

the cost of providing benefits to eligible beneficiaries for whom per beneficiary premiums are not paid.

**(3) Additional liability**

Any last signatory operator who is not a 1988 last signatory operator shall pay the monthly per beneficiary premium under paragraph (1)(B) for each eligible beneficiary described in such paragraph attributable to that operator.

**(4) Joint and several liability**

A 1988 last signatory operator or last signatory operator described in paragraph (3), and any related person to any such operator, shall be jointly and severally liable with such operator for any amount required to be paid by such operator under this section.

**(5) Deductibility**

Any premium required by this section shall be deductible without regard to any limitation on deductibility based on the prefunding of health benefits.

**(6) 1988 last signatory operator**

For purposes of this section, the term "1988 last signatory operator" means a last signatory operator which is a 1988 agreement operator.

(Added Pub. L. 102-486, title XIX, §19143(a), Oct. 24, 1992, 106 Stat. 3053.)

REFERENCES IN TEXT

The Social Security Act, referred to in subsec. (c)(3)(C), (D), is act Aug. 14, 1935, ch. 531, 49 Stat. 620, as amended. Title XVIII of the Act is classified generally to subchapter XVIII (§1395 et seq.) of chapter 7 of Title 42, The Public Health and Welfare. For complete classification of this Act to the Code, see section 1305 of Title 42 and Tables.

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in sections 9701, 9711 of this title.

**Subchapter D—Other Provisions**

- Sec. 9721. Civil enforcement.
- 9722. Sham transactions.

**§ 9721. Civil enforcement**

The provisions of section 4301 of the Employee Retirement Income Security Act of 1974 shall apply to any claim arising out of an obligation to pay any amount required to be paid by this chapter in the same manner as any claim arising out of an obligation to pay withdrawal liability under subtitle E of title IV of such Act. For purposes of the preceding sentence, a signatory operator and related persons shall be treated in the same manner as employers.

(Added Pub. L. 102-486, title XIX, §19143(a), Oct. 24, 1992, 106 Stat. 3055.)

REFERENCES IN TEXT

The Employee Retirement Income Security Act of 1974, referred to in text, is Pub. L. 93-406, Sept. 2, 1974, 88 Stat. 832, as amended. Subtitle E of title IV of the Act is classified generally to subtitle E (§1381 et seq.) of subchapter III of chapter 18 of Title 29, Labor. Section 4301 of the Act is classified to section 1451 of Title 29. For complete classification of this Act to the Code,

see Short Title note set out under section 1001 of Title 29 and Tables.

**§ 9722. Sham transactions**

If a principal purpose of any transaction is to evade or avoid liability under this chapter, this chapter shall be applied (and such liability shall be imposed) without regard to such transaction.

(Added Pub. L. 102-486, title XIX, §19143(a), Oct. 24, 1992, 106 Stat. 3056.)

**Subtitle K—Group Health Plan Portability, Access, and Renewability Requirements**

Chapter	Sec. <sup>1</sup>
100. Group health plan portability, access, and renewability requirements .....	9801

**CHAPTER 100—GROUP HEALTH PLAN PORTABILITY, ACCESS, AND RENEWABILITY REQUIREMENTS**

Sec.	
9801.	Increased portability through limitation on preexisting condition exclusions.
9802.	Prohibiting discrimination against individual participants and beneficiaries based on health status.
9803.	Guaranteed renewability in multiemployer plans and certain multiple employer welfare arrangements.
9804.	General exceptions.
9805.	Definitions.
9806.	Regulations.

CHAPTER REFERRED TO IN OTHER SECTIONS

This chapter is referred to in sections 4980B, 4980D of this title; title 29 section 1162.

**§ 9801. 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), a group health plan 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 length of the aggregate of the periods of creditable coverage (if any) applicable to the participant or beneficiary as of the enrollment date.

**(b) Definitions**

For purposes of this section—

**(1) Preexisting condition exclusion**

**(A) In general**

The term "preexisting condition exclusion" means, with respect to coverage, a

<sup>1</sup> Section numbers editorially supplied.

