's custodial parent or legal guardian.

''(7) PAYMENT TO STATE OFFICIAL TREATED AS SATISFACTION OF PLAN'S OBLIGATION TO MAKE PAYMENT TO ALTERNATE RECIPIENT.—Payment of benefits by a church group health plan to an official of a State or a political subdivision thereof whose name and address have been substituted for the address of an alternate recipient in a medical child support order, pursuant to paragraph (3)(A), shall be treated, for purposes of this subsection and part D of title IV of the Social Security Act [42 U.S.C. 651 et seq.], as payment of benefits to the alternate recipient.

''(8) EFFECTIVE DATE.—The provisions of this subsection shall take effect on the date of the issuance of interim regulations pursuant to subsection (b)(4) of this section [section 401(b)(4) of Pub. L. 105–200, 42 U.S.C. 651 note].

''(g) REPORT AND RECOMMENDATIONS REGARDING THE ENFORCEMENT OF QUALIFIED MEDICAL CHILD SUPPORT ORDERS.—Not later than 8 months after the issuance of the report to the Congress pursuant to subsection (a)(5) [section 401(a)(5) of Pub. L. 105–200, 42 U.S.C. 651 note], the Secretary of Health and Human Services and the Secretary of Labor shall jointly submit to each House of the Congress a report containing recommendations for appropriate legislation to improve the effectiveness of, and enforcement of, qualified medical child support orders under the provisions of subsection (f) of this section and section 609(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1169(a)).''

PLAN AMENDMENTS NOT REQUIRED UNTIL JANUARY 1, 1994

For provisions setting forth circumstances under which any amendment to a plan required to be made by an amendment made by section 4301(d) of Pub. L. 103–66 shall not be required to be made before the first plan year beginning on or after Jan. 1, 1994, see section 4301(d) of Pub. L. 103–66, set out as an Effective Date of 1993 Amendment note under section 1021 of this title.

PART 7—GROUP HEALTH PLAN REQUIREMENTS

Subpart A—Requirements Relating to Portability, Access, and Renewability

## § 1181. Increased portability through limitation on preexisting condition exclusions

### (a) Limitation on preexisting condition exclusion period; crediting for periods of previous coverage

Subject to subsection (d), a group health plan, and a health insurance issuer offering group health insurance coverage, may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if—

(1) such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date;

(2) such exclusion extends for a period of not more than 12 months (or 18 months in the case of a late enrollee) after the enrollment date; and

(3) the period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage (if any, as defined in subsection (c)(1)) applicable to the participant or beneficiary as of the enrollment date.

### (b) Definitions

For purposes of this part—

#### (1) Preexisting condition exclusion

##### (A) In general

The term ''preexisting condition exclusion'' means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

##### (B) Treatment of genetic information

Genetic information shall not be treated as a condition described in subsection (a)(1) in the absence of a diagnosis of the condition related to such information.

#### (2) Enrollment date

The term ''enrollment date'' means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

#### (3) Late enrollee

The term ''late enrollee'' means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during—

(A) the first period in which the individual is eligible to enroll under the plan, or

(B) a special enrollment period under subsection (f).

**(4) Waiting period**

The term ''waiting period'' means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

**(c) Rules relating to crediting previous coverage**

**(1) "Creditable coverage" defined**

For purposes of this part, the term ''creditable coverage'' means, with respect to an individual, coverage of the individual under any of the following:

(A) A group health plan.

(B) Health insurance coverage.

(C) Part A or part B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.; 1395j et seq.].

(D) Title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], other than coverage consisting solely of benefits under section 1928 [42 U.S.C. 1396s].

(E) Chapter 55 of title 10.

(F) A medical care program of the Indian Health Service or of a tribal organization.

(G) A State health benefits risk pool.

(H) A health plan offered under chapter 89 of title 5.

(I) A public health plan (as defined in regulations).

(J) A health benefit plan under section 2504(e) of title 22.

Such term does not include coverage consisting solely of coverage of excepted benefits (as defined in section 1191b(c) of this title).

**(2) Not counting periods before significant breaks in coverage**

**(A) In general**

A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

**(B) Waiting period not treated as a break in coverage**

For purposes of subparagraph (A) and subsection (d)(4), any period that an individual is in a waiting period for any coverage under a group health plan (or for group health insurance coverage) or is in an affiliation period (as defined in subsection (g)(2)) shall not be taken into account in determining the continuous period under subparagraph (A).

**(C) TAA-eligible individuals**

In the case of plan years beginning before January 1, 2014—

**(i) TAA pre-certification period rule**

In the case of a TAA-eligible individual, the period beginning on the date the individual has a TAA-related loss of coverage and ending on the date that is 7 days after the date of the issuance by the Secretary (or by any person or entity designated by the Secretary) of a qualified health insurance costs credit eligibility certificate for such individual for purposes of section 7527 of title 26 shall not be taken into account in determining the continuous period under subparagraph (A).

**(ii) Definitions**

The terms ''TAA-eligible individual'' and ''TAA-related loss of coverage'' have the meanings given such terms in section 1165(b)(4) of this title.

**(3) Method of crediting coverage**

**(A) Standard method**

Except as otherwise provided under subparagraph (B), for purposes of applying subsection (a)(3), a group health plan, and a health insurance issuer offering group health insurance coverage, shall count a period of creditable coverage without regard to the specific benefits covered during the period.

**(B) Election of alternative method**

A group health plan, or a health insurance issuer offering group health insurance coverage, may elect to apply subsection (a)(3) based on coverage of benefits within each of several classes or categories of benefits specified in regulations rather than as provided under subparagraph (A). Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a group health plan or issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.

**(C) Plan notice**

In the case of an election with respect to a group health plan under subparagraph (B) (whether or not health insurance coverage is provided in connection with such plan), the plan shall—

(i) prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election, and

(ii) include in such statements a description of the effect of this election.

**(4) Establishment of period**

Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection (e) or in such other manner as may be specified in regulations.

**(d) Exceptions**

**(1) Exclusion not applicable to certain newborns**

Subject to paragraph (4), a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the

date of birth, is covered under creditable coverage.

**(2) Exclusion not applicable to certain adopted children**

Subject to paragraph (4), a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption.

**(3) Exclusion not applicable to pregnancy**

A group health plan, and health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

**(4) Loss if break in coverage**

Paragraphs (1) and (2) shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

**(e) Certifications and disclosure of coverage**

**(1) Requirement for certification of period of creditable coverage**

**(A) In general**

A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide the certification described in subparagraph (B)—

(i) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision,

(ii) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision, and

(iii) on the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in clause (i) or (ii), whichever is later.

