

payment if the results of the genetic test indicate that tamoxifen is not medically appropriate for C.

Example 4. (i) *Facts.* A group health plan offers a diabetes disease management program to all similarly situated individuals for whom it is medically appropriate based on whether the individuals have or are at risk for diabetes. The program provides enhanced benefits related only to diabetes for individuals who qualify for the program. The plan sends out a notice to all participants that describes the diabetes disease management program and explains the terms for eligibility. Individuals interested in enrolling in the program are advised to contact the plan to demonstrate that they have diabetes or that they are at risk for diabetes. For individuals who do not currently have diabetes, genetic information may be used to demonstrate that an individual is at risk.

(ii) *Conclusion.* In this *Example 4*, the plan may condition benefits under the disease management program upon a showing by an individual that the individual is at risk for diabetes, even if such showing may involve genetic information, provided that the plan requests genetic information only when necessary to make a determination regarding whether the disease management program is medically appropriate for the individual and only requests the minimum amount of information necessary to make that determination.

Example 5. (i) *Facts.* Same facts as *Example 4*, except that the plan includes a questionnaire that asks about the occurrence of diabetes in members of the individual's family as part of the notice describing the disease management program.

(ii) *Conclusion.* In this *Example 5*, the plan violates the requirements of paragraph (d)(1) of this section because the requests for genetic information are not limited to those situations in which it is necessary to make a determination regarding whether the disease management program is medically appropriate for the individuals.

Example 6. (i) *Facts.* Same facts as *Example 4*, except the disease management program provides an enhanced benefit in the form of a lower annual deductible to individuals under the program; the lower deductible applies with respect to all medical expenses incurred by the individual. Thus, whether or not a claim relates to diabetes, the individual is provided with a lower deductible based on the individual providing the plan with genetic information.

(ii) *Conclusion.* In this *Example 6*, because the enhanced benefits include benefits not related to the determination of medical appropriateness, making available the enhanced benefits is within the meaning of underwriting purposes. Accordingly, the plan may not request or require genetic information (including family history information)

in determining eligibility for enhanced benefits under the program because such a request would be for underwriting purposes and would violate paragraph (d)(1) of this section.

(f) *Applicability date.* This section applies for plan years beginning on or after December 7, 2009.

[74 FR 51688, Oct. 7, 2009]

§ 146.125 Applicability dates.

Section 144.103, §§146.111 through 146.119, §146.143, and §146.145 are applicable for plan years beginning on or after July 1, 2005. Until the applicability date for this regulation, plans and issuers are required to continue to comply with the corresponding sections of 45 CFR parts 144 and 146, contained in the 45 CFR, parts 1 to 199, edition revised as of October 1, 2004.

[69 FR 78797, Dec. 30, 2004; 70 FR 21147, Apr. 25, 2005]

Subpart C—Requirements Related to Benefits

§ 146.130 Standards relating to benefits for mothers and newborns.

(a) *Hospital length of stay*—(1) *General rule.* Except as provided in paragraph (a)(5) of this section, a group health plan, or a health insurance issuer offering group health insurance coverage, that provides benefits for a hospital length of stay in connection with childbirth for a mother or her newborn may not restrict benefits for the stay to less than—

(i) 48 hours following a vaginal delivery; or

(ii) 96 hours following a delivery by cesarean section.

(2) *When stay begins*—(i) *Delivery in a hospital.* If delivery occurs in a hospital, the hospital length of stay for the mother or newborn child begins at the time of delivery (or in the case of multiple births, at the time of the last delivery).

(ii) *Delivery outside a hospital.* If delivery occurs outside a hospital, the hospital length of stay begins at the time the mother or newborn is admitted as a hospital inpatient in connection with childbirth. The determination of whether an admission is in connection