(1) may receive complaints from participants and beneficiaries of group health plans or group health insurance coverage offered by a health insurance issuer relating to alleged violations of the sections specified in subsection (a); and

(2) transmits such complaints to States or the Secretary of Health and Human Services (as determined appropriate by the Secretary) for potential enforcement actions.

(Pub. L. 93–406, title I, § 522, as added Pub. L. 116–260, div. BB, title I, § 104(b)(1), Dec. 27, 2020, 134 Stat. 2830.)

Editorial Notes

REFERENCES IN TEXT

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

PART 6—CONTINUATION COVERAGE AND ADDITIONAL STANDARDS FOR GROUP HEALTH PLANS

§ 1161. Plans must provide continuation coverage to certain individuals

(a) In general

The plan sponsor of each group health plan shall provide, in accordance with this part, that each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled, under the plan, to elect, within the election period, continuation coverage under the plan.

(b) Exception for certain plans

Subsection (a) shall not apply to any group health plan for any calendar year if all employers maintaining such plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year.

(Pub. L. 93–406, title I, § 601, as added Pub. L. 99–272, title X, § 10002(a), Apr. 7, 1986, 100 Stat. 227; amended Pub. L. 101–239, title VII, §§ 7862(c)(1)(B), 7891(a)(1), Dec. 19, 1989, 103 Stat. 2432, 2445.)

Editorial Notes

AMENDMENTS

1989—Subsec. (b). Pub. L. 101–239 struck out at end ''Under regulations, rules similar to the rules of subsections (a) and (b) of section 52 of title 26 (relating to employers under common control) shall apply for purposes of this subsection.''

Pub. L. 101–239, § 7891(a)(1), substituted ''Internal Revenue Code of 1986'' for ''Internal Revenue Code of 1954'', which for purposes of codification was translated as ''title 26'' thus requiring no change in text.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 7862(c)(1)(B) of Pub. L. 101–239 applicable to years beginning after Dec. 31, 1986, see section 7862(c)(1)(C) of Pub. L. 101–239, set out as a note under section 106 of Title 26, Internal Revenue Code.

Amendment by section 7891(a)(1) of Pub. L. 101–239 effective, except as otherwise provided, as if included in the provision of the Tax Reform Act of 1986, Pub. L. 99–514, to which such amendment relates, see section 7891(f) of Pub. L. 101–239, set out as a note under section 1002 of this title.

EFFECTIVE DATE

Pub. L. 99–272, title X, § 10002(d), Apr. 7, 1986, 100 Stat. 231, provided that:

''(1) GENERAL RULE.—The amendments made by this section [enacting this part and amending section 1132 of this title] shall apply to plan years beginning on or after July 1, 1986.

''(2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act [Apr. 7, 1986], the amendments made by this section shall not apply to plan years beginning before the later of—

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

''(B) January 1, 1987.

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

§ 1162. Continuation coverage

For purposes of section 1161 of this title, the term ''continuation coverage'' means coverage under the plan which meets the following requirements:

(1) Type of benefit coverage

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

(2) Period of coverage

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

(A) Maximum required period

(i) General rule for terminations and reduced hours

In the case of a qualifying event described in section 1163(2) of this title, except as provided in clause (ii), the date which is 18 months after the date of the qualifying event.

(ii) Special rule for multiple qualifying events

If a qualifying event (other than a qualifying event described in section 1163(6) of this title) occurs during the 18 months after the date of a qualifying event described in section 1163(2) of this title, the date which is 36 months after the date of

the qualifying event described in section 1163(2) of this title.

(iii) Special rule for certain bankruptcy proceedings

In the case of a qualifying event described in section 1163(6) of this title (relating to bankruptcy proceedings), the date of the death of the covered employee or qualified beneficiary (described in section 1167(3)(C)(iii) of this title), or in the case of the surviving spouse or dependent children of the covered employee, 36 months after the date of the death of the covered employee.

(iv) General rule for other qualifying events

In the case of a qualifying event not described in section 1163(2) or 1163(6) of this title, the date which is 36 months after the date of the qualifying event.

(v) Special rule for PBGC recipients

In the case of a qualifying event described in section 1163(2) of this title with respect to a covered employee who (as of such qualifying event) has a nonforfeitable right to a benefit any portion of which is to be paid by the Pension Benefit Guaranty Corporation under subchapter III, notwithstanding clause (i) or (ii), the date of the death of the covered employee, or in the case of the surviving spouse or dependent children of the covered employee, 24 months after the date of the death of the covered employee. The preceding sentence shall not require any period of coverage to extend beyond January 1, 2014.

(vi) Special rule for TAA-eligible individuals

In the case of a qualifying event described in section 1163(2) of this title with respect to a covered employee who is (as of the date that the period of coverage would, but for this clause or clause (vii), otherwise terminate under clause (i) or (ii)) a TAA-eligible individual (as defined in section 1165(b)(4)(B) of this title), the period of coverage shall not terminate by reason of clause (i) or (ii), as the case may be, before the later of the date specified in such clause or the date on which such individual ceases to be such a TAA-eligible individual. The preceding sentence shall not require any period of coverage to extend beyond January 1, 2014.

(vii) Medicare entitlement followed by qualifying event

In the case of a qualifying event described in section 1163(2) of this title that occurs less than 18 months after the date the covered employee became entitled to benefits under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], the period of coverage for qualified beneficiaries other than the covered employee shall not terminate under this subparagraph before the close of the 36-month period beginning on the date the covered employee became so entitled.

(viii) Special rule for disability

In the case of a qualified beneficiary who is determined, under title II or XVI of the Social Security Act [42 U.S.C. 401 et seq., 1381 et seq.], to have been disabled at any time during the first 60 days of continuation coverage under this part, any reference in clause (i) or (ii) to 18 months is deemed a reference to 29 months (with respect to all qualified beneficiaries), but only if the qualified beneficiary has provided notice of such determination under section 1166(3)[1] of this title before the end of such 18 months.

(B) End of plan

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

(C) Failure to pay premium

The date on which coverage ceases under the plan by reason of a failure to make timely payment of any premium required under the plan with respect to the qualified beneficiary. The payment of any premium (other than any payment referred to in the last sentence of paragraph (3)) shall be considered to be timely if made within 30 days after the date due or within such longer period as applies to or under the plan.

(D) Group health plan coverage or medicare entitlement

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

(i) covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary (other than such an exclusion or limitation which does not apply to (or is satisfied by) such beneficiary by reason of chapter 100 of title 26, part 7 of this subtitle, or title XXVII of the Public Health Service Act [42 U.S.C. 300gg et seq.]), or

(ii) in the case of a qualified beneficiary other than a qualified beneficiary described in section 1167(3)(C) of this title, entitled to benefits under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].

(E) Termination of extended coverage for disability

In the case of a qualified beneficiary who is disabled at any time during the first 60 days of continuation coverage under this part, the month that begins more than 30 days after the date of the final determination under title II or XVI of the Social Security Act [42 U.S.C. 401 et seq., 1381 et seq.] that the qualified beneficiary is no longer disabled.

(3) Premium requirements

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

[1] See References in Text note below.

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

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

In no event may the plan require the payment of any premium before the day which is 45 days after the day on which the qualified beneficiary made the initial election for continuation coverage. In the case of an individual described in the last sentence of paragraph (2)(A),[2] any reference in subparagraph (A) of this paragraph to ''102 percent'' is deemed a reference to ''150 percent'' for any month after the 18th month of continuation coverage described in clause (i) or (ii) of paragraph (2)(A).

(4) No requirement of insurability

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

(5) Conversion option

In the case of a qualified beneficiary whose period of continuation coverage expires under paragraph (2)(A), the plan must, during the 180-day period ending on such expiration date, provide to the qualified beneficiary the option of enrollment under a conversion health plan otherwise generally available under the plan.