The certification under clause (i) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

**(B) Certification**

The certification described in this subparagraph is a written certification of—

(i) the period of creditable coverage of the individual under such plan and the coverage (if any) under such COBRA continuation provision, and

(ii) the waiting period (if any) (and affiliation period, if applicable) imposed with respect to the individual for any coverage under such plan.

**(C) Issuer compliance**

To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under this paragraph if the health insurance issuer offering the coverage provides for such certification in accordance with this paragraph.

**(2) Disclosure of information on previous benefits**

In the case of an election described in subsection (c)(3)(B) by a group health plan or health insurance issuer, if the plan or issuer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under paragraph (1)—

(A) upon request of such plan or issuer, the entity which issued the certification provided by the individual shall promptly disclose to such requesting plan or issuer information on coverage of classes and categories of health benefits available under such entity's plan or coverage, and

(B) such entity may charge the requesting plan or issuer for the reasonable cost of disclosing such information.

**(3) Regulations**

The Secretary shall establish rules to prevent an entity's failure to provide information under paragraph (1) or (2) with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health insurance coverage.

**(f) Special enrollment periods**

**(1) Individuals losing other coverage**

A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

(A) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.

(B) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer (if applicable) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time.

(C) The employee's or dependent's coverage described in subparagraph (A)—

(i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or

(ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employ-

ment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated.

(D) Under the terms of the plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in subparagraph (C)(i) or termination of coverage or employer contribution described in subparagraph (C)(ii).

**(2) For dependent beneficiaries**

**(A) In general**

If—

(i) a group health plan makes coverage available with respect to a dependent of an individual,

(ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period), and

(iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption,

the group health plan shall provide for a dependent special enrollment period described in subparagraph (B) during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

**(B) Dependent special enrollment period**

A dependent special enrollment period under this subparagraph shall be a period of not less than 30 days and shall begin on the later of—

(i) the date dependent coverage is made available, or

(ii) the date of the marriage, birth, or adoption or placement for adoption (as the case may be) described in subparagraph (A)(iii).

**(C) No waiting period**

If an individual seeks to enroll a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective—

(i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(ii) in the case of a dependent's birth, as of the date of such birth; or

(iii) in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

**(3) Special rules for application in case of Medicaid and CHIP**

**(A) In general**

A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if either of the following conditions is met:

**(i) Termination of Medicaid or CHIP coverage**

The employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] or under a State child health plan under title XXI of such Act [42 U.S.C. 1397aa et seq.] and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the group health plan (or health insurance coverage) not later than 60 days after the date of termination of such coverage.

**(ii) Eligibility for employment assistance under Medicaid or CHIP**

The employee or dependent becomes eligible for assistance, with respect to coverage under the group health plan or health insurance coverage, under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if the employee requests coverage under the group health plan or health insurance coverage not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

**(B) Coordination with Medicaid and CHIP**

**(i) Outreach to employees regarding availability of Medicaid and CHIP coverage**

**(I) In general**

Each employer that maintains a group health plan in a State that provides medical assistance under a State Medicaid plan under title XIX of the Social Security Act, or child health assistance under a State child health plan under title XXI of such Act, in the form of premium assistance for the purchase of coverage under a group health plan, shall provide to each employee a written notice informing the employee of potential opportunities then currently available in the State in which the employee resides for premium assistance under such plans for health coverage of the employee or the employee's dependents.

**(II) Model notice**

Not later than 1 year after February 4, 2009, the Secretary and the Secretary of Health and Human Services, in consultation with Directors of State Medicaid agencies under title XIX of the Social Security Act and Directors of State CHIP agencies under title XXI of such Act, shall jointly develop national and State-specific model notices for purposes of subparagraph (A). The Secretary shall provide employers with such model no-

tices so as to enable employers to timely comply with the requirements of subparagraph (A). Such model notices shall include information regarding how an employee may contact the State in which the employee resides for additional information regarding potential opportunities for such premium assistance, including how to apply for such assistance.

**(III) Option to provide concurrent with provision of plan materials to employee**

An employer may provide the model notice applicable to the State in which an employee resides concurrent with the furnishing of materials notifying the employee of health plan eligibility, concurrent with materials provided to the employee in connection with an open season or election process conducted under the plan, or concurrent with the furnishing of the summary plan description as provided in section 1024(b) of this title.

**(ii) Disclosure about group health plan benefits to States for Medicaid and CHIP eligible individuals**

In the case of a participant or beneficiary of a group health plan who is covered under a Medicaid plan of a State under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act, the plan administrator of the group health plan shall disclose to the State, upon request, information about the benefits available under the group health plan in sufficient specificity, as determined under regulations of the Secretary of Health and Human Services in consultation with the Secretary that require use of the model coverage coordination disclosure form developed under section 311(b)(1)(C) of the Children's Health Insurance Program Reauthorization Act of 2009, so as to permit the State to make a determination (under paragraph (2)(B), (3), or (10) of section 2105(c) of the Social Security Act [42 U.S.C. 1397ee(c)(2)(B), (3), (10)] or otherwise) concerning the cost-effectiveness of the State providing medical or child health assistance through premium assistance for the purchase of coverage under such group health plan and in order for the State to provide supplemental benefits required under paragraph (10)(E) of such section or other authority.

**(g) Use of affiliation period by HMOs as alternative to preexisting condition exclusion**

**(1) In general**

In the case of a group health plan that offers medical care through health insurance coverage offered by a health maintenance organization, the plan may provide for an affiliation period with respect to coverage through the organization only if—

(A) no preexisting condition exclusion is imposed with respect to coverage through the organization,

(B) the period is applied uniformly without regard to any health status-related factors, and

(C) such period does not exceed 2 months (or 3 months in the case of a late enrollee).

**(2) Affiliation period**

**(A) Defined**

For purposes of this part, the term ''affiliation period'' means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

**(B) Beginning**

Such period shall begin on the enrollment date.

**(C) Runs concurrently with waiting periods**

An affiliation period under a plan shall run concurrently with any waiting period under the plan.

**(3) Alternative methods**

A health maintenance organization described in paragraph (1) may use alternative methods, from those described in such paragraph, to address adverse selection as approved by the State insurance commissioner or official or officials designated by the State to enforce the requirements of part A of title XXVII of the Public Health Service Act [42 U.S.C. 300gg et seq.] for the State involved with respect to such issuer.

