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.

ance issuer offering group health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

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

(1) In general

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

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

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

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

(2) Construction

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

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

REFERENCES IN TEXT

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

EFFECTIVE DATE

Section applicable with respect to group health plans for plan years beginning on and after Jan. 1, 1998, see section 603(c) of Pub. L. 104–204, set out as an Effective Date of 1996 Amendment note under section 1003 of this title.

§ 1185a. Parity in application of certain limits to mental health benefits

(a) In general

(1) Aggregate lifetime limits

In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits—

(A) No lifetime limit

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

(B) Lifetime limit

If the plan or coverage includes an aggregate lifetime limit on substantially all medical and surgical benefits (in this paragraph referred to as the ''applicable lifetime limit''), the plan or coverage shall either—

(i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or

(ii) not include any aggregate lifetime limit on mental health benefits that is less than the applicable lifetime limit.

(C) Rule in case of different limits

In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different aggregate lifetime limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

(2) Annual limits

In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits—

(A) No annual limit

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

(B) Annual limit

If the plan or coverage includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the ''applicable annual limit''), the plan or coverage shall either—

(i) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or

(ii) not include any annual limit on mental health benefits that is less than the applicable annual limit.

(C) Rule in case of different limits

In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different annual limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

(b) Construction

Nothing in this section shall be construed—

(1) as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits; or

(2) in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides mental health benefits, as affecting the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under the plan or coverage, except as specifically provided in subsection (a) of this section (in regard to parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits).

(c) Exemptions

(1) Small employer exemption

(A) In general

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

(B) Small employer

For purposes of subparagraph (A), the term ''small employer'' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

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

For purposes of this paragraph—

(i) Application of aggregation rule for employers

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

(ii) Employers not in existence in preceding year

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

(iii) Predecessors

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

(2) Increased cost exemption

This section shall not apply with respect to a group health plan (or health insurance coverage offered in connection with a group health plan) if the application of this section to such plan (or to such coverage) results in an increase in the cost under the plan (or for such coverage) of at least 1 percent.

(d) Separate application to each option offered

In the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, the requirements of this section shall be applied separately with respect to each such option.

(e) Definitions

For purposes of this section—

(1) Aggregate lifetime limit

The term ''aggregate lifetime limit'' means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit.

(2) Annual limit

The term ''annual limit'' means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount of benefits that may be paid with respect to such benefits in a 12-month period under the plan or health insurance coverage with respect to an individual or other coverage unit.

(3) Medical or surgical benefits

The term ''medical or surgical benefits'' means benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage (as the case may be), but does not include mental health benefits.

(4) Mental health benefits

The term ''mental health benefits'' means benefits with respect to mental health services, as defined under the terms of the plan or coverage (as the case may be), but does not include benefits with respect to treatment of substance abuse or chemical dependency.

(f) Sunset

This section shall not apply to benefits for services furnished after December 31, 2007.

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

AMENDMENTS

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

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

2004—Subsec. (f). Pub. L. 108–311 substituted ''after December 31, 2005'' for ''on or after December 31, 2004''.

2003—Subsec. (f). Pub. L. 108–197 substituted ''December 31, 2004'' for ''December 31, 2003''.

2002—Subsec. (f). Pub. L. 107–313 substituted ''December 31, 2003'' for ''December 31, 2002''.

Pub. L. 107–116 substituted ''December 31, 2002'' for ''September 30, 2001''.

EFFECTIVE DATE

Section 702(c) of Pub. L. 104–204 provided that: ''The amendments made by this section [enacting this sec-

tion] shall apply with respect to group health plans for plan years beginning on or after January 1, 1998.''

§ 1185b. Required coverage for reconstructive surgery following mastectomies

(a) In general

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

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

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

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

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

(b) Notice

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

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

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

(3) not later than January 1, 1999;

whichever is earlier.

(c) Prohibitions

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

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

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

(d) Rule of construction

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

(e) Preemption, relation to State laws

(1) In general

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

(2) ERISA

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

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

EFFECTIVE DATE

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

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

''(2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.''

Subpart C—General Provisions

§ 1191. Preemption; State flexibility; construction

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

(1) In general

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

(2) Continued preemption with respect to group health plans

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

(b) Special rules in case of portability requirements

(1) In general

Subject to paragraph (2), the provisions of this part relating to health insurance coverage offered by a health insurance issuer supersede any provision of State law which establishes, implements, or continues in effect a standard