gynecology. Such professional shall agree to otherwise adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

(B) Obstetrical and gynecological care

A group health plan or health insurance issuer described in paragraph (2) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under subparagraph (A), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

(2) Application of paragraph

A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in this paragraph is a group health plan or coverage that—

(A) provides coverage for obstetric or gynecologic care; and

(B) requires the designation by a participant, beneficiary, or enrollee of a participating primary care provider.

(3) Construction

Nothing in paragraph (1) shall be construed to—

(A) waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

(B) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.

(July 1, 1944, ch. 373, title XXVII, § 2719A, as added Pub. L. 111–148, title X, § 10101(h), Mar. 23, 2010, 124 Stat. 888.)

REFERENCES IN TEXT

Section 2701 of this Act, referred to in subsec. (b)(1)(D), is a reference to section 2701 of act July 1, 1944. Section 2701, which was classified to section 300gg of this title, was renumbered section 2704, effective for plan years beginning on or after Jan. 1, 2014, with certain exceptions, and amended, by Pub. L. 111–148, title I, §§ 1201(2), 1563(c)(1), formerly § 1562(c)(1), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911, and was transferred to section 300gg–3 of this title. A new section 2701 of act July 1, 1944, related to fair health insurance premiums, was added, effective for plan years beginning on or after Jan. 1, 2014, and amended, by Pub. L. 111–148, title I, § 1201(4), title X, § 10103(a), Mar. 23, 2010, 124 Stat. 155, 892, and is classified to section 300gg of this title.

CODIFICATION

Pub. L. 111–148, which directed amendment of subpart II of part A of ''title XVIII'' of act July 1, 1944, by inserting section 2719A after section 2719, was executed by making the insertion in subpart II of part A of title XXVII of the Act, to reflect the probable intent of Congress.

SUBPART 2—EXCLUSION OF PLANS; ENFORCEMENT; PREEMPTION

CODIFICATION

This subpart 2 designation and heading was transferred along with sections 300gg–21 to 300gg–23 of this title to appear before section 300gg–25 of this title to reflect the renumbering of the sections in the original act by Pub. L. 111–148, title I, §§ 1001(4), 1563(c)(12)(D), (13)(C), (14)(B), formerly § 1562(c)(12)(D), (13)(C), (14)(B), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 269, 911.

AMENDMENTS

2010—Pub. L. 111–148, title I, § 1563(c)(11), formerly § 1562(c)(11), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 268, 911, redesignated subpart 4 as subpart 2.

1996—Pub. L. 104–204, title VI, § 604(a)(2), Sept. 26, 1996, 110 Stat. 2939, redesignated subpart 3 as 4.

§ 300gg–21. Exclusion of certain plans

(a) Limitation on application of provisions relating to group health plans

(1) In general

The requirements of subparts 1 and 2[1] shall apply with respect to group health plans only—

(A) subject to paragraph (2), in the case of a plan that is a nonfederal governmental plan, and

(B) with respect to health insurance coverage offered in connection with a group health plan (including such a plan that is a church plan or a governmental plan).

(2) Treatment of non-Federal governmental plans

(A) Election to be excluded

Except as provided in subparagraph (D) or (E), if the plan sponsor of a nonfederal governmental plan which is a group health plan to which the provisions of subparts 1 and 2[1] otherwise apply makes an election under this subparagraph (in such form and manner as the Secretary may by regulations prescribe), then the requirements of such subparts insofar as they apply directly to group health plans (and not merely to group health insurance coverage) shall not apply to such governmental plans for such period except as provided in this paragraph.

(B) Period of election

An election under subparagraph (A) shall apply—

(i) for a single specified plan year, or

(ii) in the case of a plan provided pursuant to a collective bargaining agreement, for the term of such agreement.

An election under clause (i) may be extended through subsequent elections under this paragraph.

(C) Notice to enrollees

Under such an election, the plan shall provide for—

(i) notice to enrollees (on an annual basis and at the time of enrollment under the plan) of the fact and consequences of such election, and

[1] See References in Text note below.