(Pub. L. 93–406, title I, § 701, as added Pub. L. 104–191, title I, § 101(a), Aug. 21, 1996, 110 Stat. 1939; amended Pub. L. 104–204, title VI, § 603(b)(3)(H), Sept. 26, 1996, 110 Stat. 2938; Pub. L. 111–3, title III, § 311(b)(1)(A), Feb. 4, 2009, 123 Stat. 65; Pub. L. 111–5, div. B, title I, § 1899D(b), Feb. 17, 2009, 123 Stat. 426; Pub. L. 111–344, title I, § 114(b), Dec. 29, 2010, 124 Stat. 3615; Pub. L. 112–40, title II, § 242(a)(2), Oct. 21, 2011, 125 Stat. 419.)

REFERENCES IN TEXT

The Social Security Act, referred to in subsecs. (c)(1)(C), (D), (f)(3)(A)(i), (B)(i)(I), (II), (ii), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Parts A and B of title XVIII of the Act are classified generally to parts A (§ 1395c et seq.) and B (§ 1395j et seq.) of subchapter XVIII of chapter 7 of Title 42, The Public Health and Welfare. Titles XIX and XXI of the Act are classified generally to subchapters XIX (§ 1396 et seq.) and XXI (§ 1397aa et seq.), respectively, of chapter 7 of Title 42. For complete classification of this Act to the Code, see section 1305 of Title 42 and Tables.

Section 311(b)(1)(C) of the Children's Health Insurance Program Reauthorization Act of 2009, referred to in subsec. (f)(3)(B)(ii), is section 311(b)(1)(C) of Pub. L. 111–3, which is set out as a note under this section.

The Public Health Service Act, referred to in subsec. (g)(3), is act July 1, 1944, ch. 373, 58 Stat. 682. Part A of title XXVII of the Act is classified generally to part A (§ 300gg et seq.) of subchapter XXV of chapter 6A of Title 42. For complete classification of this Act to the Code, see Short Title note set out under section 201 of Title 42 and Tables.

AMENDMENTS

2011—Subsec. (c)(2)(C). Pub. L. 112–40 substituted ''January 1, 2014'' for ''February 13, 2011'' in introductory provisions.

2010—Subsec. (c)(2)(C). Pub. L. 111–344 substituted ''February 13, 2011'' for ''January 1, 2011'' in introductory provisions.

2009—Subsec. (c)(2)(C). Pub. L. 111–5 added subpar. (C).

Subsec. (f)(3). Pub. L. 111–3 added par. (3).

1996—Subsec. (c)(1). Pub. L. 104–204 made technical amendment to reference in original act which appears in text as reference to section 1191b of this title.

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–40 applicable to plan years beginning after Feb. 12, 2011, with transitional rules, see section 242(b) of Pub. L. 112–40, set out as a note under section 9801 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by Pub. L. 111–344 applicable to plan years beginning after Dec. 31, 2010, see section 114(d) of Pub. L. 111–344, set out as a note under section 9801 of Title 26, Internal Revenue Code.

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.

Amendment by Pub. L. 111–5 applicable to plan years beginning after Feb. 17, 2009, see section 1899D(d) of Pub. L. 111–5, set out as a note under section 9801 of Title 26, Internal Revenue Code.

Amendment by Pub. L. 111–3 effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, with certain exceptions, see section 3 of Pub. L. 111–3, set out as an Effective Date note under section 1396 of Title 42, The Public Health and Welfare.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–204 applicable with respect to group health plans for plan years beginning on and after Jan. 1, 1998, see section 603(c) of Pub. L. 104–204, set out as a note under section 1003 of this title.

EFFECTIVE DATE

Pub. L. 104–191, title I, §101(g), Aug. 21, 1996, 110 Stat. 1953, provided that:

''(1) IN GENERAL.—Except as provided in this section, this section [enacting this part and amending sections 1003, 1021, 1022, 1024, 1132, 1136, and 1144 of this title] (and the amendments made by this section) shall apply with respect to group health plans for plan years beginning after June 30, 1997.

''(2) DETERMINATION OF CREDITABLE COVERAGE.—

''(A) PERIOD OF COVERAGE.—

''(i) IN GENERAL.—Subject to clause (ii), no period before July 1, 1996, shall be taken into account under part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (as added by this section) [this part] in determining creditable coverage.

''(ii) SPECIAL RULE FOR CERTAIN PERIODS.—The Secretary of Labor, consistent with section 104 [42 U.S.C. 300gg–92 note], shall provide for a process whereby individuals who need to establish creditable coverage for periods before July 1, 1996, and who would have such coverage credited but for clause (i) may be given credit for creditable coverage for such periods through the presentation of documents or other means.

''(B) CERTIFICATIONS, ETC.—

''(i) IN GENERAL.—Subject to clauses (ii) and (iii), subsection (e) of section 701 of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1181(e)](as added by this section) shall apply to events occurring after June 30, 1996.

''(ii) NO CERTIFICATION REQUIRED TO BE PROVIDED BEFORE JUNE 1, 1997.—In no case is a certification required to be provided under such subsection before June 1, 1997.

''(iii) CERTIFICATION ONLY ON WRITTEN REQUEST FOR EVENTS OCCURRING BEFORE OCTOBER 1, 1996.—In the case of an event occurring after June 30, 1996, and before October 1, 1996, a certification is not required to be provided under such subsection unless an individual (with respect to whom the certification is otherwise required to be made) requests such certification in writing.

''(C) TRANSITIONAL RULE.—In the case of an individual who seeks to establish creditable coverage for any period for which certification is not required because it relates to an event occurring before June 30, 1996—

''(i) the individual may present other credible evidence of such coverage in order to establish the period of creditable coverage; and

''(ii) a group health plan and a health insurance issuer shall not be subject to any penalty or enforcement action with respect to the plan's or issuer's crediting (or not crediting) such coverage if the plan or issuer has sought to comply in good faith with the applicable requirements under the amendments made by this section [enacting this part and amending sections 1003, 1021, 1022, 1024, 1132, 1136, and 1144 of this title].

''(3) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—Except as provided in paragraph (2), 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 enactment of this Act [Aug. 21, 1996], part 7 of subtitle B of title I of Employee Retirement Income Security Act of 1974 [this part] (other than section 701(e) thereof [29 U.S.C. 1181(e)]) 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) July 1, 1997.

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 of such part shall not be treated as a termination of such collective bargaining agreement.

''(4) TIMELY REGULATIONS.—The Secretary of Labor, consistent with section 104 [42 U.S.C. 300gg–92 note], shall first issue by not later than April 1, 1997, such regulations as may be necessary to carry out the amendments made by this section.

''(5) LIMITATION ON ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this section, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before January 1, 1998, or, if later, the date of issuance of regulations referred to in paragraph (4), if the plan or issuer has sought to comply in good faith with such requirements.''