(Pub. L. 93–406, title I, § 602, as added Pub. L. 99–272, title X, § 10002(a), Apr. 7, 1986, 100 Stat. 228; amended Pub. L. 99–509, title IX, § 9501(b)(1)(B), (2)(B), Oct. 21, 1986, 100 Stat. 2076, 2077; Pub. L. 99–514, title XVIII, § 1895(d)(1)(B), (2)(B), (3)(B), (4)(B), Oct. 22, 1986, 100 Stat. 2936–2938; Pub. L. 101–239, title VI, § 6703(a), (b), title VII, §§ 7862(c)(3)(B), (4)(A), (5)(B), 7871(c), Dec. 19, 1989, 103 Stat. 2296, 2432, 2433, 2435; Pub. L. 104–188, title I, § 1704(g)(1)(B), Aug. 20, 1996, 110 Stat. 1880; Pub. L. 104–191, title IV, § 421(b)(1), Aug. 21, 1996, 110 Stat. 2088; Pub. L. 111–5, div. B, title I, § 1899F(a), Feb. 17, 2009, 123 Stat. 428; Pub. L. 111–344, title I, § 116(a), Dec. 29, 2010, 124 Stat. 3615; Pub. L. 112–40, title II, § 243(a)(1), (2), Oct. 21, 2011, 125 Stat. 420.)

Editorial Notes

REFERENCES IN TEXT

The Social Security Act, referred to in par. (2)(A)(vii), (viii), (D)(ii), (E), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Titles II, XVI, and XVIII of the Social Security Act are classified generally to subchapters II (§ 401 et seq.), XVI (§ 1381 et seq.), and XVIII (§ 1395 et seq.), respectively, of chapter 7 of Title 42, The Public Health and Welfare. For complete classification of this Act to the Code, see section 1305 of Title 42 and Tables.

Section 1166(3) of this title, referred to in par. (2)(A)(viii), was redesignated as section 1166(a)(3) of this title by Pub. L. 101–239, title VII, § 7891(d)(1)(A)(ii)(I), Dec. 19, 1989, 103 Stat. 2445.

The Public Health Service Act, referred to in par. (2)(D)(i), is act July 1, 1944, ch. 373, 58 Stat. 682. Title XXVII of the Act is classified generally to subchapter XXV (§ 300gg et seq.) of chapter 6A of Title 42, The Public Health and Welfare. For complete classification of this Act to the Code, see Short Title note set out under section 201 of Title 42 and Tables.

The last sentence of paragraph (2)(A), referred to in par. (3), probably means par. (2)(A)(viii) of this section, which was originally enacted as the concluding provisions of par. (2)(A) and subsequently designated as cl. (vi) and redesignated as cl. (viii) of par. (2)(A) by Pub. L. 111–5, div. B, title I, § 1899F(a)(2), (3), Feb. 17, 2009, 123 Stat. 428.

AMENDMENTS

2011—Par. (2)(A)(v), (vi). Pub. L. 112–40 substituted ''January 1, 2014'' for ''February 12, 2011''.

2010—Par. (2)(A)(v), (vi). Pub. L. 111–344 substituted ''February 12, 2011'' for ''December 31, 2010''.

2009—Par. (2)(A)(v). Pub. L. 111–5, § 1899F(a)(3), added cl. (v). Former cl. (v) redesignated (vii).

Pub. L. 111–5, § 1899F(a)(1), transferred cl. (v) to appear after cl. (iv). See 1989 Amendment note below.

Par. (2)(A)(vi). Pub. L. 111–5, § 1899F(a)(3), added cl. (vi). Former cl. (vi) redesignated (viii).

Pub. L. 111–5, § 1899F(a)(2), designated concluding provisions as cl. (vi) and inserted heading.

Par. (2)(A)(vii), (viii). Pub. L. 111–5, § 1899F(a)(3), redesignated cls. (v) and (vi) as (vii) and (viii), respectively.

1996—Par. (2)(A). Pub. L. 104–191, § 421(b)(1)(A), in closing provisions, substituted ''In the case of a qualified beneficiary'' for ''In the case of an individual'' and ''at any time during the first 60 days of continuation coverage under this part'' for ''at the time of a qualifying event described in section 1163(2) of this title'', struck out ''with respect to such event'' after ''(ii) to 18 months'', and inserted ''(with respect to all qualified beneficiaries)'' after ''29 months''.

Par. (2)(A)(v). Pub. L. 104–188 amended cl. (v) generally. Prior to amendment, cl. (v) read as follows:

''(v) QUALIFYING EVENT INVOLVING MEDICARE ENTITLEMENT.—In the case of an event described in section 1163(4) of this title (without regard to whether such event is a qualifying event), the period of coverage for qualified beneficiaries other than the covered employee for such event or any subsequent qualifying event shall not terminate before the close of the 36-month period beginning on the date the covered employee becomes entitled to benefits under title XVIII of the Social Security Act.''

Par. (2)(D)(i). Pub. L. 104–191, § 421(b)(1)(B), inserted ''(other than such an exclusion or limitation which does not apply to (or is satisfied by) such beneficiary by reason of chapter 100 of title 26, part 7 of this subtitle, or title XXVII of the Public Health Service Act [42 U.S.C. 300gg et seq.])'' before '', or'' at end.

Par. (2)(E). Pub. L. 104–191, § 421(b)(1)(C), substituted ''at any time during the first 60 days of continuation coverage under this part'' for ''at the time of a qualifying event described in section 1163(2) of this title''.

1989—Par. (2)(A). Pub. L. 101–239, § 6703(a)(1), inserted after and below cl. (iv) ''In the case of an individual who is determined, under title II or XVI of the Social Security Act, to have been disabled at the time of a qualifying event described in section 1163(2) of this title, any reference in clause (i) or (ii) to 18 months with respect to such event is deemed a reference to 29 months, but only if the qualified beneficiary has provided notice of such determination under section 1166(3) of this title before the end of such 18 months.''

Par. (2)(A)(iii). Pub. L. 101–239, § 7871(c), substituted ''described in section 1163(6)'' for ''described in 1163(6)''.

Par. (2)(A)(v). Pub. L. 101–239, § 7862(c)(5)(B), added cl. (v) after concluding provisions inserted by Pub. L. 101–239, § 6703(a)(1). See above.

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

Par. (2)(E). Pub. L. 101–239, § 6703(a)(2), added subpar. (E).

Par. (3). Pub. L. 101–239, § 7862(c)(4)(A), which directed substitution of ''In no event may the plan require the payment of any premium before the day which is 45 days after the day on which the qualified beneficiary made the initial election for continuation coverage.'' for last sentence of par. (3), was executed by making

[2] See References in Text note below.

the substitution for the following sentence: ''If an election is made after the qualifying event, the plan shall permit payment for continuation coverage during the period preceding the election to be made within 45 days of the date of the election.'', notwithstanding the sentence added at the end of par. (3) by Pub. L. 101–239, §6703(b).

Pub. L. 101–239, §6703(b), inserted at end ''In the case of an individual described in the last sentence of paragraph (2)(A), any reference in subparagraph (A) of this paragraph to '102 percent' is deemed a reference to '150 percent' for any month after the 18th month of continuation coverage described in clause (i) or (ii) of paragraph (2)(A).''

1986—Par. (1). Pub. L. 99–514, §1895(d)(1)(B), inserted ''If coverage is modified under the plan for any group of similarly situated beneficiaries, such coverage shall also be modified in the same manner for all individuals who are qualified beneficiaries under the plan pursuant to this part in connection with such group.''

Par. (2)(A). Pub. L. 99–514, §1895(d)(2)(B), amended subpar. (A) generally. Prior to amendment, subpar. (A) read as follows:

''(A) MAXIMUM PERIOD.—In the case of—

''(i) a qualifying event described in section 1163(2) of this title (relating to terminations and reduced hours), the date which is 18 months after the date of the qualifying event, and

''(ii) any qualifying event not described in clause (i), the date which is 36 months after the date of the qualifying event.''

Par. (2)(A)(ii). Pub. L. 99–509, §9501(b)(1)(B)(i), inserted ''(other than a qualifying event described in section 1163(6) of this title)''.

Par. (2)(A)(iii). Pub. L. 99–509, §9501(b)(1)(B)(iv), added cl. (iii). Former cl. (iii) redesignated (iv).