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**

For purposes of this section, genetic information shall not be treated as a condition described in subsection (a)(1) 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, the date of enrollment of the individual in the plan 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).

**(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.

(D) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928.

(E) Chapter 55 of title 10, United States Code.

(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, United States Code.

(I) A public health plan (as defined in regulations).

(J) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

Such term does not include coverage consisting solely of coverage of excepted benefits (as defined in section 9805(c)).

**(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), any period that an individual is in a waiting period for any coverage under a group health plan or is in an affiliation period shall not be taken into account in determining the continuous period under subparagraph (A).

**(C) Affiliation period**

**(i) In general**

For purposes of this section, 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. During such an affiliation period, the organization is not required to provide health care services or benefits and no premium shall be charged to the participant or beneficiary.

**(ii) Beginning**

Such period shall begin on the enrollment date.

**(iii) Runs concurrently with waiting periods**

Any such affiliation period shall run concurrently with any waiting period under the plan.

**(3) Method of crediting coverage**

**(A) Standard method**

Except as otherwise provided under subparagraph (B), for purposes of applying subsection (a)(3), a group health plan shall count a period of creditable coverage without regard to the specific benefits for which coverage is offered during the period.

**(B) Election of alternative method**

A group health plan may elect to apply subsection (a)(3) based on coverage of any 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 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), 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) 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 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 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**

For purposes of this section, a group health plan 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 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 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 health insurance coverage offered in connection with the plan, the plan is deemed to have satisfied the certification requirement under this paragraph if the issuer provides for such certification in accordance with this paragraph.

**(2) Disclosure of information on previous benefits****(A) In general**

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

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

(ii) 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 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 individual.

(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 the health insurance issuer offering health insurance coverage in connection with the plan) 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**

The 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 coverage of 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.

(Added Pub. L. 104-191, title IV, §401(a), Aug. 21, 1996, 110 Stat. 2073.)

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. Section 1928 of the Act is classified to section 1396s of Title 42. For complete classification of this Act to the Code, see section 1305 of Title 42 and Tables.

EFFECTIVE DATE

Section 401(c) of Pub. L. 104-191 provided that:

“(1) IN GENERAL.—The amendments made by this section [enacting this subtitle] shall apply to 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 chapter 100 of the Internal Revenue Code of 1986 (as added by this section) in determining creditable coverage.

“(ii) SPECIAL RULE FOR CERTAIN PERIODS.—The Secretary of the Treasury, 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 9801 of the Internal Revenue Code of 1986 (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.

“(3) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—Except as provided in paragraph (2), in the case of a group health plan maintained pursuant to 1 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], the amendments made by this section 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 added by this section shall not be treated as a termination of such collective bargaining agreement.

“(4) **TIMELY REGULATIONS.**—The Secretary of the Treasury, consistent with section 104, 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.”

**SECTION REFERRED TO IN OTHER SECTIONS**

This section is referred to in section 9802 of this title.

**§ 9802. 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 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 following 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 9801, paragraph (1) shall not be construed—

- (A) to require a group health plan to provide particular benefits (or benefits with respect to a specific procedure, treatment, or service) other than those provided under the terms of such plan; or
- (B) to prevent such a plan 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 may not require any individual (as a condition of enrollment or con-

tinued 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 factor described in subsection (a)(1) 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 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.

(Added Pub. L. 104-191, title IV, § 401(a), Aug. 21, 1996, 110 Stat. 2078.)

**SECTION REFERRED TO IN OTHER SECTIONS**

This section is referred to in section 9803 of this title.

**§ 9803. Guaranteed renewability in multi-employer plans and certain multiple employer welfare arrangements**

**(a) In general**

A group health plan which is a multiemployer plan (as defined in section 414(f)) or which is a multiple employer welfare arrangement may not deny an employer continued access to the same or different coverage under such 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, because 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 a factor described in section 9802(a)(1) in relation to such individuals or their dependents; or
- (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.

(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.

**(b) Multiple employer welfare arrangement**

For purposes of subsection (a), the term “multiple employer welfare arrangement” has the meaning given such term by section 3(40) of the Employee Retirement Income Security Act of 1974, as in effect on the date of the enactment of this section.