WORKING GROUP TO DEVELOP MODEL COVERAGE COORDINATION DISCLOSURE FORM

Pub. L. 111–3, title III, §311(b)(1)(C), Feb. 4, 2009, 123 Stat. 68, provided that:

''(i) MEDICAID, CHIP, AND EMPLOYER-SPONSORED COVERAGE COORDINATION WORKING GROUP.—

''(I) IN GENERAL.—Not later than 60 days after the date of enactment of this Act [Feb. 4, 2009], the Secretary of Health and Human Services and the Secretary of Labor shall jointly establish a Medicaid, CHIP, and Employer-Sponsored Coverage Coordination Working Group (in this subparagraph referred to

as the 'Working Group'). The purpose of the Working Group shall be to develop the model coverage coordination disclosure form described in subclause (II) and to identify the impediments to the effective coordination of coverage available to families that include employees of employers that maintain group health plans and members who are eligible for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] or child health assistance or other health benefits coverage under title XXI of such Act [42 U.S.C. 1397aa et seq.].

''(II) MODEL COVERAGE COORDINATION DISCLOSURE FORM DESCRIBED.—The model form described in this subclause is a form for plan administrators of group health plans to complete for purposes of permitting a State to determine the availability and cost-effectiveness of the coverage available under such plans to employees who have family members who are eligible for premium assistance offered under a State plan under title XIX or XXI of such Act and to allow for coordination of coverage for enrollees of such plans. Such form shall provide the following information in addition to such other information as the Working Group determines appropriate:

''(aa) A determination of whether the employee is eligible for coverage under the group health plan.

''(bb) The name and contract information of the plan administrator of the group health plan.

''(cc) The benefits offered under the plan.

''(dd) The premiums and cost-sharing required under the plan.

''(ee) Any other information relevant to coverage under the plan.

''(ii) MEMBERSHIP.—The Working Group shall consist of not more than 30 members and shall be composed of representatives of—

''(I) the Department of Labor;

''(II) the Department of Health and Human Services;

''(III) State directors of the Medicaid program under title XIX of the Social Security Act;

''(IV) State directors of the State Children's Health Insurance Program under title XXI of the Social Security Act;

''(V) employers, including owners of small businesses and their trade or industry representatives and certified human resource and payroll professionals;

''(VI) plan administrators and plan sponsors of group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1167(1)]);

''(VII) health insurance issuers; and

''(VIII) children and other beneficiaries of medical assistance under title XIX of the Social Security Act or child health assistance or other health benefits coverage under title XXI of such Act.

''(iii) COMPENSATION.—The members of the Working Group shall serve without compensation.

''(iv) ADMINISTRATIVE SUPPORT.—The Department of Health and Human Services and the Department of Labor shall jointly provide appropriate administrative support to the Working Group, including technical assistance. The Working Group may use the services and facilities of either such Department, with or without reimbursement, as jointly determined by such Departments.

''(v) REPORT.—

''(I) REPORT BY WORKING GROUP TO THE SECRETARIES.—Not later than 18 months after the date of the enactment of this Act, the Working Group shall submit to the Secretary of Labor and the Secretary of Health and Human Services the model form described in clause (i)(II) along with a report containing recommendations for appropriate measures to address the impediments to the effective coordination of coverage between group health plans and the State plans under titles XIX and XXI of the Social Security Act.

''(II) REPORT BY SECRETARIES TO THE CONGRESS.—Not later than 2 months after receipt of the report pursuant to subclause (I), the Secretaries shall jointly submit a report to each House of the Congress regarding the recommendations contained in the report under such subclause.

''(vi) TERMINATION.—The Working Group shall terminate 30 days after the date of the issuance of its report under clause (v).''

[For definitions of ''CHIP'' and ''Medicaid'' as used in section 311(b)(1)(C) of Pub. L. 111–3, set out above, see section 1(c)(1), (2) of Pub. L. 111–3, set out as a Definitions note under section 1396 of Title 42, The Public Health and Welfare.]

IMPLEMENTATION OF 2009 AMENDMENT

Pub. L. 111–3, title III, § 311(b)(1)(D), Feb. 4, 2009, 123 Stat. 69, provided that: ''The Secretary of Labor and the Secretary of Health and Human Services shall develop the initial model notices under section 701(f)(3)(B)(i)(II) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1181(f)(3)(B)(i)(II)], and the Secretary of Labor shall provide such notices to employers, not later than the date that is 1 year after the date of enactment of this Act [Feb. 4, 2009], and each employer shall provide the initial annual notices to such employer's employees beginning with the first plan year that begins after the date on which such initial model notices are first issued. The model coverage coordination disclosure form developed under subparagraph (C) [set out above] shall apply with respect to requests made by States beginning with the first plan year that begins after the date on which such model coverage coordination disclosure form is first issued.''

## § 1182. Prohibiting discrimination against individual participants and beneficiaries based on health status

### (a) In eligibility to enroll

#### (1) In general

Subject to paragraph (2), a group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(A) Health status.

(B) Medical condition (including both physical and mental illnesses).

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

(G) Evidence of insurability (including conditions arising out of acts of domestic violence).

(H) Disability.

#### (2) No application to benefits or exclusions

To the extent consistent with section 1181 of this title, paragraph (1) shall not be construed—

(A) to require a group health plan, or group health insurance coverage, to provide particular benefits other than those provided under the terms of such plan or coverage, or

(B) to prevent such a plan or coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

**(3) Construction**

For purposes of paragraph (1), rules for eligibility to enroll under a plan include rules defining any applicable waiting periods for such enrollment.

**(b) In premium contributions**

**(1) In general**

A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

**(2) Construction**

Nothing in paragraph (1) shall be construed—

(A) to restrict the amount that an employer may be charged for coverage under a group health plan except as provided in paragraph (3); or

(B) to prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

**(3) No group-based discrimination on basis of genetic information**

**(A) In general**

For purposes of this section, a group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not adjust premium or contribution amounts for the group covered under such plan on the basis of genetic information.

**(B) Rule of construction**

Nothing in subparagraph (A) or in paragraphs (1) and (2) of subsection (d) shall be construed to limit the ability of a health insurance issuer offering health insurance coverage in connection with a group health plan to increase the premium for an employer based on the manifestation of a disease or disorder of an individual who is enrolled in the plan. In such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the employer.

**(c) Genetic testing**

**(1) Limitation on requesting or requiring genetic testing**

A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request or require an individual or a family member of such individual to undergo a genetic test.

**(2) Rule of construction**

Paragraph (1) shall not be construed to limit the authority of a health care professional who is providing health care services to an individual to request that such individual undergo a genetic test.