Par. (2)(A)(iv). Pub. L. 99–509, §9501(b)(1)(B)(ii), (iii), redesignated cl. (iii) as (iv) and inserted ''or 1163(6)''.

Par. (2)(C). Pub. L. 99–514, §1895(d)(3)(B), inserted ''The payment of any premium (other than any payment referred to in the last sentence of paragraph (3)) shall be considered to be timely if made within 30 days after the date due or within such longer period as applies to or under the plan.''

Par. (2)(D). Pub. L. 99–514, §1895(d)(4)(B)(ii), (iii), substituted ''Group health plan coverage or medicare eligibility'' for ''Reemployment or medicare eligibility'' as heading and substituted ''covered under any other group health plan (as an employee or otherwise)'' for ''a covered employee under any other group health plan'' in cl. (i).

Par. (2)(D)(ii). Pub. L. 99–509, §9501(b)(2)(B), inserted ''in the case of a qualified beneficiary other than a qualified beneficiary described in section 1167(3)(C) of this title'' before ''entitled''.

Par. (2)(E). Pub. L. 99–514, §1895(d)(4)(B)(i), struck out subpar. (E), remarriage of spouse, which read as follows: ''In the case of an individual who is a qualified beneficiary by reason of being the spouse of a covered employee, the date on which the beneficiary remarries and becomes covered under a group health plan.''

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–40 applicable to periods of coverage which would (without regard to the amendments made by section 243 of Pub. L. 112–40) end on or after the date which is 30 days after Oct. 21, 2011, see section 243(b) of Pub. L. 112–40, set out as a note under section 4980B of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by Pub. L. 111–344 applicable to periods of coverage which would (without regard to such amendment) end on or after Dec. 31, 2010, see section 116(d) of Pub. L. 111–344, set out as a note under section 4980B 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 periods of coverage which would (without regard to amendment by Pub. L. 111–5) end on or after Feb. 17, 2009, see section 1899F(d) of Pub. L. 111–5, set out as a note under section 4980B of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1996 AMENDMENTS

Amendment by Pub. L. 104–191 effective Jan. 1, 1997, regardless of whether qualifying event occurred before, on, or after such date, see section 421(d) of Pub. L. 104–191 set out as a note under section 4980B of Title 26, Internal Revenue Code.

Amendment by Pub. L. 104–188 applicable to plan years beginning after Dec. 31, 1989, see section 1704(g)(2) of Pub. L. 104–188, set out as a note under section 4980B of Title 26.

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–239, title VI, §6703(d), Dec. 19, 1989, 103 Stat. 2296, provided that: ''The amendments made by this section [amending this section and section 1166 of this title] shall apply to plan years beginning on or after the date of the enactment of this Act [Dec. 19, 1989], regardless of whether the qualifying event occurred before, on, or after such date.''

Amendment by section 7862(c)(3)(B) of Pub. L. 101–239 applicable to (i) qualifying events occurring after Dec. 31, 1989, and (ii) in the case of qualified beneficiaries who elected continuation coverage after Dec. 31, 1988, the period for which the required premium was paid (or was attempted to be paid but was rejected as such), see section 7862(c)(3)(D) of Pub. L. 101–239, set out as a note under section 162 of Title 26, Internal Revenue Code.

Amendment by section 7862(c)(4)(A) of Pub. L. 101–239 applicable to plan years beginning after Dec. 31, 1989, see section 7862(c)(4)(C) of Pub. L. 101–239, set out as a note under section 4980B of Title 26.

Amendment by section 7862(c)(5)(B) of Pub. L. 101–239 applicable to plan years beginning after Dec. 31, 1989, see section 7862(c)(5)(C) of Pub. L. 101–239, set out as a note under section 4980B of Title 26.

EFFECTIVE DATE OF 1986 AMENDMENTS

Amendment by Pub. L. 99–514 effective, except as otherwise provided, as if included in enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99–272, see section 1895(e) of Pub. L. 99–514, set out as a note under section 162 of Title 26, Internal Revenue Code.

Amendment by Pub. L. 99–509 effective, except as otherwise provided, as if included in title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99–272, see section 9501(e) of Pub. L. 99–509, set out as a note under section 162 of Title 26.

PLAN AMENDMENTS NOT REQUIRED UNTIL JANUARY 1, 1989

For provisions directing that if any amendments made by subtitle A or subtitle C of title XI [§§1101–1147 and 1171–1177] or title XVIII [§§1800–1899A] of Pub. L. 99–514 require an amendment to any plan, such plan amendment shall not be required to be made before the first plan year beginning on or after Jan. 1, 1989, see section 1140 of Pub. L. 99–514, set out as a note under section 401 of Title 26, Internal Revenue Code.

§ 1163. Qualifying event

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

(1) The death of the covered employee.

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

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

(4) The covered employee becoming entitled to benefits under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].

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

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

In the case of an event described in paragraph (6), a loss of coverage includes a substantial elimination of coverage with respect to a qualified beneficiary described in section 1167(3)(C) of this title within one year before or after the date of commencement of the proceeding.

(Pub. L. 93–406, title I, § 603, as added Pub. L. 99–272, title X, § 10002(a), Apr. 7, 1986, 100 Stat. 229; amended Pub. L. 99–509, title IX, § 9501(a)(2), Oct. 21, 1986, 100 Stat. 2076.)

Editorial Notes

REFERENCES IN TEXT

The Social Security Act, referred to in par. (4), is act Aug. 14, 1935, ch. 531, 49 Stat. 620, as amended. Title XVIII of the Social Security Act is classified generally to subchapter XVIII (§ 1395 et seq.) 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.

AMENDMENTS

1986—Pub. L. 99–509 added par. (6) and last sentence.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–509 effective, except as otherwise provided, as if included in title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99–272, see section 9501(e) of Pub. L. 99–509, set out as a note under section 162 of Title 26, Internal Revenue Code.

§ 1164. Applicable premium

For purposes of this part—

(1) In general

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

(2) Special rule for self-insured plans

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

(A) In general

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

(i) is determined on an actuarial basis, and

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

(B) Determination on basis of past cost

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

(i) the cost to the plan for similarly situated beneficiaries for the same period occurring during the preceding determination period under paragraph (3), adjusted by

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

(C) Subparagraph (B) not to apply where significant change

An administrator may not elect to have subparagraph (B) apply in any case in which there is any significant difference, between the determination period and the preceding determination period, in coverage under, or in employees covered by, the plan. The determination under the preceding sentence for any determination period shall be made at the same time as the determination under paragraph (3).

(3) Determination period

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

(Pub. L. 93–406, title I, § 604, as added Pub. L. 99–272, title X, § 10002(a), Apr. 7, 1986, 100 Stat. 229.)

§ 1165. Election

(a) In general

For purposes of this part—

(1) Election period

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

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

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

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

(i) the date described in subparagraph (A), or

(ii) in the case of any qualified beneficiary who receives notice under section 1166(4)[1] of this title, the date of such notice.

[1] See References in Text note below.

(2) Effect of election on other beneficiaries

Except as otherwise specified in an election, any election of continuation coverage by a qualified beneficiary described in subparagraph (A)(i) or (B) of section 1167(3) of this title shall be deemed to include an election of continuation coverage on behalf of any other qualified beneficiary who would lose coverage under the plan by reason of the qualifying event. If there is a choice among types of coverage under the plan, each qualified beneficiary is entitled to make a separate selection among such types of coverage.

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

(1) In general

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

(2) Commencement of coverage; no reach-back

Any continuation coverage elected by a TAA-eligible individual under paragraph (1) shall commence at the beginning of the 60-day election period described in such paragraph and shall not include any period prior to such 60-day election period.

(3) Preexisting conditions

With respect to an individual who elects continuation coverage pursuant to paragraph (1), the period—

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

(B) ending on the first day of the 60-day election period described in paragraph (1),

shall be disregarded for purposes of determining the 63-day periods referred to in section 1181(c)(2) of this title, section 2701(c)(2) of the Public Health Service Act,[1] and section 9801(c)(2) of title 26.

(4) Definitions

For purposes of this subsection:

(A) Nonelecting TAA-eligible individual

The term ''nonelecting TAA-eligible individual'' means a TAA-eligible individual who—

(i) has a TAA-related loss of coverage; and

(ii) did not elect continuation coverage under this part during the TAA-related election period.