(ii) certification and disclosure of creditable coverage under the plan with respect to enrollees in accordance with section 2701(e).[1]

(D) Election not applicable to requirements concerning genetic information

The election described in subparagraph (A) shall not be available with respect to the provisions of subsections (a)(1)(F), (b)(3), (c), and (d) of section 2702[1] and the provisions of sections 2701[1] and 2702(b)[1] to the extent that such provisions apply to genetic information.

(E) Election not applicable

The election described in subparagraph (A) shall not be available with respect to the provisions of subparts I and II.

(b) Exception for certain benefits

The requirements of subparts 1 and 2[1] shall not apply to any individual coverage or any group health plan (or group health insurance coverage) in relation to its provision of excepted benefits described in section 300gg–91(c)(1) of this title.

(c) Exception for certain benefits if certain conditions met

(1) Limited, excepted benefits

The requirements of subparts 1 and 2[1] shall not apply to any individual coverage or 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 300gg–91(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 subparts 1 and 2[1] shall not apply to any individual coverage or 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 300gg–91(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 or, with respect to individual coverage, under any health insurance coverage maintained by the same health insurance issuer.

(3) Supplemental excepted benefits

The requirements of this part shall not apply to any individual coverage or any group health plan (and group health insurance coverage) in relation to its provision of excepted benefits described in section 300gg–91(c)(4)[1] 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.

(July 1, 1944, ch. 373, title XXVII, §2722, formerly §2721, as added Pub. L. 104–191, title I, §102(a), Aug. 21, 1996, 110 Stat. 1967; amended Pub. L. 104–204, title VI, §604(b)(1), Sept. 26, 1996, 110 Stat. 2940; Pub. L. 110–233, title I, §102(c), May 21, 2008, 122 Stat. 895; renumbered §2735, renumbered §2722, and amended Pub. L. 111–148, title I, §§1001(4), 1563(a), (c)(12), formerly §1562(a), (c)(12), title X, §10107(a), (b)(1), Mar. 23, 2010, 124 Stat. 130, 264, 268, 911.)

REFERENCES IN TEXT

Subparts 1 and 2, referred to in subsecs. (a)(1), (2)(A), (b), and (c)(1), (2), may refer to subparts I and II of this part. Pub. L. 111–148, title I, §§1001(5), 1201(1), 1563(c)(2), (11), formerly §1562(c)(2), (11), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 154, 265, 268, 911, amended this part by substituting ''SUBPART I—GENERAL REFORM'' for ''SUBPART 1—PORTABILITY, ACCESS, AND RENEWABILITY REQUIREMENTS'' (preceding section 300gg of this title), effective for plan years beginning on or after Jan. 1, 2014, by inserting SUBPART II—IMPROVING COVERAGE'' (preceding section 300gg–11 of this title), by striking out ''SUBPART 2—OTHER REQUIREMENTS'' (preceding section 300gg–4 of this title), and by redesignating subpart 4 as subpart 2 ''EXCLUSION OF PLANS; ENFORCEMENT; PREEMPTION'' (preceding section 300gg–21 of this title).

Section 2701, referred to in subsec. (a)(2)(C)(ii), (D), is a reference to section 2701 of act July 1, 1944. Section 2701, which was classified to section 300gg of this title,

was renumbered section 2704, effective for plan years beginning on or after Jan. 1, 2014, with certain exceptions, and amended, by Pub. L. 111–148, title I, §§1201(2), 1563(c)(1), formerly §1562(c)(1), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911, and was transferred to section 300gg–3 of this title. A new section 2701 of act July 1, 1944, related to fair health insurance premiums, was added, effective for plan years beginning on or after Jan. 1, 2014, and amended, by Pub. L. 111–148, title I, §1201(4), title X, §10103(a), Mar. 23, 2010, 124 Stat. 155, 892, and is classified to section 300gg of this title.