**(3) Rule of construction regarding payment**

**(A) In general**

Nothing in paragraph (1) shall be construed to preclude a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, from obtaining and using the results of a genetic test in making a determination regarding payment (as such term is defined for the purposes of applying the regulations promulgated by the Secretary of Health and Human Services under part C of title XI of the Social Security Act [42 U.S.C. 1320d et seq.] and section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) consistent with subsection (a).

**(B) Limitation**

For purposes of subparagraph (A), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, may request only the minimum amount of information necessary to accomplish the intended purpose.

**(4) Research exception**

Notwithstanding paragraph (1), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, may request, but not require, that a participant or beneficiary undergo a genetic test if each of the following conditions is met:

(A) The request is made, in writing, pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research.

(B) The plan or issuer clearly indicates to each participant or beneficiary, or in the case of a minor child, to the legal guardian of such beneficiary, to whom the request is made that—

(i) compliance with the request is voluntary; and

(ii) non-compliance will have no effect on enrollment status or premium or contribution amounts.

(C) No genetic information collected or acquired under this paragraph shall be used for underwriting purposes.

(D) The plan or issuer notifies the Secretary in writing that the plan or issuer is conducting activities pursuant to the exception provided for under this paragraph, including a description of the activities conducted.

(E) The plan or issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under this paragraph.

**(d) Prohibition on collection of genetic information**

**(1) In general**

A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request, require, or purchase genetic information for underwriting purposes (as defined in section 1191b of this title).

**(2) Prohibition on collection of genetic information prior to enrollment**

A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the plan or coverage in connection with such enrollment.

**(3) Incidental collection**

If a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of paragraph (2) if such request, requirement, or purchase is not in violation of paragraph (1).

**(e) Application to all plans**

The provisions of subsections (a)(1)(F), (b)(3), (c), and (d), and subsection (b)(1) and section 1181 of this title with respect to genetic information, shall apply to group health plans and health insurance issuers without regard to section 1191a(a) of this title.

**(f) Genetic information of a fetus or embryo**

Any reference in this part to genetic information concerning an individual or family member of an individual shall—

(1) with respect to such an individual or family member of an individual who is a pregnant woman, include genetic information of any fetus carried by such pregnant woman; and

(2) with respect to an individual or family member utilizing an assisted reproductive technology, include genetic information of any embryo legally held by the individual or family member.

(Pub. L. 93–406, title I, § 702, as added Pub. L. 104–191, title I, § 101(a), Aug. 21, 1996, 110 Stat. 1945; amended Pub. L. 110–233, title I, § 101(a)–(c), May 21, 2008, 122 Stat. 883, 885.)

REFERENCES IN TEXT

The Social Security Act, referred to in subsec. (c)(3)(A), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Part C of title XI of the Act is classified generally to part C (§ 1320d et seq.) of subchapter XI 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.

Section 264 of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (c)(3)(A), is section 264 of Pub. L. 104–191, which is set out as a note under section 1320d–2 of Title 42, The Public Health and Welfare.

AMENDMENTS

2008—Subsec. (b)(2)(A). Pub. L. 110–233, § 101(a)(1), inserted ''except as provided in paragraph (3)'' before semicolon.

Subsec. (b)(3). Pub. L. 110–233, § 101(a)(2), added par. (3).

Subsecs. (c) to (e). Pub. L. 110–233, § 101(b), added subsecs. (c) to (e).

Subsec. (f). Pub. L. 110–233, § 101(c), added subsec. (f).

EFFECTIVE DATE OF 2008 AMENDMENT

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

**§ 1183. Guaranteed renewability in multiemployer plans and multiple employer welfare arrangements**

A group health plan which is a multiemployer plan or which is a multiple employer welfare arrangement may not deny an employer whose employees are covered under such a plan continued access to the same or different coverage under the terms of such a plan, other than—

(1) for nonpayment of contributions;

(2) for fraud or other intentional misrepresentation of material fact by the employer;

(3) for noncompliance with material plan provisions;

(4) because the plan is ceasing to offer any coverage in a geographic area;

(5) in the case of a plan that offers benefits through a network plan, there is no longer any individual enrolled through the employer who lives, resides, or works in the service area of the network plan and the plan applies this paragraph uniformly without regard to the claims experience of employers or any health status-related factor in relation to such individuals or their dependents; and

(6) for failure to meet the terms of an applicable collective bargaining agreement, to renew a collective bargaining or other agreement requiring or authorizing contributions to the plan, or to employ employees covered by such an agreement.

(Pub. L. 93–406, title I, § 703, as added Pub. L. 104–191, title I, § 101(a), Aug. 21, 1996, 110 Stat. 1946.)

Subpart B—Other Requirements

**§ 1185. Standards relating to benefits for mothers and newborns**

**(a) Requirements for minimum hospital stay following birth**

**(1) In general**

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

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

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

(ii) restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, fol-

lowing a cesarean section, to less than 96 hours; or

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

**(2) Exception**

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

**(b) Prohibitions**

A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not—

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

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

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

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

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

**(c) Rules of construction**

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

(A) to give birth in a hospital; or

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

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

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

**(d) Notice under group health plan**

The imposition of the requirements of this section shall be treated as a material modification in the terms of the plan described in section 1022(a)(1)[1] of this title, for purposes of assuring notice of such requirements under the plan; except that the summary description required to be provided under the last sentence of section 1024(b)(1) of this title with respect to such modification shall be provided by not later than 60 days after the first day of the first plan year in which such requirements apply.

**(e) Level and type of reimbursements**

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

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

**(1) In general**

The requirements of this section shall not apply with respect to health insurance coverage if there is a State law (as defined in section 1191(d)(1) of this title) for a State that regulates such coverage that is described in any of the following subparagraphs:

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

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

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

**(2) Construction**

Section 1191(a)(1) of this title shall not be construed as superseding a State law described in paragraph (1).

(Pub. L. 93–406, title I, §711, as added Pub. L. 104–204, title VI, §603(a)(5), Sept. 26, 1996, 110 Stat. 2935.)

REFERENCES IN TEXT

Section 1022(a)(1) of this title, referred to in subsec. (d), was redesignated section 1022(a) of this title by Pub. L. 105–34, title XV, §1503(b)(1)(B), Aug. 5, 1997, 111 Stat. 1061.

EFFECTIVE DATE

Section applicable with respect to group health plans for plan years beginning on and after Jan. 1, 1998, see

[1] See References in Text note below.

section 603(c) of Pub. L. 104–204, set out as an Effective Date of 1996 Amendment note under section 1003 of this title.

