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 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 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 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, 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) Level and type of reimbursements

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

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

The requirements of this section shall not apply with respect to health insurance coverage if there is a State law (including a decision, rule, regulation, or other State action having the effect of law) for a State that regulates such coverage that is described in any of the following paragraphs:

(1) 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 caesarean section.

(2) 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.

(3) 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.

(Added Pub. L. 105–34, title XV, § 1531(a)(4), Aug. 5, 1997, 111 Stat. 1081; amended Pub. L. 105–206, title VI, § 6015(e), July 22, 1998, 112 Stat. 821.)

AMENDMENTS

1998—Subsecs. (e), (f). Pub. L. 105–206 redesignated subsec. (f) as (e).

EFFECTIVE DATE OF 1998 AMENDMENT

Amendment by Pub. L. 105–206 effective, except as otherwise provided, as if included in the provisions of the Taxpayer Relief Act of 1997, Pub. L. 105–34, to which such amendment relates, see section 6024 of Pub. L. 105–206, set out as a note under section 1 of this title.

EFFECTIVE DATE

Section applicable with respect to group health plans for plan years beginning on or after Jan. 1, 1998, see section 1531(c) of Pub. L. 105–34, set out as an Effective Date of 1997 Amendment note under section 4980D of this title.

§ 9812. Parity in mental health and substance use disorder benefits

(a) In general

(1) Aggregate lifetime limits

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

(A) No lifetime limit

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

(B) Lifetime limit

If the plan includes an aggregate lifetime limit on substantially all medical and surgical benefits (in this paragraph referred to as the ''applicable lifetime limit''), the plan 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 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 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 that provides both medical and surgical benefits and mental health or substance use disorder benefits—

(A) No annual limit

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

(B) Annual limit

If the plan includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the ''applicable annual limit''), the plan 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 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 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 that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan 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, 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 and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

(B) Definitions

In this paragraph:

(i) Financial requirement

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

(ii) Predominant

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

(iii) Treatment limitation

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

(4) Availability of plan information

The criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits shall be made available by the plan administrator in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request. The reason for any denial under the plan 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 to the participant or beneficiary in accordance with regulations.

(5) Out-of-network providers

In the case of a plan that provides both medical and surgical benefits and mental health or substance use disorder benefits, if the plan provides coverage for medical or surgical benefits provided by out-of-network providers, the plan 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 to provide any mental health or substance use disorder benefits; or

(2) in the case of a group health plan that provides mental health or substance use disorder benefits, as affecting the terms and conditions of the plan relating to such benefits under the plan, 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 for any plan year of a small employer.

(B) Small employer

For purposes of subparagraph (A), the term ''small employer'' means, 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. For purposes of the preceding sentence, all persons treated as a single employer under subsection (b), (c), (m), or (*o*) of section 414 shall be treated as 1 employer and rules similar to rules of subparagraphs (B) and (C) of section 4980D(d)(2) shall apply.

(2) Cost exemption

(A) In general

With respect to a group health plan, if the application of this section to such plan 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 during the following plan year, and such exemption shall apply to the plan 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 involved regardless of any increase in total costs.

(B) Applicable percentage

With respect to a plan, 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 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 for a period of 6 years following the notification made under subparagraph (E).

(D) 6-month determinations

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

(E) Notification

(i) In general

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 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;

(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 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 subpara-

graph (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, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan 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, 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 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, 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.

(Added Pub. L. 105–34, title XV, §1531(a)(4), Aug. 5, 1997, 111 Stat. 1083; amended Pub. L. 107–116, title VII, §701(c), Jan. 10, 2002, 115 Stat. 2228; Pub. L. 107–147, title VI, §610(a), Mar. 9, 2002, 116 Stat. 60; Pub. L. 108–311, title III, §302(a), Oct. 4, 2004, 118 Stat. 1178; Pub. L. 109–151, §1(c), Dec. 30, 2005, 119 Stat. 2886; Pub. L. 109–432, div. A, title I, §115(a), Dec. 20, 2006, 120 Stat. 2941; Pub. L. 110–245, title IV, §401(a), June 17, 2008, 122 Stat. 1649; Pub. L. 110–343, div. C, title V, §512(c), (g)(3)(A), Oct. 3, 2008, 122 Stat. 3888, 3892; Pub. L. 115–141, div. U, title IV, §401(a)(349), Mar. 23, 2018, 132 Stat. 1201.)