(B) TAA-eligible individual

The term ''TAA-eligible individual'' means—

(i) an eligible TAA recipient (as defined in paragraph (2) of section 35(c) of title 26), and

(ii) an eligible alternative TAA recipient (as defined in paragraph (3) of such section).

(C) TAA-related election period

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

(D) TAA-related loss of coverage

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

(Pub. L. 93–406, title I, §605, as added Pub. L. 99–272, title X, §10002(a), Apr. 7, 1986, 100 Stat. 230; amended Pub. L. 99–514, title XVIII, §1895(d)(5)(B), Oct. 22, 1986, 100 Stat. 2939; Pub. L. 107–210, div. A, title II, §203(e)(1), Aug. 6, 2002, 116 Stat. 969.)

Editorial Notes

REFERENCES IN TEXT

Section 1166(4) of this title, referred to in subsec. (a)(1)(C)(ii), was redesignated as section 1166(a)(4) of this title by Pub. L. 101–239, title VII, §7891(d)(1)(A)(ii)(I), Dec. 19, 1989, 103 Stat. 2445.

Section 2701 of the Public Health Service Act, referred to in subsec. (b)(3), was classified to section 300gg of Title 42, The Public Health and Welfare, was renumbered section 2704, effective for plan years beginning on or after Jan. 1, 2014, with certain exceptions, and amended, by Pub. L. 111–148, title I, §§1201(2), 1563(c)(1), formerly §1562(c)(1), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911, and was transferred to section 300gg–3 of Title 42. A new section 2701, related to fair health insurance premiums, was added and amended by Pub. L. 111–148, title I, §1201(4), title X, §10103(a), Mar. 23, 2010, 124 Stat. 155, 892, and is classified to section 300gg of Title 42.

AMENDMENTS

2002—Pub. L. 107–210 designated existing provisions as subsec. (a), inserted heading, and added subsec. (b).

1986—Par. (2). Pub. L. 99–514 inserted ''of continuation coverage'' after ''any election'' and inserted at end ''If there is a choice among types of coverage under the plan, each qualified beneficiary is entitled to make a separate selection among such types of coverage.''

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2002 AMENDMENT

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

EFFECTIVE DATE OF 1986 AMENDMENT

Amendment by Pub. L. 99–514 effective, except as otherwise provided, as if included in enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99–272, see section 1895(e) of Pub. L. 99–514, set out as a note under section 162 of Title 26, Internal Revenue Code.

CONSTRUCTION OF 2002 AMENDMENT

Nothing in amendment by Pub. L. 107–210, other than provisions relating to COBRA continuation coverage and reporting requirements, to be construed as creating new mandate on any party regarding health insurance coverage, see section 203(f) of Pub. L. 107–210, set out as a Construction note under section 35 of Title 26, Internal Revenue Code.

PLAN AMENDMENTS NOT REQUIRED UNTIL JANUARY 1, 1989

For provisions directing that if any amendments made by subtitle A or subtitle C of title XI [§§1101–1147

and 1171–1177] or title XVIII [§§ 1800–1899A] of Pub. L. 99–514 require an amendment to any plan, such plan amendment shall not be required to be made before the first plan year beginning on or after Jan. 1, 1989, see section 1140 of Pub. L. 99–514, as amended, set out as a note under section 401 of Title 26, Internal Revenue Code.

§ 1166. Notice requirements

(a) In general

In accordance with regulations prescribed by the Secretary—

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

(2) the employer of an employee under a plan must notify the administrator of a qualifying event described in paragraph (1), (2), (4), or (6) of section 1163 of this title within 30 days (or, in the case of a group health plan which is a multiemployer plan, such longer period of time as may be provided in the terms of the plan) of the date of the qualifying event,

(3) each covered employee or qualified beneficiary is responsible for notifying the administrator of the occurrence of any qualifying event described in paragraph (3) or (5) of section 1163 of this title within 60 days after the date of the qualifying event and each qualified beneficiary who is determined, under title II or XVI of the Social Security Act [42 U.S.C. 401 et seq., 1381 et seq.], to have been disabled at any time during the first 60 days of continuation coverage under this part is responsible for notifying the plan administrator of such determination within 60 days after the date of the determination and for notifying the plan administrator within 30 days after the date of any final determination under such title or titles that the qualified beneficiary is no longer disabled, and

(4) the administrator shall notify—

(A) in the case of a qualifying event described in paragraph (1), (2), (4), or (6) of section 1163 of this title, any qualified beneficiary with respect to such event, and

(B) in the case of a qualifying event described in paragraph (3) or (5) of section 1163 of this title where the covered employee notifies the administrator under paragraph (3), any qualified beneficiary with respect to such event,

of such beneficiary's rights under this subsection.

(b) Alternative means of compliance with requirements for notification of multiemployer plans by employers

The requirements of subsection (a)(2) shall be considered satisfied in the case of a multiemployer plan in connection with a qualifying event described in paragraph (2) of section 1163 of this title if the plan provides that the determination of the occurrence of such qualifying event will be made by the plan administrator.

(c) Rules relating to notification of qualified beneficiaries by plan administrator

For purposes of subsection (a)(4), any notification shall be made within 14 days (or, in the case of a group health plan which is a multiemployer plan, such longer period of time as may be provided in the terms of the plan) of the date on which the administrator is notified under paragraph (2) or (3), whichever is applicable, and any such notification to an individual who is a qualified beneficiary as the spouse of the covered employee shall be treated as notification to all other qualified beneficiaries residing with such spouse at the time such notification is made.

(Pub. L. 93–406, title I, § 606, as added Pub. L. 99–272, title X, § 10002(a), Apr. 7, 1986, 100 Stat. 230; amended Pub. L. 99–509, title IX, § 9501(d)(2), Oct. 21, 1986, 100 Stat. 2077; Pub. L. 99–514, title XVIII, § 1895(d)(6)(B), Oct. 22, 1986, 100 Stat. 2939; Pub. L. 101–239, title VI, § 6703(c), title VII, § 7891(d)(1)(A), Dec. 19, 1989, 103 Stat. 2296, 2445; Pub. L. 104–191, title IV, § 421(b)(2), Aug. 21, 1996, 110 Stat. 2088.)

Editorial Notes

REFERENCES IN TEXT

The Social Security Act, referred to in subsec. (a)(3), is act Aug. 14, 1935, ch. 531, 49 Stat. 620, as amended. Titles II and XVI of the Social Security Act are classified generally to subchapters II (§ 401 et seq.) and XVI (§ 1381 et seq.), respectively, of chapter 7 of Title 42, The Public Health and Welfare. For complete classification of this Act to the Code, see section 1305 of Title 42 and Tables.

AMENDMENTS

1996—Subsec. (a)(3). Pub. L. 104–191 substituted ''at any time during the first 60 days of continuation coverage under this part'' for ''at the time of a qualifying event described in section 1163(2) of this title''.

1989—Pub. L. 101–239, § 7891(d)(1)(A)(ii), designated first sentence as subsec. (a), added subsec. (b), designated second sentence as subsec. (c), and substituted ''For purposes of subsection (a)(4)'' for ''For purposes of paragraph (4)''.

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

Pub. L. 101–239, § 7891(d)(1)(A)(i)(I), inserted ''(or, in the case of a group health plan which is a multiemployer plan, such longer period of time as may be provided in the terms of the plan)'' after ''30 days'' in par. (2).

Pub. L. 101–239, § 6703(c), inserted ''and each qualified beneficiary who is determined, under title II or XVI of the Social Security Act, to have been disabled at the time of a qualifying event described in section 1163(2) of this title is responsible for notifying the plan administrator of such determination within 60 days after the date of the determination and for notifying the plan administrator within 30 days after the date of any final determination under such title or titles that the qualified beneficiary is no longer disabled'' before comma in par. (3).

1986—Par. (2). Pub. L. 99–509 substituted ''(4), or (6)'' for ''or (4)''.

Par. (3). Pub. L. 99–514 inserted ''within 60 days after the date of the qualifying event''.