### § 1185a. 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 health insurance coverage offered in connection with such a plan) 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 health insurance coverage offered in connection with such a plan) 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 health insurance coverage offered in connection with such a plan) 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),[1]

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

**(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 health insurance coverage offered in connection with such a plan) to provide any mental health or substance use disorder benefits; or

(2) in the case of a group health plan (or health insurance coverage offered in connection with such a plan) 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**

**(A) In general**

This section shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year of a small employer.

**(B) Small employer**

For purposes of subparagraph (A), 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 2 (or 1 in the case of an employer residing in a State that permits small groups to include a single individual) but not more than 50 employees on business days during the preceding calendar year.

**(C) Application of certain rules in determination of employer size**

For purposes of this paragraph—

**(i) Application of aggregation rule for employers**

Rules similar to the rules under subsections (b), (c), (m), and (*o*) of section 414 of title 26 shall apply for purposes of treating persons as a single employer.

**(ii) 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 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.

**(iii) Predecessors**

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

**(2) Cost exemption**

**(A) In general**

With respect to a group health plan (or health insurance coverage offered in connection with such a plan), 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.

**(f) Secretary report**

The Secretary shall, by January 1, 2012, and every two years thereafter, submit to the appropriate committees of Congress a report on compliance of group health plans (and health insurance coverage offered in connection with such

plans) with the requirements of this section. Such report shall include the results of any surveys or audits on compliance of group health plans (and health insurance coverage offered in connection with such plans) with such requirements and an analysis of the reasons for any failures to comply.

**(g) Notice and assistance**

The Secretary, in cooperation with the Secretaries of Health and Human Services and Treasury, as appropriate, shall publish and widely disseminate guidance and information for group health plans, participants and beneficiaries, applicable State and local regulatory bodies, and the National Association of Insurance Commissioners concerning the requirements of this section and shall provide assistance concerning such requirements and the continued operation of applicable State law. Such guidance and information shall inform participants and beneficiaries of how they may obtain assistance under this section, including, where appropriate, assistance from State consumer and insurance agencies.

(Pub. L. 93–406, title I, §712, as added Pub. L. 104–204, title VII, §702(a), Sept. 26, 1996, 110 Stat. 2944; amended Pub. L. 107–116, title VII, §701(a), Jan. 10, 2002, 115 Stat. 2228; Pub. L. 107–313, §2(a), Dec. 2, 2002, 116 Stat. 2457; Pub. L. 108–197, §2(a), Dec. 19, 2003, 117 Stat. 2898; Pub. L. 108–311, title III, §302(b), Oct. 4, 2004, 118 Stat. 1178; Pub. L. 109–151, §1(a), Dec. 30, 2005, 119 Stat. 2886; Pub. L. 109–432, div. A, title I, §115(b), Dec. 20, 2006, 120 Stat. 2941; Pub. L. 110–245, title IV, §401(b), June 17, 2008, 122 Stat. 1649; Pub. L. 110–343, div. C, title V, §512(a), (g)(1)(A), Oct. 3, 2008, 122 Stat. 3881, 3892.)

AMENDMENTS

2008—Pub. L. 110–343, §512(g)(1)(A), 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(a)(8), 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(a)(7), 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(a)(1), added pars. (3) to (5).

Subsec. (b)(1). Pub. L. 110–343, §512(a)(8), substituted ''mental health or substance use disorder benefits'' for ''mental health benefits''.

Subsec. (b)(2). Pub. L. 110–343, §512(a)(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) (in regard to parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits).''

Subsec. (c)(1)(B). Pub. L. 110–343, §512(a)(3)(A), inserted ''(or 1 in the case of an employer residing in a State that permits small groups to include a single individual)'' after ''of at least 2'' and struck out ''and who employs at least 2 employees on the first day of the plan year'' after ''preceding calendar year''.

Subsec. (c)(2). Pub. L. 110–343, §512(a)(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(a)(8), substituted ''mental health or substance use disorder benefits'' for ''mental health benefits''.

Subsec. (e)(4). Pub. L. 110–343, §512(a)(8), which directed amendment of this section by substituting ''mental health or substance use disorder benefits'' for ''mental health benefits'' wherever appearing (except in provisions amended by Pub. L. 110–343, §512(a)(7)), was not executed to par. (4) as added by Pub. L. 110–343, §512(a)(4), to reflect the probable intent of Congress. See below.

Pub. L. 110–343, §512(a)(4), added par. (4) and struck out former par. (4). 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(a)(4), added par. (5).

Subsec. (f). Pub. L. 110–343, §512(a)(6), added subsec. (f).

Pub. L. 110–343, §512(a)(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).

Subsec. (g). Pub. L. 110–343, §512(a)(6), added subsec. (g).

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

Amendment by Pub. L. 110–343 applicable with respect to group health plans for plan years beginning after the date that is 1 year after Oct. 3, 2008, except that amendment by section 512(a)(5) of Pub. L. 110–343 effective Jan. 1, 2009, with special rule for collective bargaining agreements, see section 512(e) of Pub. L. 110–343, set out as a note under section 300gg–26 of Title 42, The Public Health and Welfare.

EFFECTIVE DATE

Pub. L. 104–204, title VII, §702(c), Sept. 26, 1996, 110 Stat. 2946, 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.''

## § 1185b. Required coverage for reconstructive surgery following mastectomies

**(a) In general**

A group health plan, and a health insurance issuer providing health insurance coverage in con-

nection with a group health plan, that provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for—

(1) all stages of reconstruction of the breast on which the mastectomy has been performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) prostheses and physical complications of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

**(b) Notice**

A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance with regulations promulgated by the Secretary. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan or issuer and shall be transmitted—

(1) in the next mailing made by the plan or issuer to the participant or beneficiary;

(2) as part of any yearly informational packet sent to the participant or beneficiary; or

(3) not later than January 1, 1999;

whichever is earlier.

**(c) Prohibitions**

A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not—

(1) deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section; and

(2) penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide incentives (monetary or otherwise) to an attending provider, to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

**(d) Rule of construction**

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

**(e) Preemption, relation to State laws**

**(1) In general**

Nothing in this section shall be construed to preempt any State law in effect on October 21, 1998, with respect to health insurance coverage that requires coverage of at least the coverage of reconstructive breast surgery otherwise required under this section.

**(2) ERISA**

Nothing in this section shall be construed to affect or modify the provisions of section 1144 of this title with respect to group health plans.

(Pub. L. 93–406, title I, § 713, as added Pub. L. 105–277, div. A, § 101(f) [title IX, § 902(a)], Oct. 21, 1998, 112 Stat. 2681–337, 2681–436.)