AMENDMENTS

2018—Subsec. (a)(3)(B)(i). Pub. L. 115–141 substituted period for comma at end.

2008—Pub. L. 110–343, §512(g)(3)(A), substituted ''Parity in mental health and substance use disorder benefits'' for ''Parity in the application of certain limits to mental health benefits'' in section catchline.

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

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

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

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

Subsec. (b)(2). Pub. L. 110–343, §512(c)(2), amended par. (2) generally. Prior to amendment, par. (2) read as follows: ''in the case of a group health 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, 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). Pub. L. 110–343, §512(c)(3)(A), amended par. (1) generally. Prior to amendment, text read as follows: ''This section shall not apply to any group health plan for any plan year of a small employer (as defined in section 4980D(d)(2)).''

Subsec. (c)(2). Pub. L. 110–343, §512(c)(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 if the application of this section to such plan results in an increase in the cost under the plan of at least 1 percent.''

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

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

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

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

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

''(1) on or after September 30, 2001, and before January 10, 2002,

''(2) on or after January 1, 2004, and before the date of the enactment of the Working Families Tax Relief Act of 2004,

''(3) on or after January 1, 2008, and before the date of the enactment of the Heroes Earnings Assistance and Relief Tax Act of 2008, and

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

Subsec. (f)(3), (4). Pub. L. 110–245 added pars. (3) and (4) and struck out former par. (3) which read as follows: ''after December 31, 2007.''

2006—Subsec. (f)(3). Pub. L. 109–432 substituted ''December 31, 2007'' for ''December 31, 2006''.

2005—Subsec. (f)(3). Pub. L. 109–151 substituted ''December 31, 2006'' for ''December 31, 2005''.

2004—Subsec. (f)(2), (3). Pub. L. 108–311 added pars. (2) and (3) and struck out former par. (2) which read as follows: ''after December 31, 2003.''

2002—Subsec. (f). Pub. L. 107–147 amended heading and text of subsec. (f) generally. Prior to amendment, text read as follows: ''This section shall not apply to benefits for services furnished on or after December 31, 2002.''

Subsec. (f). 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(c)(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 OF 2004 AMENDMENT

Pub. L. 108–311, title III, § 302(d), Oct. 4, 2004, 118 Stat. 1179, provided that: ''The amendments made by this section [amending this section, section 1185a of Title 29, Labor, and section 300gg–5 of Title 42, The Public Health and Welfare] shall take effect on the date of the enactment of this Act [Oct. 4, 2004].''

EFFECTIVE DATE OF 2002 AMENDMENT

Pub. L. 107–147, title VI, § 610(b), Mar. 9, 2002, 116 Stat. 60, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to plan years beginning after December 31, 2000.''

EFFECTIVE DATE

Section applicable with respect to group health plans for plan years beginning on or after Jan. 1, 1998, see section 1531(c) of Pub. L. 105–34, set out as an Effective Date of 1997 Amendment note under section 4980D of this title.

§ 9813. 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, a leave of absence of such child from a postsecondary educational institution (including an institution of higher education as defined in section 102 of the Higher Education Act of 1965), 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 shall not terminate coverage of such child under such plan 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.

(2) Dependent child described

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

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

(B) was enrolled in the plan, on the basis of being a student at a postsecondary 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 only if the plan, or the issuer of health insurance coverage offered in connection with the plan, 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 shall include, with any notice regarding a requirement for certification of student status for coverage under the plan, 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, 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.

(Added Pub. L. 110–381, § 2(c)(1), Oct. 9, 2008, 122 Stat. 4084.)

REFERENCES IN TEXT

Section 102 of the Higher Education Act of 1965, referred to in subsec. (a), is classified to section 1002 of Title 20, Education.

EFFECTIVE DATE

Pub. L. 110–381, § 2(d), Oct. 9, 2008, 122 Stat. 4086, provided that: ''The amendments made by this Act [enact-