Section 2702, referred to in subsec. (a)(2)(D), is a reference to section 2702 of act July 1, 1944. Section 2702, which was classified to section 300gg–1 of this title, was amended by Pub. L. 111–148, title I, §1201(3), Mar. 23, 2010, 124 Stat. 154, and was transferred to subsecs. (b) to (f) of section 300gg–4 of this title, effective for plan years beginning on or after Jan. 1, 2014. A new section 2702 of act July 1, 1944, related to guaranteed availability of coverage, was added by Pub. L. 111–148, title I, §1201(4), Mar. 23, 2010, 124 Stat. 156, effective for plan years beginning on or after Jan. 1, 2014, and is classified to section 300gg–1 of this title.

Section 300gg–91(c)(4) of this title, referred to in subsec. (c)(3), was in the original ''section 27971(c)(4)'' and was translated as reading ''section 2791(c)(4)'', meaning section 2791(c)(4) of act July 1, 1944, as added by Pub. L. 104–191, §102(a), to reflect the probable intent of Congress. Act July 1, 1944, does not contain a section 27971.

PRIOR PROVISIONS

A prior section 2722 of act July 1, 1944, was renumbered section 2723 and is classified to section 300gg–22 of this title.

AMENDMENTS

2010—Pub. L. 111–148, §1563(c)(12)(B), formerly §1562(c)(12)(B), as renumbered by Pub. L. 111–148, §10107(b)(1), which directed amendment of section by substituting ''subpart 1'' for ''subparts 1 through 3'' wherever appearing, could not be executed because the words ''subparts 1 through 3'' did not appear subsequent to amendments by section 1563(a)(2)(A), (B)(ii), (3), (4)(A), (B)(i) of Pub. L. 111–148. See below.

Subsec. (a). Pub. L. 111–148, §1563(c)(12)(C), formerly §1562(c)(12)(C), as renumbered by Pub. L. 111–148, §10107(b)(1), redesignated subsec. (b) as (a).

Pub. L. 111–148, §§1563(a)(1) and 1563(c)(12)(A), formerly §§1562(a)(1) and 1562(c)(12)(A), as renumbered by Pub. L. 111–148, §10107(b)(1), made identical amendment, striking out subsec. (a). Prior to amendment, text read as follows: ''The requirements of subparts 1 and 3 shall not apply to any group health plan (and 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.''

Subsec. (b). Pub. L. 111–148, §1563(c)(12)(C), formerly §1562(c)(12)(C), as renumbered by Pub. L. 111–148, §10107(b)(1), redesignated subsec. (c) as (b). Former subsec. (b) redesignated (a).

Pub. L. 111–148, §1563(a)(2)(A), formerly §1562(a)(2)(A), as renumbered by Pub. L. 111–148, §10107(b)(1), substituted ''subparts 1 and 2'' for ''subparts 1 through 3'' in introductory provisions.

Pub. L. 111–148, §1563(a)(2)(B)(ii), formerly §1562(a)(2)(B)(ii), as renumbered by Pub. L. 111–148, §10107(b)(1), substituted ''subparts 1 and 2'' for ''subparts 1 through 3''.

Pub. L. 111–148, §1563(a)(2)(B)(i), formerly §1562(a)(2)(B)(i), as renumbered by Pub. L. 111–148, §10107(b)(1), substituted ''subparagraph (D) or (E)'' for ''subparagraph (D)''.

Subsec. (b)(2)(E). Pub. L. 111–148, §10107(a), substituted ''subparts I and II'' for ''subpart 1''.

Pub. L. 111–148, §1563(a)(2)(B)(iii), formerly §1562(a)(2)(B)(iii), as renumbered by Pub. L. 111–148, §10107(b)(1), added subpar. (E).

Subsec. (c). Pub. L. 111–148, §1563(c)(12)(C), formerly §1562(c)(12)(C), as renumbered by Pub. L. 111–148, §10107(b)(1), redesignated subsec. (d) as (c). Former subsec. (c) redesignated (b).

