

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 insur-

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.

(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

or requirement applicable to imposition of a preexisting condition exclusion specifically governed by section 1181 of this title which differs from the standards or requirements specified in such section.

(2) Exceptions

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

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

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

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

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

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

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

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

(c) Rules of construction

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

(d) Definitions

For purposes of this section—

(1) State law

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

(2) State

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

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

AMENDMENTS

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

EFFECTIVE DATE OF 1996 AMENDMENT

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

EFFECTIVE DATE

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

§ 1191a. Special rules relating to group health plans

(a) General exception for certain small group health plans

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

(b) Exception for certain benefits

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

(c) Exception for certain benefits if certain conditions met

(1) Limited, excepted benefits

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

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

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

(2) Noncoordinated, excepted benefits

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

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

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

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

(3) Supplemental excepted benefits

The requirements of this part shall not apply to any group health plan (and group health insurance coverage) in relation to its provision of excepted benefits described in section 1191b(c)(4) of this title if the benefits are

provided under a separate policy, certificate, or contract of insurance.

(d) Treatment of partnerships

For purposes of this part—

(1) Treatment as a group health plan

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

(2) Employer

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

(3) Participants of group health plans

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

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

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

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

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

AMENDMENTS

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

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

EFFECTIVE DATE OF 1996 AMENDMENT

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

EFFECTIVE DATE

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

§ 1191b. Definitions

(a) Group health plan

For purposes of this part—

(1) In general

The term “group health plan” means an employee welfare benefit plan to the extent that

the plan provides medical care (as defined in paragraph (2) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(2) Medical care

The term “medical care” means amounts paid for—

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

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

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

(b) Definitions relating to health insurance

For purposes of this part—

(1) Health insurance coverage

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

(2) Health insurance issuer

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

(3) Health maintenance organization

The term “health maintenance organization” means—

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

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

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

(4) Group health insurance coverage

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

(c) Excepted benefits

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

(1) Benefits not subject to requirements

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

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

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

(D) Workers' compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for on-site medical clinics.

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

(2) Benefits not subject to requirements if offered separately

(A) Limited scope dental or vision benefits.

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

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

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

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

(B) Hospital indemnity or other fixed indemnity insurance.

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

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

(d) Other definitions

For purposes of this part—

(1) COBRA continuation provision

The term “COBRA continuation provision” means any of the following:

(A) Part 6 of this subtitle.

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

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

(2) Health status-related factor

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

(3) Network plan

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

(4) Placed for adoption

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

(Pub. L. 93-406, title I, §733, formerly §706, as added Pub. L. 104-191, title I, §101(a), Aug. 21,

1996, 110 Stat. 1949; renumbered §733, Pub. L. 104-204, title VI, §603(a)(3), Sept. 26, 1996, 110 Stat. 2935.)

REFERENCES IN TEXT

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

EFFECTIVE DATE

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

§ 1191c. Regulations

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

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

REFERENCES IN TEXT

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

EFFECTIVE DATE

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

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

SUBTITLE A—JURISDICTION, ADMINISTRATION, AND ENFORCEMENT

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

(a) Additional material required of applicants

Before issuing an advance determination of whether a pension, profit-sharing, or stock bonus plan, a trust which is a part of such a plan, or an annuity or bond purchase plan meets the requirements of part I of subchapter D of chapter 1 of title 26, the Secretary of the Treasury shall require the person applying for the determination to provide, in addition to any material and information necessary for such determination, such other material and information as may reasonably be made available at the time such application is made as the Secretary