Par. (4)(A). Pub. L. 99–509 substituted ''(4), or (6)'' for ''or (4)''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–191 effective Jan. 1, 1997, regardless of whether qualifying event occurred before, on, or after such date, see section 421(d) of Pub. L.

104–191 set out as a note under section 4980B of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 6703(c) of Pub. L. 101–239 applicable to plan years beginning on or after Dec. 19, 1989, regardless of whether the qualifying event occurred before, on, or after such date, see section 6703(d) of Pub. L. 101–239, set out as a note under section 1162 of this title.

Amendment by section 7891(d)(1)(A) of Pub. L. 101–239 applicable with respect to plan years beginning on or after Jan. 1, 1990, see section 7891(d)(1)(C) of Pub. L. 101–239, set out as a note under section 4980B of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1986 AMENDMENTS

Amendment by Pub. L. 99–514 applicable only with respect to qualifying events occurring after Oct. 22, 1986, see section 1895(d)(6)(D) of Pub. L. 99–514, set out as a note under section 162 of Title 26, Internal Revenue Code.

Amendment by Pub. L. 99–509 effective, except as otherwise provided, as if included in title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99–272, see section 9501(e) of Pub. L. 99–509, set out as a note under section 162 of Title 26.

PLAN AMENDMENTS NOT REQUIRED UNTIL JANUARY 1, 1989

For provisions directing that if any amendments made by subtitle A or subtitle C of title XI [§§ 1101–1147 and 1171–1177] or title XVIII [§§ 1800–1899A] of Pub. L. 99–514 require an amendment to any plan, such plan amendment shall not be required to be made before the first plan year beginning on or after Jan. 1, 1989, see section 1140 of Pub. L. 99–514, as amended, set out as a note under section 401 of Title 26, Internal Revenue Code.

NOTIFICATION TO COVERED EMPLOYEES

Pub. L. 99–272, title X, § 10002(e), Apr. 7, 1986, 100 Stat. 232, provided that: ''At the time that the amendments made by this section [enacting this part and amending section 1132 of this title] apply to a group health plan (within the meaning of section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1167(1)]), the plan shall notify each covered employee, and spouse of the employee (if any), who is covered under the plan at that time of the continuation coverage required under part 6 of subtitle B of title I of such Act [this part]. The notice furnished under this subsection is in lieu of notice that may otherwise be required under section 606(1) of such Act [29 U.S.C. 1166(1)] with respect to such individuals.''

§ 1167. Definitions and special rules

For purposes of this part—

(1) Group health plan

The term ''group health plan'' means an employee welfare benefit plan providing medical care (as defined in section 213(d) of title 26) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise. Such term shall not include any plan substantially all of the coverage under which is for qualified long-term care services (as defined in section 7702B(c) of title 26). Such term shall not include any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of title 26).

(2) Covered employee

The term ''covered employee'' means an individual who is (or was) provided coverage under a group health plan by virtue of the performance of services by the individual for 1 or more persons maintaining the plan (including as an employee defined in section 401(c)(1) of title 26).

(3) Qualified beneficiary

(A) In general

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

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

(ii) as the dependent child of the employee.

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

(B) Special rule for terminations and reduced employment

In the case of a qualifying event described in section 1163(2) of this title, the term ''qualified beneficiary'' includes the covered employee.

(C) Special rule for retirees and widows

In the case of a qualifying event described in section 1163(6) of this title, the term ''qualified beneficiary'' includes a covered employee who had retired on or before the date of substantial elimination of coverage and any other individual who, on the day before such qualifying event, is a beneficiary under the plan—

(i) as the spouse of the covered employee,

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

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

(4) Employer

Subsection (n) (relating to leased employees) and subsection (t) (relating to application of controlled group rules to certain employee benefits) of section 414 of title 26 shall apply for purposes of this part in the same manner and to the same extent as such subsections apply for purposes of section 106 of title 26. Any regulations prescribed by the Secretary pursuant to the preceding sentence shall be consistent and coextensive with any regulations prescribed for similar purposes by the Secretary of the Treasury (or such Secretary's delegate) under such subsections.

(5) Optional extension of required periods

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

(A) that the period of extended coverage referred to in section 1162(2) of this title commences with the date of the loss of coverage, and

(B) that the applicable notice period provided under section 1166(a)(2) of this title commences with the date of the loss of coverage.

(Pub. L. 93–406, title I, §607, as added Pub. L. 99–272, title X, §10002(a), Apr. 7, 1986, 100 Stat. 231; amended Pub. L. 99–509, title IX, §9501(c)(2), Oct. 21, 1986, 100 Stat. 2077; Pub. L. 99–514, title XVIII, §1895(d)(8), (9)(A), Oct. 22, 1986, 100 Stat. 2940; Pub. L. 100–647, title III, §3011(b)(6), Nov. 10, 1988, 102 Stat. 3625; Pub. L. 101–239, title VII, §§7862(c)(2)(A), (6)(A), 7891(a)(1), (d)(2)(B)(i), Dec. 19, 1989, 103 Stat. 2432, 2433, 2445, 2446; Pub. L. 104–191, title III, §321(d)(2), title IV, §421(b)(3), Aug. 21, 1996, 110 Stat. 2058, 2088; Pub. L. 114–255, div. C, title XVIII, §18001(b)(2), Dec. 13, 2016, 130 Stat. 1344.)

Editorial Notes

AMENDMENTS

2016—Par. (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).''

1996—Par. (1). Pub. L. 104–191, §321(d)(2), inserted at end ''Such term shall not include any plan substantially all of the coverage under which is for qualified long-term care services (as defined in section 7702B(c) of title 26).''

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

1989—Pub. L. 101–239, §7891(d)(2)(B)(i)(I), inserted ''and special rules'' after ''Definitions'' in section catchline.

Par. (1). Pub. L. 101–239, §7862(c)(6)(A), repealed Pub. L. 100–647, §3011(b)(6), see 1988 Amendment note below.

Pub. L. 101–239, §7891(a)(1), substituted ''Internal Revenue Code of 1986'' for ''Internal Revenue Code of 1954'', which for purposes of codification was translated as ''title 26'' thus requiring no change in text.

Par. (2). Pub. L. 101–239, §7862(c)(2)(A), substituted ''the performance of services by the individual for 1 or more persons maintaining the plan (including as an employee defined in section 401(c)(1) of title 26)'' for ''the individual's employment or previous employment with an employer''.

Par. (5). Pub. L. 101–239, §7891(d)(2)(B)(i)(II), added par. (5).

1988—Par. (1). Pub. L. 100–647, §3011(b)(6), which directed amendment of par. (1) by substituting ''section 162(i)(2) of title 26'' for ''section 162(i)(3) of title 26'', was repealed by Pub. L. 101–239, §7862(c)(6)(A).

Pub. L. 99–514, §1895(d)(8), amended par. (1) generally. Prior to amendment, par. (1) read as follows: ''The term 'group health plan' means an employee welfare benefit plan that is a group health plan (within the meaning of section 162(i)(3) of title 26).''

Par. (3)(C). Pub. L. 99–509 added subpar. (C).

Par. (4). Pub. L. 99–514, §1895(d)(9)(A), added par. (4).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2016 AMENDMENT

Pub. L. 114–255, div. C, title XVIII, §18001(b)(3), Dec. 13, 2016, 130 Stat. 1344, provided that: ''The amendments made by this subsection [amending this section and section 1191b of this title] shall apply to plan years beginning after December 31, 2016.''

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by section 321(d)(2) of Pub. L. 104–191 applicable to contracts issued after Dec. 31, 1996, see section 321(f) of Pub. L. 104–191, set out as an Effective Date note under section 7702B of Title 26, Internal Revenue Code.

Amendment by section 421(b)(3) of Pub. L. 104–191 effective Jan. 1, 1997, regardless of whether qualifying event occurred before, on, or after such date, see section 421(d) of Pub. L. 104–191 set out as a note under section 4980B of Title 26.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 7862(c)(2)(A) of Pub. L. 101–239 applicable to plan years beginning after Dec. 31, 1989, see section 7862(c)(2)(C) of Pub. L. 101–239, set out as a note under section 4980B of Title 26, Internal Revenue Code.