Pub. L. 111–148, §1563(a)(3), formerly §1562(a)(3), as renumbered by Pub. L. 111–148, §10107(b)(1), substituted ''subparts 1 and 2 shall not apply to any individual coverage or any group'' for ''subparts 1 through 3 shall not apply to any group''.

Subsec. (d). Pub. L. 111–148, §1563(c)(12)(C), formerly §1562(c)(12)(C), as renumbered by Pub. L. 111–148, §10107(b)(1), redesignated subsec. (e) as (d). Former subsec. (d) redesignated (c).

Pub. L. 111–148, §1563(a)(4)(A), formerly §1562(a)(4)(A), as renumbered by Pub. L. 111–148, §10107(b)(1), substituted ''subparts 1 and 2 shall not apply to any individual coverage or any group'' for ''subparts 1 through 3 shall not apply to any group'' in introductory provisions.

Pub. L. 111–148, §1563(a)(4)(B)(i), formerly §1562(a)(4)(B)(i), as renumbered by Pub. L. 111–148, §10107(b)(1), substituted ''subparts 1 and 2 shall not apply to any individual coverage or any group'' for ''subparts 1 through 3 shall not apply to any group'' in introductory provisions.

Subsec. (d)(2)(C). Pub. L. 111–148, §1563(a)(4)(B)(ii), formerly §1562(a)(4)(B)(ii), as renumbered by Pub. L. 111–148, §10107(b)(1), which directed amendment of subpar. (C) by inserting ''or, with respect to individual coverage, under any health insurance coverage maintained by the same health insurance issuer'' without language specifying placement, was executed by making the insertion before period at end to reflect the probable intent of Congress.

Subsec. (d)(3). Pub. L. 111–148, §1563(a)(4)(C), formerly §1562(a)(4)(C), as renumbered by Pub. L. 111–148, §10107(b)(1), substituted ''any individual coverage or any group'' for ''any group''.

Subsec. (e). Pub. L. 111–148, §1563(c)(12)(C), formerly §1562(c)(12)(C), as renumbered by Pub. L. 111–148, §10107(b)(1), redesignated subsec. (e) as (d).

2008—Subsec. (b)(2)(A). Pub. L. 110–233, §102(c)(1), substituted ''Except as provided in subparagraph (D), if the plan sponsor'' for ''If the plan sponsor''.

Subsec. (b)(2)(D). Pub. L. 110–233, §102(c)(2), added subpar. (D).

1996—Subsec. (a). Pub. L. 104–204, §604(b)(1)(A), substituted ''subparts 1 and 3'' for ''subparts 1 and 2''.

Subsec. (b) to (d). Pub. L. 104–204, §604(b)(1)(B), substituted ''subparts 1 through 3'' for ''subparts 1 and 2'' wherever appearing.

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–233, title I, §102(d)(2), May 21, 2008, 122 Stat. 895, provided that: ''The amendments made by this section [enacting section 300gg–53 of this title and amending this section and sections 300gg–1, 300gg–22, 300gg–61, and 300gg–91 of this title] shall apply—

''(A) with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning after the date that is 1 year after the date of enactment of this Act [May 21, 2008]; and

''(B) with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market after the date that is 1 year after the date of enactment of this Act.''

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–204 applicable with respect to group health plans for plan years beginning on or after Jan. 1, 1998, see section 604(c) of Pub. L. 104–204 set out as an Effective Date note under section 300gg–25 of this title.

EFFECTIVE DATE

Section applicable with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning after June 30, 1997, except as otherwise provided, see section 102(c) of Pub. L. 104–191, set out as a note under section 300gg of this title.

REGULATIONS

Pub. L. 110–233, title I, §102(d)(1), May 21, 2008, 122 Stat. 895, provided that: ''Not later than 12 months after the date of enactment of this Act [May 21, 2008], the Secretary of Health and Human Services shall issue final regulations to carry out the amendments made by this section [see Effective Date of 2008 Amendment note above].''

