of this part do not supersede any provision of State law to the extent that such provision requires special enrollment periods in addition to those required under section 2702 of the Act.

(d) *Definitions*—(1) *State law*. For purposes of this section 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 is treated as a State law rather than a law of the United States.

(2) *State*. For purposes of this section the term *State* includes a State (as defined in § 144.103), any political subdivisions of a State, or any agency or instrumentality of either.

[69 FR 78797, Dec. 30, 2004; 70 FR 21147, Apr. 25, 2005; 79 FR 10315, Feb. 24, 2014]

§ 146.145 Special rules relating to group health plans.

(a) *Group health plan*—(1) *Definition*. A group health plan means an employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees (including both current and former employees) or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(2) *Determination of number of plans*. [Reserved]

(b) *Excepted benefits*—(1) *In general*. The requirements of subparts B and C of this part do not apply to any group health plan (or any group health insurance coverage) in relation to its provision of the benefits described in paragraph (b) (2), (3), (4), or (5) of this section (or any combination of these benefits).

(2) *Benefits excepted in all circumstances*. The following benefits are excepted in all circumstances—

(i) Coverage only for accident (including accidental death and dismemberment);

(ii) Disability income coverage;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Coverage issued as a supplement to liability insurance;

(v) Workers' compensation or similar coverage;

(vi) Automobile medical payment insurance;

(vii) Credit-only insurance (for example, mortgage insurance); and

(viii) Coverage for on-site medical clinics.

(3) *Limited excepted benefits*—(i) *In general*. Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan as described in paragraph (b)(3)(ii) of this section. In addition, benefits provided under a health flexible spending arrangement are excepted benefits if they satisfy the requirements of paragraph (b)(3)(v) of this section.

(ii) *Not an integral part of a group health plan*. For purposes of this paragraph (b)(3), benefits are not an integral part of a group health plan (whether the benefits are provided through the same plan or a separate plan) only if the following two requirements are satisfied—

(A) Participants must have the right to elect not to receive coverage for the benefits; and

(B) If a participant elects to receive coverage for the benefits, the participant must pay an additional premium or contribution for that coverage.

(iii) *Limited scope*—(A) *Dental benefits*. Limited scope dental benefits are benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth).

(B) *Vision benefits*. Limited scope vision benefits are benefits substantially all of which are for treatment of the eye.

(iv) *Long-term care*. Long-term care benefits are benefits that are either—

(A) Subject to State long-term care insurance laws;

(B) For qualified long-term care services, as defined in section 7702B(c)(1) of the Internal Revenue Code, or provided under a qualified long-term care insurance contract, as defined in section 7702B(b) of the Internal Revenue Code; or

(C) Based on cognitive impairment or a loss of functional capacity that is expected to be chronic.

(v) *Health flexible spending arrangements.* Benefits provided under a health flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code) are excepted for a class of participants only if they satisfy the following two requirements—

(A) Other group health plan coverage, not limited to excepted benefits, is made available for the year to the class of participants by reason of their employment; and

(B) The arrangement is structured so that the maximum benefit payable to any participant in the class for a year cannot exceed two times the participant's salary reduction election under the arrangement for the year (or, if greater, cannot exceed $500 plus the amount of the participant's salary reduction election). For this purpose, any amount that an employee can elect to receive as taxable income but elects to apply to the health flexible spending arrangement is considered a salary reduction election (regardless of whether the amount is characterized as salary or as a credit under the arrangement).

(4) *Noncoordinated benefits*—(i) *Excepted benefits that are not coordinated.* Coverage for only a specified disease or illness (for example, cancer-only policies) or hospital indemnity or other fixed indemnity insurance is excepted only if it meets each of the conditions specified in paragraph (b)(4)(ii) of this section. To be hospital indemnity or other fixed indemnity insurance, the insurance must pay a fixed dollar amount per day (or per other period) of hospitalization or illness (for example, $100/day) regardless of the amount of expenses incurred.

(ii) *Conditions.* Benefits are described in paragraph (b)(4)(i) of this section only if—

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

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

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

(iii) *Example.* The rules of this paragraph (b)(4) are illustrated by the following example:

Example. (i) *Facts.* An employer sponsors a group health plan that provides coverage through an insurance policy. The policy provides benefits only for hospital stays at a fixed percentage of hospital expenses up to a maximum of $100 a day.

(ii) *Conclusion.* In this *Example,* even though the benefits under the policy satisfy the conditions in paragraph (b)(4)(ii) of this section, because the policy pays a percentage of expenses incurred rather than a fixed dollar amount, the benefits under the policy are not excepted benefits under this paragraph (b)(4). This is the result even if, in practice, the policy pays the maximum of $100 for every day of hospitalization.

(5) *Supplemental benefits.* (i) The following benefits are excepted only if they are provided under a separate policy, certificate, or contract of insurance—

(A) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act; also known as Medigap or MedSupp insurance);

(B) Coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code (also known as TRICARE supplemental programs); and

(C) Similar supplemental coverage provided to coverage under a group health plan. To be similar supplemental coverage, the coverage must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles. Similar supplemental coverage does not include coverage that becomes secondary or supplemental only under a coordination-of-benefits provision.

(ii) The rules of this paragraph (b)(5) are illustrated by the following example:

Example. (i) *Facts.* An employer sponsors a group health plan that provides coverage for both active employees and retirees. The coverage for retirees supplements benefits provided by Medicare, but does not meet the requirements for a supplemental policy under section 1882(g)(1) of the Social Security Act.

(ii) *Conclusion.* In this *Example,* the coverage provided to retirees does not meet the definition of supplemental excepted benefits

under this paragraph (b)(5) because the coverage is not Medicare supplemental insurance as defined under section 1882(g)(1) of the Social Security Act, is not a TRICARE supplemental program, and is not supplemental to coverage provided under a group health plan.