Pub. L. 101–239, title VII, §7862(c)(6)(B), Dec. 19, 1989, 103 Stat. 2433, provided that: ''Subparagraph (A) [repealing section 3011(b)(6) of Pub. L. 100–647, which amended this section] shall be effective as if included in the enactment of section 3011(b) of the Technical and Miscellaneous Revenue Act of 1988 [Pub. L. 100–647].''

Amendment by section 7891(a)(1) of Pub. L. 101–239 effective, except as otherwise provided, as if included in the provision of the Tax Reform Act of 1986, Pub. L. 99–514, to which such amendment relates, see section 7891(f) of Pub. L. 101–239, set out as a note under section 1002 of this title.

Amendment by section 7891(d)(2)(B)(i) of Pub. L. 101–239 applicable with respect to plan years beginning on or after Jan. 1, 1990, see section 7891(d)(2)(C) of Pub. L. 101–239, set out as a note under section 4980B of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 1988 AMENDMENT

Amendment by Pub. L. 100–647 applicable to taxable years beginning after Dec. 31, 1988, but not applicable to any plan for any plan year to which section 162(k) of Title 26, Internal Revenue Code (as in effect on the day before Nov. 10, 1988) did not apply by reason of section 10001(e)(2) of Pub. L. 99–272, see section 3011(d) of Pub. L. 100–647, set out as a note under section 162 of Title 26.

EFFECTIVE DATE OF 1986 AMENDMENTS

Pub. L. 99–514, title XVIII, §1895(d)(9)(B), Oct. 22, 1986, 100 Stat. 2940, provided that: ''The amendment made by subparagraph (A) [amending this section] shall take effect in the same manner and to the same extent as the amendments made by subsections (e) and (i) of section 1151 of this Act [amending sections 132 and 414 of Title 26, Internal Revenue Code, see section 1151(k) of Pub. L. 99–514, set out as an Effective Date note under section 89 of Title 26].''

Amendment by section 1895(d)(8) of Pub. L. 99–514 effective, except as otherwise provided, as if included in enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99–272, see section 1895(e) of Pub. L. 99–514, set out as a note under section 162 of Title 26.

Amendment by Pub. L. 99–509 effective, except as otherwise provided, as if included in title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99–272, see section 9501(e) of Pub. L. 99–509, set out as a note under section 162 of Title 26.

PLAN AMENDMENTS NOT REQUIRED UNTIL JANUARY 1, 1989

For provisions directing that if any amendments made by subtitle A or subtitle C of title XI [§§1101–1147 and 1171–1177] or title XVIII [§§1800–1899A] of Pub. L. 99–514 require an amendment to any plan, such plan amendment shall not be required to be made before the first plan year beginning on or after Jan. 1, 1989, see section 1140 of Pub. L. 99–514, as amended, set out as a note under section 401 of Title 26, Internal Revenue Code.

§ 1168. Regulations

The Secretary may prescribe regulations to carry out the provisions of this part.

(Pub. L. 93–406, title I, §608, as added Pub. L. 99–272, title X, §10002(a), Apr. 7, 1986, 100 Stat. 231.)

§ 1169. Additional standards for group health plans

(a) Group health plan coverage pursuant to medical child support orders

(1) In general

Each group health plan shall provide benefits in accordance with the applicable requirements of any qualified medical child support order. A qualified medical child support order with respect to any participant or beneficiary shall be deemed to apply to each group health plan which has received such order, from which the participant or beneficiary is eligible to receive benefits, and with respect to which the requirements of paragraph (4) are met.

(2) Definitions

For purposes of this subsection—

(A) Qualified medical child support order

The term ''qualified medical child support order'' means a medical child support order—

(i) which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a participant or beneficiary is eligible under a group health plan, and

(ii) with respect to which the requirements of paragraphs (3) and (4) are met.

(B) Medical child support order

The term ''medical child support order'' means any judgment, decree, or order (including approval of a settlement agreement) which—

(i) provides for child support with respect to a child of a participant under a group health plan or provides for health benefit coverage to such a child, is made pursuant to a State domestic relations law (including a community property law), and relates to benefits under such plan, or

(ii) is made pursuant to a law relating to medical child support described in section 1908 of the Social Security Act [42 U.S.C. 1396g–1] (as added by section 13822[1] of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan,

if such judgment, decree, or order (I) is issued by a court of competent jurisdiction or (II) is issued through an administrative process established under State law and has the force and effect of law under applicable State law. For purposes of this subparagraph, an administrative notice which is issued pursuant to an administrative process referred to in subclause (II) of the preceding sentence and which has the effect of an order described in clause (i) or (ii) of the preceding sentence shall be treated as such an order.

(C) Alternate recipient

The term ''alternate recipient'' means any child of a participant who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant.

(D) Child

The term ''child'' includes any child adopted by, or placed for adoption with, a participant of a group health plan.

(3) Information to be included in qualified order

A medical child support order meets the requirements of this paragraph only if such order clearly specifies—

(A) the name and the last known mailing address (if any) of the participant and the name and mailing address of each alternate recipient covered by the order, except that, to the extent provided in the order, the name and mailing address of an official of a State or a political subdivision thereof may be substituted for the mailing address of any such alternate recipient,

(B) a reasonable description of the type of coverage to be provided to each such alternate recipient, or the manner in which such type of coverage is to be determined, and

(C) the period to which such order applies.

(4) Restriction on new types or forms of benefits

A medical child support order meets the requirements of this paragraph only if such order does not require a plan to provide any type or form of benefit, or any option, not otherwise provided under the plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in section 1908 of the Social Security Act [42 U.S.C. 1396g–1] (as added by section 13822[1] of the Omnibus Budget Reconciliation Act of 1993).

(5) Procedural requirements

(A) Timely notifications and determinations

In the case of any medical child support order received by a group health plan—

(i) the plan administrator shall promptly notify the participant and each alternate recipient of the receipt of such order and the plan's procedures for determining whether medical child support orders are qualified medical child support orders, and

(ii) within a reasonable period after receipt of such order, the plan administrator shall determine whether such order is a qualified medical child support order and notify the participant and each alternate recipient of such determination.

(B) Establishment of procedures for determining qualified status of orders

Each group health plan shall establish reasonable procedures to determine whether medical child support orders are qualified medical child support orders and to administer the provision of benefits under such qualified orders. Such procedures—

(i) shall be in writing,

(ii) shall provide for the notification of each person specified in a medical child support order as eligible to receive benefits under the plan (at the address included in the medical child support order) of such procedures promptly upon receipt by the plan of the medical child support order, and

[1] So in original. Probably should be section ''13623''.

(iii) shall permit an alternate recipient to designate a representative for receipt of copies of notices that are sent to the alternate recipient with respect to a medical child support order.

(C) National Medical Support Notice deemed to be a qualified medical child support order

(i) In general

If the plan administrator of a group health plan which is maintained by the employer of a noncustodial parent of a child or to which such an employer contributes receives an appropriately completed National Medical Support Notice promulgated pursuant to section 401(b) of the Child Support Performance and Incentive Act of 1998 in the case of such child, and the Notice meets the requirements of paragraphs (3) and (4), 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 group health plan who is a noncustodial 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, if necessary, any steps 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 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) Actions taken by fiduciaries

If a plan fiduciary acts in accordance with part 4 of this subtitle in treating a medical child support order as being (or not being) a qualified medical child support order, then the plan's obligation to the participant and each alternate recipient shall be discharged to the extent of any payment made pursuant to such act of the fiduciary.

(7) Treatment of alternate recipients

(A) Treatment as beneficiary generally

A person who is an alternate recipient under a qualified medical child support order shall be considered a beneficiary under the plan for purposes of any provision of this chapter.

(B) Treatment as participant for purposes of reporting and disclosure requirements

A person who is an alternate recipient under any medical child support order shall be considered a participant under the plan for purposes of the reporting and disclosure requirements of part 1 of this subtitle.

(8) Direct provision of benefits provided to alternate recipients

Any payment for benefits made by a 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.

