

qualified medical child support order, the plan administrator, within 40 business days after the date of the Notice, shall—

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

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

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

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

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

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

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

PLAN AMENDMENTS NOT REQUIRED UNTIL
JANUARY 1, 1994

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

PART 7—GROUP HEALTH PLAN REQUIREMENTS

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

§ 1181. Increased portability through limitation on preexisting condition exclusions

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

Subject to subsection (d) of this section, 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) of this section) 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) of this section 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) of this section.

(4) Waiting period

The term “waiting period” means, with respect to a group health plan and an individual

who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

(c) Rules relating to crediting previous coverage

(1) “Creditable coverage” defined

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

- (A) A group health plan.
- (B) Health insurance coverage.
- (C) Part A or part B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.; 1395j et seq.].
- (D) Title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], other than coverage consisting solely of benefits under section 1928 [42 U.S.C. 1396s].
- (E) Chapter 55 of title 10.
- (F) A medical care program of the Indian Health Service or of a tribal organization.
- (G) A State health benefits risk pool.
- (H) A health plan offered under chapter 89 of title 5.
- (I) A public health plan (as defined in regulations).
- (J) A health benefit plan under section 2504(e) of title 22.

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

(2) Not counting periods before significant breaks in coverage

(A) In general

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

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

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

(3) Method of crediting coverage

(A) Standard method

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

(B) Election of alternative method

A group health plan, or a health insurance issuer offering group health insurance cov-

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

(C) Plan notice

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

- (i) prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election, and
- (ii) include in such statements a description of the effect of this election.

(4) Establishment of period

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

(d) Exceptions

(1) Exclusion not applicable to certain newborns

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

(2) Exclusion not applicable to certain adopted children

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

(3) Exclusion not applicable to pregnancy

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

(4) Loss if break in coverage

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

(e) Certifications and disclosure of coverage**(1) Requirement for certification of period of creditable coverage****(A) In general**

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

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

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

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

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

(B) Certification

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

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

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

(C) Issuer compliance

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

(2) Disclosure of information on previous benefits

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

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

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

(3) Regulations

The Secretary shall establish rules to prevent an entity's failure to provide information

under paragraph (1) or (2) with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health insurance coverage.

(f) Special enrollment periods**(1) Individuals losing other coverage**

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

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

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

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

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

(ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated.

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

(2) For dependent beneficiaries**(A) In general**

If—

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

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

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

the group health plan shall provide for a dependent special enrollment period described in subparagraph (B) during which the person

(or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

(B) Dependent special enrollment period

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

- (i) the date dependent coverage is made available, or
- (ii) the date of the marriage, birth, or adoption or placement for adoption (as the case may be) described in subparagraph (A)(iii).

(C) No waiting period

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

- (i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;
- (ii) in the case of a dependent's birth, as of the date of such birth; or
- (iii) in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

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

(1) In general

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

- (A) no preexisting condition exclusion is imposed with respect to coverage through the organization,
- (B) the period is applied uniformly without regard to any health status-related factors, and
- (C) such period does not exceed 2 months (or 3 months in the case of a late enrollee).

(2) Affiliation period

(A) Defined

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

(B) Beginning

Such period shall begin on the enrollment date.

(C) Runs concurrently with waiting periods

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

(3) Alternative methods

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

(Pub. L. 93-406, title I, §701, as added Pub. L. 104-191, title I, §101(a), Aug. 21, 1996, 110 Stat. 1939; amended Pub. L. 104-204, title VI, §603(b)(3)(H), Sept. 26, 1996, 110 Stat. 2938.)

REFERENCES IN TEXT

The Social Security Act, referred to in subsec. (c)(1)(C), (D), is act Aug. 14, 1935, ch. 531, 49 Stat. 620, as amended. Parts A and B of title XVIII of the Act are classified generally to parts A (§1395c et seq.) and B (§1395j et seq.) of subchapter XVIII of chapter 7 of Title 42, The Public Health and Welfare. Title XIX of the Act is classified generally to subchapter XIX (§1396 et seq.) of chapter 7 of Title 42. For complete classification of this Act to the Code, see section 1305 of Title 42 and Tables.

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

AMENDMENTS

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

EFFECTIVE DATE OF 1996 AMENDMENT

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

EFFECTIVE DATE

Section 101(g) of Pub. L. 104-191 provided that:

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

"(2) DETERMINATION OF CREDITABLE COVERAGE.—

"(A) PERIOD OF COVERAGE.—

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

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

"(B) CERTIFICATIONS, ETC.—

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

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

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

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

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

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

“(3) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—Except as provided in paragraph (2), in the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act [Aug. 21, 1996], part 7 of subtitle B of title I of Employee Retirement Income Security Act of 1974 [this part] (other than section 701(e) thereof [29 U.S.C. 1181(e)]) shall not apply to plan years beginning before the later of—

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

“(B) July 1, 1997.

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

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

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

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

(a) In eligibility to enroll

(1) In general

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

ing health status-related factors in relation to the individual or a dependent of the individual:

(A) Health status.

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

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

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

(H) Disability.

(2) No application to benefits or exclusions

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

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

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

(3) Construction

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

(b) In premium contributions

(1) In general

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

(2) Construction

Nothing in paragraph (1) shall be construed—

(A) to restrict the amount that an employer may be charged for coverage under a group health plan; or

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

(Pub. L. 93-406, title I, §702, as added Pub. L. 104-191, title I, §101(a), Aug. 21, 1996, 110 Stat. 1945.)

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

A group health plan which is a multiemployer plan or which is a multiple employer welfare ar-

rangement may not deny an employer whose employees are covered under such a plan continued access to the same or different coverage under the terms of such a plan, other than—

- (1) for nonpayment of contributions;
- (2) for fraud or other intentional misrepresentation of material fact by the employer;
- (3) for noncompliance with material plan provisions;
- (4) because the plan is ceasing to offer any coverage in a geographic area;
- (5) in the case of a plan that offers benefits through a network plan, there is no longer any individual enrolled through the employer who lives, resides, or works in the service area of the network plan and the plan applies this paragraph uniformly without regard to the claims experience of employers or any health status-related factor in relation to such individuals or their dependents; and
- (6) for failure to meet the terms of an applicable collective bargaining agreement, to renew a collective bargaining or other agreement requiring or authorizing contributions to the plan, or to employ employees covered by such an agreement.

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

Subpart B—Other Requirements

§ 1185. Standards relating to benefits for mothers and newborns

(a) Requirements for minimum hospital stay following birth

(1) In general

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

- (A) except as provided in paragraph (2)—
 - (i) restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a normal vaginal delivery, to less than 48 hours; or
 - (ii) restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a cesarean section, to less than 96 hours; or

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

(2) Exception

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

(b) Prohibitions

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

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

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

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

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

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

(c) Rules of construction

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

(A) to give birth in a hospital; or

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

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

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

(d) Notice under group health plan

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

(e) Level and type of reimbursements

Nothing in this section shall be construed to prevent a group health plan or a health insur-

¹ See References in Text note below.