(c) *Treatment of partnerships.* For purposes of this part:

(1) *Treatment as a group health plan.* Any plan, fund, or program that would not be (but for this paragraph (c)) an employee welfare benefit plan and that is established or maintained by a partnership, to the extent that the 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, is treated (subject to paragraph (c)(2) of this section) as an employee welfare benefit plan that is a group health plan.

(2) *Employment relationship.* In the case of a group health plan, the term *employer* also includes the partnership in relation to any bona fide partner. In addition, the term *employee* also includes any bona fide partner. Whether or not an individual is a bona fide partner is determined based on all the relevant facts and circumstances, including whether the individual performs services on behalf of the partnership.

(3) *Participants of group health plans.* In the case of a group health plan, the term *participant* also includes any individual described in paragraph (c)(3)(i) or (ii) of this section if the individual is, or may become, eligible to receive a benefit under the plan or the individual's beneficiaries may be eligible to receive any such benefit.

(i) In connection with a group health plan maintained by a partnership, the individual is a partner in relation to the partnership.

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

(d) *Determining the average number of employees.* [Reserved]

[69 FR 78798, Dec. 30, 2004, as amended at 74 FR 51692, Oct. 7, 2009; 78 FR 65092, Oct. 30, 2013]

EFFECTIVE DATE NOTE: At 79 FR 59136, Oct. 1, 2014, §146.145 was amended by revising paragraphs (b)(3)(i) and (b)(3)(ii), and adding paragraph (b)(3)(vi), effective Dec. 1, 2014. For the convenience of the user, the added and revised text is set forth as follows:

§ 146.145 Special rules relating to group health plans.

* * * * *

(b) * * *

(3) * * *

(i) *In general.* Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan as described in paragraph (b)(3)(ii) of this section. In addition, benefits provided under a health flexible spending arrangement are excepted benefits if they satisfy the requirements of paragraph (b)(3)(v) of this section. Furthermore, benefits provided under an employee assistance program are excepted benefits if they satisfy the requirements of paragraph (b)(3)(vi) of this section.

(ii) *Not an integral part of a group health plan.* For purposes of this paragraph (b)(3), benefits are not an integral part of a group health plan (whether the benefits are provided through the same plan, a separate plan, or as the only plan offered to participants) if either paragraph (b)(3)(ii)(A) or (B) are satisfied.

(A) Participants may decline coverage. For example, a participant may decline coverage if the participant can opt out of the coverage upon request, whether or not there is a participant contribution required for the coverage.

(B) Claims for the benefits are administered under a contract separate from claims administration for any other benefits under the plan.

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(vi) *Employee assistance programs.* Benefits provided under employee assistance programs are excepted if they satisfy all of the requirements of this paragraph (b)(3)(vi).

(A) The program does not provide significant benefits in the nature of medical care. For this purpose, the amount, scope and duration of covered services are taken into account.

(B) The benefits under the employee assistance program are not coordinated with benefits under another group health plan, as follows:

(*1*) Participants in the other group health plan must not be required to use and exhaust benefits under the employee assistance program (making the employee assistance program a gatekeeper) before an individual is eligible for benefits under the other group health plan; and

(*2*) Participant eligibility for benefits under the employee assistance program must not be dependent on participation in another group health plan.

(C) No employee premiums or contributions are required as a condition of participation in the employee assistance program.

(D) There is no cost sharing under the employee assistance program.

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Subpart E—Provisions Applicable to Only Health Insurance Issuers

§ 146.150 Guaranteed availability of coverage for employers in the small group market.

(a) *Issuance of coverage in the small group market.* Subject to paragraphs (c) through (f) of this section, each health insurance issuer that offers health insurance coverage in the small group market in a State must—

(1) Offer, to any small employer in the State, all products that are approved for sale in the small group market and that the issuer is actively marketing, and must accept any employer that applies for any of those products; and

(2) Accept for enrollment under the coverage every eligible individual (as defined in paragraph (b) of this section) who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the group health plan, or during a special enrollment period, and may not impose any restriction on an eligible individual's being a participant or beneficiary, which is inconsistent with the nondiscrimination provisions of § 146.121.

(b) *Eligible individual defined.* For purposes of this section, the term ''eligible individual'' means an individual who is eligible—

(1) To enroll in group health insurance coverage offered to a group health plan maintained by a small employer, in accordance with the terms of the group health plan;

(2) For coverage under the rules of the health insurance issuer which are uniformly applicable in the State to small employers in the small group market; and

(3) For coverage in accordance with all applicable State laws governing the issuer and the small group market.

(c) *Special rules for network plans.* (1) In the case of a health insurance issuer that offers health insurance coverage in the small group market through a network plan, the issuer may—

(i) Limit the employers that may apply for the coverage to those with eligible individuals who live, work, or reside in the service area for the network plan; and

(ii) Within the service area of the plan, deny coverage to employers if the issuer has demonstrated to the applicable State authority (if required by the State authority) that—

(A) It will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees; and

(B) It is applying this paragraph (c)(1) uniformly to all employers without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to those employees and dependents.

(2) An issuer that denies health insurance coverage to an employer in any service area, in accordance with paragraph (c)(1)(ii) of this section, may not offer coverage in the small group market within the service area to any employer for a period of 180 days after the date the coverage is denied. This paragraph (c)(2) does not limit the issuer's ability to renew coverage already in force or relieve the issuer of the responsibility to renew that coverage.

(3) Coverage offered within a service area after the 180-day period specified in paragraph (c)(2) of this section is subject to the requirements of this section.

(d) *Application of financial capacity limits.* (1) A health insurance issuer may deny health insurance coverage in