(Added Pub. L. 104-191, title IV, § 401(a), Aug. 21, 1996, 110 Stat. 2079.)

## REFERENCES IN TEXT

Section 3(40) of the Employee Retirement Income Security Act of 1974, referred to in subsec. (b), is classified to section 1002(40) of Title 29, Labor.

The date of the enactment of this section, referred to in subsec. (b), is the date of enactment of Pub. L. 104-191, which was approved Aug. 21, 1996.

## SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in section 4980D of this title.

**§ 9804. General exceptions****(a) Exception for certain plans**

The requirements of this chapter shall not apply to—

- (1) any governmental plan, and
- (2) any 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 chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9805(c)(1).

**(c) Exception for certain benefits if certain conditions met****(1) Limited, excepted benefits**

The requirements of this chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9805(c)(2) 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 chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9805(c)(3) 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 chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9805(c)(4) if the benefits are provided under a separate policy, certificate, or contract of insurance.

(Added Pub. L. 104-191, title IV, § 401(a), Aug. 21, 1996, 110 Stat. 2080.)

**§ 9805. Definitions****(a) Group health plan**

For purposes of this chapter, the term “group health plan” has the meaning given to such term by section 5000(b)(1).

**(b) Definitions relating to health insurance**

For purposes of this chapter—

**(1) Health insurance coverage****(A) In general**

Except as provided in subparagraph (B), the term “health insurance coverage” means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) 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.

**(B) No application to certain excepted benefits**

In applying subparagraph (A), excepted benefits described in subsection (c)(1) shall not be treated as benefits consisting of medical care.

**(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 514(b)(2) of the Employee Retirement Income Security Act of 1974, as in effect on the date of the enactment of this section). 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.

**(c) Excepted benefits**

For purposes of this chapter, 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 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan.

**(d) Other definitions**

For purposes of this chapter—

**(1) COBRA continuation provision**

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

(A) Section 4980B, other than subsection (f)(1) thereof insofar as it relates to pediatric vaccines.

(B) Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.), other than section 609 of such Act.

(C) Title XXII of the Public Health Service Act.

**(2) Governmental plan**

The term “governmental plan” has the meaning given such term by section 414(d).

**(3) Medical care**

The term “medical care” has the meaning given such term by section 213(d) determined without regard to—

(A) paragraph (1)(C) thereof, and

(B) so much of paragraph (1)(D) thereof as relates to qualified long-term care insurance.

**(4) Network plan**

The term “network plan” means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care are provided, in whole or in part, through a defined set of providers under contract with the issuer.

**(5) Placed for adoption defined**

The term “placement”, or being “placed”, for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child’s placement with such person terminates upon the termination of such legal obligation.

(Added Pub. L. 104–191, title IV, §401(a), Aug. 21, 1996, 110 Stat. 2080.)

REFERENCES IN TEXT

The Employee Retirement Income Security Act of 1974, referred to in subsecs. (b)(2) and (d)(1)(B), is Pub. L. 93–406, Sept. 2, 1974, 88 Stat. 832, as amended. Section 514(b)(2) of the Act is classified to section 1144(b)(2) of Title 29, Labor. Section 609 of the Act is classified to section 1169 of Title 29. Part 6 of subtitle B of title I of the Act is classified generally to part 6 (§1161 et seq.) of subtitle B of subchapter I of chapter 18 of Title 29. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

The date of the enactment of this section, referred to in subsec. (b)(2), is the date of enactment of Pub. L. 104–191, which was approved Aug. 21, 1996.

Section 1882(g)(1) of the Social Security Act, referred to in subsec. (c)(4), is classified to section 1395ss(g)(1) of Title 42, The Public Health and Welfare.

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. For complete classification of this Act to the Code, see Short Title note set out under section 201 of Title 42 and Tables.

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in section 4980D, 9801, 9804 of this title.

**§ 9806. 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 chapter. The Secretary may promulgate any interim final rules as the Secretary determines are appropriate to carry out this chapter.

(Added Pub. L. 104–191, title IV, §401(a), Aug. 21, 1996, 110 Stat. 2082.)

REFERENCES IN TEXT

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