(9) Payment to State official treated as satisfaction of plan's obligation to make payment to alternate recipient

Payment of benefits by a 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 qualified medical child support order, pursuant to paragraph (3)(A), shall be treated, for purposes of this subchapter, as payment of benefits to the alternate recipient.

(b) Rights of States with respect to group health plans where participants or beneficiaries thereunder are eligible for medicaid benefits

(1) Compliance by plans with assignment of rights

A group health plan shall provide that payment for benefits with respect to a participant under the plan will be made in accordance with any assignment of rights made by or on behalf of such participant or a beneficiary of the participant as required by a State plan for medical assistance approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] pursuant to section 1912(a)(1)(A) of such Act [42 U.S.C. 1396k(a)(1)(A)] (as in effect on August 10, 1993).

(2) Enrollment and provision of benefits without regard to medicaid eligibility

A group health plan shall provide that, in enrolling an individual as a participant or beneficiary or in determining or making any payments for benefits of an individual as a participant or beneficiary, the fact that the individual is eligible for or is provided medical assistance under a State plan for medical assistance approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] will not be taken into account.

(3) Acquisition by States of rights of third parties

A group health plan shall provide that, to the extent that payment has been made under

a State plan for medical assistance approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] in any case in which a group health plan has a legal liability to make payment for items or services constituting such assistance, payment for benefits under the plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to a participant to such payment for such items or services.

(c) Group health plan coverage of dependent children in cases of adoption

(1) Coverage effective upon placement for adoption

In any case in which a group health plan provides coverage for dependent children of participants or beneficiaries, such plan shall provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of participants or beneficiaries under the plan, irrespective of whether the adoption has become final.

(2) Restrictions based on preexisting conditions at time of placement for adoption prohibited

A group health plan may not restrict coverage under the plan of any dependent child adopted by a participant or beneficiary, or placed with a participant or beneficiary for adoption, solely on the basis of a preexisting condition of such child at the time that such child would otherwise become eligible for coverage under the plan, if the adoption or placement for adoption occurs while the participant or beneficiary is eligible for coverage under the plan.

(3) Definitions

For purposes of this subsection—

(A) Child

The term ''child'' means, in connection with any adoption, or placement for adoption, of the child, an individual who has not attained age 18 as of the date of such adoption or placement for adoption.

(B) Placement for adoption

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

(d) Continued coverage of costs of a pediatric vaccine under group health plans

A group health plan may not reduce its coverage of the costs of pediatric vaccines (as defined under section 1928(h)(6) of the Social Security Act [42 U.S.C. 1396s(h)(6)] as amended by section 13830[2] of the Omnibus Budget Reconciliation Act of 1993) below the coverage it provided as of May 1, 1993.

(e) Regulations

Any regulations prescribed under this section shall be prescribed by the Secretary of Labor, in consultation with the Secretary of Health and Human Services.

(Pub. L. 93–406, title I, §609, as added Pub. L. 103–66, title IV, §4301(a), Aug. 10, 1993, 107 Stat. 371; amended Pub. L. 104–193, title III, §381(a), Aug. 22, 1996, 110 Stat. 2257; Pub. L. 105–33, title V, §§5611(a), (b), 5612(a), 5613(a), (b), Aug. 5, 1997, 111 Stat. 647, 648; Pub. L. 105–200, title IV, §401(d), (h)(2)(A)(iii), (B), (3)(A), July 16, 1998, 112 Stat. 662, 668.)

Editorial Notes

REFERENCES IN TEXT

Section 401(b) of the Child Support Performance and Incentive Act of 1998, referred to in subsec. (a)(5)(C)(i), is section 401(b) of Pub. L. 105–200, which was formerly set out as a note under section 651 of Title 42, The Public Health and Welfare.

This chapter, referred to in subsec. (a)(7)(A), was in the original ''this Act'', meaning Pub. L. 93–406, known as the Employee Retirement Income Security Act of 1974. Titles I, III, and IV of such Act are classified principally to this chapter. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of this title and Tables.

The Social Security Act, referred to in subsec. (b), is act Aug. 14, 1935, ch. 531, 49 Stat. 620, as amended. Title XIX of the Act is classified generally to subchapter XIX (§1396 et seq.) 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.

AMENDMENTS

1998—Subsec. (a)(2)(B)(ii). Pub. L. 105–200, §401(h)(2)(A)(iii), substituted ''is made pursuant to'' for ''enforces''.

Subsec. (a)(2)(D). Pub. L. 105–200, §401(h)(2)(B), added subpar. (D).

Subsec. (a)(5)(C). Pub. L. 105–200, §401(d), added subpar. (C).

Subsec. (a)(9). Pub. L. 105–200, §401(h)(3)(A), substituted ''the address of an alternate recipient'' for ''the name and address of an alternate recipient''.

1997—Subsec. (a)(1). Pub. L. 105–33, §5613(b), inserted at end ''A qualified medical child support order with respect to any participant or beneficiary shall be deemed to apply to each group health plan which has received such order, from which the participant or beneficiary is eligible to receive benefits, and with respect to which the requirements of paragraph (4) are met.''

Subsec. (a)(2)(B). Pub. L. 105–33, §5612(a), inserted at end of concluding provisions ''For purposes of this subparagraph, an administrative notice which is issued pursuant to an administrative process referred to in subclause (II) of the preceding sentence and which has the effect of an order described in clause (i) or (ii) of the preceding sentence shall be treated as such an order.''

Subsec. (a)(3)(A). Pub. L. 105–33, §5611(a), inserted at end ''except that, to the extent provided in the order, the name and mailing address of an official of a State or a political subdivision thereof may be substituted for the mailing address of any such alternate recipient,''.

Subsec. (a)(3)(B). Pub. L. 105–33, §5613(a)(1), (2), struck out ''by the plan'' after ''to be provided'' and inserted ''and'' at end.

Subsec. (a)(3)(C). Pub. L. 105–33, §5613(a)(3), substituted a period for '', and'' at end.

Subsec. (a)(3)(D). Pub. L. 105–33, §5613(a)(4), struck out subpar. (D) which read as follows: ''each plan to which such order applies.''

[2] So in original. Probably should be section ''13631''.

Subsec. (a)(9). Pub. L. 105–33, § 5611(b), added par. (9).

1996—Subsec. (a)(2)(B). Pub. L. 104–193 substituted ''which—'' for ''issued by a court of competent jurisdiction which—'' in introductory provisions, substituted a comma for a period at end of cl. (ii), and inserted concluding provisions after cl. (ii).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 1998 AMENDMENT

Amendment by section 401(h)(2)(A)(iii) of Pub. L. 105–200 effective as if included in the enactment of section 4301(c)(4)(A) of the Omnibus Budget Reconciliation Act of 1993, Pub. L. 103–66, see section 401(h)(2)(C) of Pub. L. 105–200, set out as a note under section 1144 of this title.

Pub. L. 105–200, title IV, § 401(h)(3)(B), July 16, 1998, 112 Stat. 668, provided that: ''The amendment made by subparagraph (A) [amending this section] shall be effective as if included in the enactment of section 5611(b) of the Balanced Budget Act of 1997 [Pub. L. 105–33].''

EFFECTIVE DATE OF 1997 AMENDMENT

Pub. L. 105–33, title V, § 5611(c), Aug. 5, 1997, 111 Stat. 647, provided that: ''The amendments made by this section [amending this section] shall apply with respect to medical child support orders issued on or after the date of the enactment of this Act [Aug. 5, 1997].''

Pub. L. 105–33, title V, § 5612(b), Aug. 5, 1997, 111 Stat. 647, provided that: ''The amendment made by this section [amending this section] shall be effective as if included in the enactment of section 381 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2257).''

Pub. L. 105–33, title V, § 5613(c), Aug. 5, 1997, 111 Stat. 648, provided that: ''The amendments made by this section [amending this section] shall apply with respect to medical child support orders issued on or after the date of the enactment of this Act [Aug. 5, 1997].''