EFFECTIVE DATE

Pub. L. 105–277, div. A, § 101(f) [title IX, § 902(c)], Oct. 21, 1998, 112 Stat. 2681–337, 2681–438, provided that:

''(1) IN GENERAL.—The amendments made by this section [enacting this section] shall apply with respect to plan years beginning on or after the date of enactment of this Act [Oct. 21, 1998].

''(2) 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 this section shall not be treated as a termination of such collective bargaining agreement.''

## § 1185c. 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 health insurance coverage offered in connection with such plan, 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 provides health insurance coverage in connection with a group health plan, 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 health insurance coverage offered in connection with the plan, 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-secondary educational institution (as described in subsection (a)), immediately before the first day of the medically necessary leave of absence involved.

**(3) Certification by physician**

Paragraph (1) shall apply to a group health plan or health insurance coverage offered by an issuer in connection with such plan only if the plan or issuer of the coverage has received written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) described in subsection (a) is medically necessary.

**(c) Notice**

A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, shall include, with any notice regarding a requirement for certification of student status for coverage under the plan or coverage, a description of the terms of this section for continued coverage during medically necessary leaves of absence. Such description shall be in language which is understandable to the typical plan participant.

**(d) No change in benefits**

A dependent child whose benefits are continued under this section shall be entitled to the same benefits as if (during the medically necessary leave of absence) the child continued to be a covered student at the institution of higher education and was not on a medically necessary leave of absence.

**(e) Continued application in case of changed coverage**

If—

(1) a dependent child of a participant or beneficiary is in a period of coverage under a group health plan or health insurance coverage offered in connection with such a plan, pursuant to a medically necessary leave of absence of the child described in subsection (b);

(2) the manner in which the participant or beneficiary is covered under the plan changes, whether through a change in health insurance coverage or health insurance issuer, a change between health insurance coverage and self-insured coverage, or otherwise; and

(3) the coverage as so changed continues to provide coverage of beneficiaries as dependent children,

this section shall apply to coverage of the child under the changed coverage for the remainder of the period of the medically necessary leave of absence of the dependent child under the plan in the same manner as it would have applied if the changed coverage had been the previous coverage.

(Pub. L. 93–406, title I, §714, as added Pub. L. 110–381, §2(a)(1), Oct. 9, 2008, 122 Stat. 4081.)

EFFECTIVE DATE

Section applicable with respect to plan years beginning on or after the date that is one year after Oct. 9, 2008, and to medically necessary leaves of absence beginning during such plan years, see section 2(d) of Pub. L. 110–381, set out as a note under section 9813 of Title 26, Internal Revenue Code.

### § 1185d. Additional market reforms

**(a) General rule**

Except as provided in subsection (b)—

(1) the provisions of part A of title XXVII of the Public Health Service Act [42 U.S.C. 300gg et seq.] (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart; and

(2) to the extent that any provision of this part conflicts with a provision of such part A with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.

**(b) Exception**

Notwithstanding subsection (a), the provisions of sections 2716 and 2718 of title XXVII of the Public Health Service Act [42 U.S.C. 300gg–16, 300gg–18] (as amended by the Patient Protection and Affordable Care Act) shall not apply with respect to self-insured group health plans, and the provisions of this part shall continue to apply to such plans as if such sections of the Public Health Service Act (as so amended) had not been enacted.

(Pub. L. 93–406, title I, §715, as added Pub. L. 111–148, title I, §1563(e), formerly §1562(e), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 270, 911.)

REFERENCES IN TEXT

The Public Health Service Act, referred to in text, is act July 1, 1944, ch. 373, 58 Stat. 682. Part A of title XXVII of the Act is classified generally to part A (§300gg et seq.) of subchapter XXV 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 this Title 42 and Tables.

The Patient Protection and Affordable Care Act, referred to in text, is Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 119. For complete classification of this Act to the Code, see Short Title note set out under section 18001 of Title 42, The Public Health and Welfare, and Tables.

## Subpart C—General Provisions

### § 1191. Preemption; State flexibility; construction

**(a) Continued applicability of State law with respect to health insurance issuers**

**(1) In general**

Subject to paragraph (2) and except as provided in subsection (b), this part shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard

or requirement prevents the application of a requirement of this part.

**(2) Continued preemption with respect to group health plans**

Nothing in this part shall be construed to affect or modify the provisions of section 1144 of this title with respect to group health plans.

**(b) Special rules in case of portability requirements**

**(1) In general**

Subject to paragraph (2), the provisions of this part relating to health insurance coverage offered by a health insurance issuer supersede any provision of State law which establishes, implements, or continues in effect a standard or requirement applicable to imposition of a preexisting condition exclusion specifically governed by section 1181 of this title which differs from the standards or requirements specified in such section.

**(2) Exceptions**

Only in relation to health insurance coverage offered by a health insurance issuer, the provisions of this part do not supersede any provision of State law to the extent that such provision—

(A) substitutes for the reference to ''6-month period'' in section 1181(a)(1) of this title a reference to any shorter period of time;

(B) substitutes for the reference to ''12 months'' and ''18 months'' in section 1181(a)(2) of this title a reference to any shorter period of time;

(C) substitutes for the references to ''63 days'' in sections 1181(c)(2)(A) and (d)(4)(A) of this title a reference to any greater number of days;

(D) substitutes for the reference to ''30-day period'' in sections 1181(b)(2) and (d)(1) of this title a reference to any greater period;

(E) prohibits the imposition of any preexisting condition exclusion in cases not described in section 1181(d) of this title or expands the exceptions described in such section;

(F) requires special enrollment periods in addition to those required under section 1181(f) of this title; or

(G) reduces the maximum period permitted in an affiliation period under section 1181(g)(1)(B) of this title.

**(c) Rules of construction**

Except as provided in section 1185 of this title, nothing in this part shall be construed as requiring a group health plan or health insurance coverage to provide specific benefits under the terms of such plan or coverage.

**(d) Definitions**

For purposes of this section—

**(1) State law**

The term ''State law'' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

**(2) State**

The term ''State'' includes a State, the Northern Mariana Islands, any political subdivisions of a State or such Islands, or any agency or instrumentality of either.

(Pub. L. 93–406, title I, § 731, formerly § 704, as added Pub. L. 104–191, title I, § 101(a), Aug. 21, 1996, 110 Stat. 1946; renumbered § 731 and amended Pub. L. 104–204, title VI, § 603(a)(3), (b)(1), Sept. 26, 1996, 110 Stat. 2935, 2937.)