EFFECTIVE DATE OF 1996 AMENDMENT

Pub. L. 104–193, title III, § 381(b), Aug. 22, 1996, 110 Stat. 2257, provided that:

''(1) IN GENERAL.—The amendments made by this section [amending this section] shall take effect on the date of the enactment of this Act [Aug. 22, 1996].

''(2) PLAN AMENDMENTS NOT REQUIRED UNTIL JANUARY 1, 1997.—Any amendment to a plan required to be made by an amendment made by this section shall not be required to be made before the 1st plan year beginning on or after January 1, 1997, if—

''(A) during the period after the date before the date of the enactment of this Act and before such 1st plan year, the plan is operated in accordance with the requirements of the amendments made by this section; and

''(B) such plan amendment applies retroactively to the period after the date before the date of the enactment of this Act and before such 1st plan year.

A plan shall not be treated as failing to be operated in accordance with the provisions of the plan merely because it operates in accordance with this paragraph.''

[For provisions relating to effective date of title III of Pub. L. 104–193, see section 395(a)–(c) of Pub. L. 104–193, set out as a note under section 654 of Title 42, The Public Health and Welfare.]

NATIONAL MEDICAL SUPPORT NOTICES FOR HEALTH PLANS; QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Pub. L. 105–200, title IV, § 401(e)–(g), July 16, 1998, 112 Stat. 663–668, as amended by Pub. L. 109–171, title VII, § 7307(a)(2)(B), (C), Feb. 8, 2006, 120 Stat. 146, provided that:

''(e) NATIONAL MEDICAL SUPPORT NOTICES FOR STATE OR LOCAL GOVERNMENTAL GROUP HEALTH PLANS.—

''(1) IN GENERAL.—Each State or local governmental group health plan shall provide benefits in accordance with the applicable requirements of any National Medical Support Notice.

''(2) 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 State or local governmental group health plan, the plan administrator, within 40 business days after the date of the Notice, shall—

''(A) 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 any official of a State or political subdivision thereof substituted in the Notice for the name of such child in accordance with procedures appliable [sic] under subsection (b)(2) of this section [section 401(b)(2) of Pub. L. 105–200, 42 U.S.C. 651 note]) to effectuate the coverage; and

''(B) 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.

''(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as requiring a State or local governmental 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.

''(4) DEFINITIONS.—For purposes of this subsection—

''(A) STATE OR LOCAL GOVERNMENTAL GROUP HEALTH PLAN.—The term 'State or local governmental group health plan' means a group health plan which is established or maintained for its employees by the government of any State, any political subdivision of a State, or any agency or instrumentality of either of the foregoing.

''(B) ALTERNATE RECIPIENT.—The term 'alternate recipient' means any child of a participant who is recognized under a National Medical Support Notice as having a right to enrollment under a State or local governmental group health plan with respect to such participant.

''(C) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1167(1)].

''(D) STATE.—The term 'State' includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

''(E) OTHER TERMS.—The terms 'participant' and 'administrator' shall have the meanings provided such terms, respectively, by paragraphs (7) and (16) of section 3 of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1002].

''(5) 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].

''(f) QUALIFIED MEDICAL CHILD SUPPORT ORDERS AND NATIONAL MEDICAL SUPPORT NOTICES FOR CHURCH PLANS.—

''(1) IN GENERAL.—Each church group health plan shall provide benefits in accordance with the applicable requirements of any qualified medical child support order. A qualified medical child support order with respect to any participant or beneficiary shall be deemed to apply to each such group health plan which has received such order, from which the participant or beneficiary is eligible to receive benefits, and with respect to which the requirements of paragraph (4) are met.

''(2) DEFINITIONS.—For purposes of this subsection—

''(A) CHURCH GROUP HEALTH PLAN.—The term 'church group health plan' means a group health plan which is a church plan.

''(B) QUALIFIED MEDICAL CHILD SUPPORT ORDER.—The term 'qualified medical child support order' means a medical child support order—

''(i) which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a participant or beneficiary is eligible under a church group health plan; and

''(ii) with respect to which the requirements of paragraphs (3) and (4) are met.

''(C) MEDICAL CHILD SUPPORT ORDER.—The term 'medical child support order' means any judgment, decree, or order (including approval of a settlement agreement) which—

''(i) provides for child support with respect to a child of a participant under a church group health plan or provides for health benefit coverage to such a child, is made pursuant to a State domestic relations law (including a community property law), and relates to benefits under such plan; or

''(ii) is made pursuant to a law relating to medical child support described in section 1908 of the Social Security Act [42 U.S.C. 1396g–1] (as added by section 13822 [13623] of the Omnibus Budget Reconciliation Act of 1993 [Pub. L. 103–66]) with respect to a church group health plan,

if such judgment, decree, or order: (I) is issued by a court of competent jurisdiction; or (II) is issued through an administrative process established under State law and has the force and effect of law under applicable State law. For purposes of this paragraph, an administrative notice which is issued pursuant to an administrative process referred to in subclause (II) of the preceding sentence and which has the effect of an order described in clause (i) or (ii) of the preceding sentence shall be treated as such an order.

''(D) ALTERNATE RECIPIENT.—The term 'alternate recipient' means any child of a participant who is recognized under a medical child support order as having a right to enrollment under a church group health plan with respect to such participant.

''(E) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1167(1)].

''(F) STATE.—The term 'State' includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

''(G) OTHER TERMS.—The terms 'participant', 'beneficiary', 'administrator', and 'church plan' shall have the meanings provided such terms, respectively, by paragraphs (7), (8), (16), and (33) of section 3 of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1102].

''(3) INFORMATION TO BE INCLUDED IN QUALIFIED ORDER.—A medical child support order meets the requirements of this paragraph only if such order clearly specifies—

''(A) the name and the last known mailing address (if any) of the participant and the name and mailing address of each alternate recipient covered by the order, except that, to the extent provided in the order, the name and mailing address of an official of a State or a political subdivision thereof may be substituted for the mailing address of any such alternate recipient;

''(B) a reasonable description of the type of coverage to be provided to each such alternate recipient, or the manner in which such type of coverage is to be determined; and

''(C) the period to which such order applies.

''(4) RESTRICTION ON NEW TYPES OR FORMS OF BENEFITS.—A medical child support order meets the requirements of this paragraph only if such order does not require a church group health plan to provide any type or form of benefit, or any option, not otherwise provided under the plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in section 1908 of the Social Security Act [42 U.S.C. 1396g–1] (as added by section 13822 [13623] of the Omnibus Budget Reconciliation Act of 1993 [Pub. L. 103–66]).

''(5) PROCEDURAL REQUIREMENTS.—

''(A) TIMELY NOTIFICATIONS AND DETERMINATIONS.—In the case of any medical child support order received by a church group health plan—

''(i) the plan administrator shall promptly notify the participant and each alternate recipient of the receipt of such order and the plan's procedures for determining whether medical child support orders are qualified medical child support orders; and

''(ii) within a reasonable period after receipt of such order, the plan administrator shall determine whether such order is a qualified medical child support order and notify the participant and each alternate recipient of such determination.

''(B) ESTABLISHMENT OF PROCEDURES FOR DETERMINING QUALIFIED STATUS OF ORDERS.—Each church group health plan shall establish reasonable procedures to determine whether medical child support orders are qualified medical child support orders and to administer the provision of benefits under such qualified orders. Such procedures—

''(i) shall be in writing;

''(ii) shall provide for the notification of each person specified in a medical child support order as eligible to receive benefits under the plan (at the address included in the medical child support order) of such procedures promptly upon receipt by the plan of the medical child support order; and

''(iii) shall permit an alternate recipient to designate a representative for receipt of copies of notices that are sent to the alternate recipient with respect to a medical child support order.

''(C) NATIONAL MEDICAL SUPPORT NOTICE DEEMED TO BE A QUALIFIED MEDICAL CHILD SUPPORT ORDER.—

''(i) IN GENERAL.—If the plan administrator of any church group health plan which is maintained by the employer of a parent of a child or to which such an employer contributes receives an appropriately completed National Medical Support Notice promulgated pursuant to subsection (b) of this section [section 401(b) of Pub. L. 105–200, 42 U.S.C. 651 note] in the case of such 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 ben-

efits) 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.