AMENDMENTS

1996—Subsec. (c). Pub. L. 104–204, § 603(b)(1), substituted ''Except as provided in section 1185 of this title, nothing'' for ''Nothing''.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–204 applicable with respect to group health plans for plan years beginning on and after Jan. 1, 1998, see section 603(c) of Pub. L. 104–204, set out as a note under section 1003 of this title.

EFFECTIVE DATE

Section applicable with respect to group health plans for plan years beginning after June 30, 1997, except as otherwise provided, see section 101(g) of Pub. L. 104–191, set out as a note under section 1181 of this title.

## § 1191a. Special rules relating to group health plans

**(a) General exception for certain small group health plans**

The requirements of this part (other than section 1185 of this title) shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year if, on the first day of such plan year, such plan has less than 2 participants who are current employees.

**(b) Exception for certain benefits**

The requirements of this part shall not apply to any group health plan (and group health insurance coverage) in relation to its provision of excepted benefits described in section 1191b(c)(1) of this title.

**(c) Exception for certain benefits if certain conditions met**

**(1) Limited, excepted benefits**

The requirements of this part shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 1191b(c)(2) of this title if the benefits—

(A) are provided under a separate policy, certificate, or contract of insurance; or

(B) are otherwise not an integral part of the plan.

**(2) Noncoordinated, excepted benefits**

The requirements of this part shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 1191b(c)(3) of this title if all of the following conditions are met:

(A) The benefits are provided under a separate policy, certificate, or contract of insurance.

(B) There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor.

(C) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor.

**(3) Supplemental excepted benefits**

The requirements of this part shall not apply to any group health plan (and group health insurance coverage) in relation to its provision of excepted benefits described in section 1191b(c)(4) of this title if the benefits are provided under a separate policy, certificate, or contract of insurance.

**(d) Treatment of partnerships**

For purposes of this part—

**(1) Treatment as a group health plan**

Any plan, fund, or program which would not be (but for this subsection) an employee welfare benefit plan and which is established or maintained by a partnership, to the extent that such plan, fund, or program provides medical care (including items and services paid for as medical care) to present or former partners in the partnership or to their dependents (as defined under the terms of the plan, fund, or program), directly or through insurance, reimbursement, or otherwise, shall be treated (subject to paragraph (2)) as an employee welfare benefit plan which is a group health plan.

**(2) Employer**

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

**(3) Participants of group health plans**

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

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

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

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

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

AMENDMENTS

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

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

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–204 applicable with respect to group health plans for plan years beginning on and after Jan. 1, 1998, see section 603(c) of Pub. L. 104–204, set out as a note under section 1003 of this title.

EFFECTIVE DATE

Section applicable with respect to group health plans for plan years beginning after June 30, 1997, except as otherwise provided, see section 101(g) of Pub. L. 104–191, set out as a note under section 1181 of this title.

## § 1191b. Definitions

**(a) Group health plan**

For purposes of this part—

**(1) In general**

The term ''group health plan'' means an employee welfare benefit plan to the extent that the plan provides medical care (as defined in paragraph (2) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise. Such term shall not include any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of title 26).

**(2) Medical care**

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

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

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

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

**(b) Definitions relating to health insurance**

For purposes of this part—

**(1) Health insurance coverage**

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

**(2) Health insurance issuer**

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

**(3) Health maintenance organization**

The term ''health maintenance organization'' means—

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

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

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

**(4) Group health insurance coverage**

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

**(c) Excepted benefits**

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

**(1) Benefits not subject to requirements**

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

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

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

(D) Workers' compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for on-site medical clinics.

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

**(2) Benefits not subject to requirements if offered separately**

(A) Limited scope dental or vision benefits.

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

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

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

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

(B) Hospital indemnity or other fixed indemnity insurance.

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

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

**(d) Other definitions**

For purposes of this part—

**(1) COBRA continuation provision**

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

(A) Part 6 of this subtitle.

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

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

**(2) Health status-related factor**

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

**(3) Network plan**

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

**(4) Placed for adoption**

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

**(5) Family member**

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

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

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

**(6) Genetic information**

**(A) In general**

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

(i) such individual's genetic tests,

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

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

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

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

**(C) Exclusions**

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

**(7) Genetic test**

**(A) In general**

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

**(B) Exceptions**

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

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

(ii) an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be de-

tected by a health care professional with appropriate training and expertise in the field of medicine involved.

**(8) Genetic services**

The term ''genetic services'' means—

(A) a genetic test;

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

(C) genetic education.

**(9) Underwriting purposes**

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

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

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

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

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

(Pub. L. 93–406, title I, §733, formerly §706, as added Pub. L. 104–191, title I, §101(a), Aug. 21, 1996, 110 Stat. 1949; renumbered §733, Pub. L. 104–204, title VI, §603(a)(3), Sept. 26, 1996, 110 Stat. 2935; amended Pub. L. 110–233, title I, §101(d), May 21, 2008, 122 Stat. 885; Pub. L. 114–255, div. C, title XVIII, §18001(b)(1), Dec. 13, 2016, 130 Stat. 1343.)

REFERENCES IN TEXT

The Public Health Service Act, referred to in subsec. (d)(1)(C), is act July 1, 1944, ch. 373, 58 Stat. 682, as amended. Title XXII of the Act is classified generally to subchapter XX (§300bb–1 et seq.) of chapter 6A of Title 42, The Public Health and Welfare. For complete classification of this Act to the Code, see Short Title note set out under section 201 of Title 42 and Tables.

AMENDMENTS

2016—Subsec. (a)(1). Pub. L. 114–255 inserted at end ''Such term shall not include any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of title 26).''

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

EFFECTIVE DATE OF 2016 AMENDMENT

Amendment by Pub. L. 114–255 applicable to plan years beginning after Dec. 31, 2016, see section 18001(b)(3) of Pub. L. 114–255, set out as a note under section 1167 of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

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

EFFECTIVE DATE

Section applicable with respect to group health plans for plan years beginning after June 30, 1997, except as otherwise provided, see section 101(g) of Pub. L. 104–191, set out as a note under section 1181 of this title.

### § 1191c. Regulations

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

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

REFERENCES IN TEXT

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

EFFECTIVE DATE

Section applicable with respect to group health plans for plan years beginning after June 30, 1997, except as otherwise provided, see section 101(g) of Pub. L. 104–191, set out as a note under section 1181 of this title.

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

### SUBTITLE A—JURISDICTION, ADMINISTRATION, AND ENFORCEMENT

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

**(a) Additional material required of applicants**

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

**(b) Opportunity to comment on application**

(1) Whenever an application is made to the Secretary of the Treasury for a determination of whether a pension, profit-sharing, or stock bonus plan, a trust which is a part of such a plan, or an annuity or bond purchase plan meets