ASSURING COORDINATION

Pub. L. 110–233, title I, §106, May 21, 2008, 122 Stat. 905, provided that: ''Except as provided in section 105(b)(1) [42 U.S.C. 1320d–9 note], the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury shall ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that—

''(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under this title [enacting sections 300gg–53 and 1320d–9 of this title and section 9834 of Title 26, Internal Revenue Code, amending this section, sections 300gg–1, 300gg–22, 300gg–61, 300gg–91, and 1395ss of this title, sections 9802 and 9832 of Title 26, and sections 1132, 1182, and 1191b of Title 29, Labor, and enacting provisions set out as notes under this section, sections 1320d–9 and 1395ss of this title, section 9802 of Title 26, and section 1132 of Title 29] (and the amendments made by this title) are administered so as to have the same effect at all times; and

''(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.''

§ 300gg–22. Enforcement

(a) State enforcement

(1) State authority

Subject to section 300gg–23[1] of this title, each State may require that health insurance issuers that issue, sell, renew, or offer health insurance coverage in the State in the individual or group market meet the requirements of this part with respect to such issuers.

(2) Failure to implement provisions

In the case of a determination by the Secretary that a State has failed to substantially enforce a provision (or provisions) in this part with respect to health insurance issuers in the State, the Secretary shall enforce such provision (or provisions) under subsection (b) of this section insofar as they relate to the issuance, sale, renewal, and offering of health insurance coverage in connection with group health plans or individual health insurance coverage in such State.

(b) Secretarial enforcement authority

(1) Limitation

The provisions of this subsection shall apply to enforcement of a provision (or provisions) of this part only—

(A) as provided under subsection (a)(2) of this section; and

(B) with respect to individual health insurance coverage or group health plans that are non-Federal governmental plans.

(2) Imposition of penalties

In the cases described in paragraph (1)—

(A) In general

Subject to the succeeding provisions of this subsection, any non-Federal governmental plan that is a group health plan and any health insurance issuer that fails to meet a provision of this part applicable to such plan or issuer is subject to a civil money penalty under this subsection.

(B) Liability for penalty

In the case of a failure by—

(i) a health insurance issuer, the issuer is liable for such penalty, or

(ii) a group health plan that is a non-Federal governmental plan which is—

(I) sponsored by 2 or more employers, the plan is liable for such penalty, or

(II) not so sponsored, the employer is liable for such penalty.

(C) Amount of penalty

(i) In general

The maximum amount of penalty imposed under this paragraph is $100 for each day for each individual with respect to which such a failure occurs.

(ii) Considerations in imposition

In determining the amount of any penalty to be assessed under this paragraph, the Secretary shall take into account the previous record of compliance of the entity being assessed with the applicable provisions of this part and the gravity of the violation.

(iii) Limitations

(I) Penalty not to apply where failure not discovered exercising reasonable diligence

No civil money penalty shall be imposed under this paragraph on any failure during any period for which it is established to the satisfaction of the Secretary that none of the entities against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

(II) Penalty not to apply to failures corrected within 30 days

No civil money penalty shall be imposed under this paragraph on any failure if such failure was due to reasonable cause and not to willful neglect, and such failure is corrected during the 30-day period beginning on the first day any of the entities against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

(D) Administrative review

(i) Opportunity for hearing

The entity assessed shall be afforded an opportunity for hearing by the Secretary upon request made within 30 days after the date of the issuance of a notice of assessment. In such hearing the decision shall be made on the record pursuant to section 554 of title 5. If no hearing is requested, the as-

[1] See References in Text note below.

sessment shall constitute a final and unappealable order.

(ii) Hearing procedure

If a hearing is requested, the initial agency decision shall be made by an administrative law judge, and such decision shall become the final order unless the Secretary modifies or vacates the decision. Notice of intent to modify or vacate the decision of the administrative law judge shall be issued to the parties within 30 days after the date of the decision of the judge. A final order which takes effect under this paragraph shall be subject to review only as provided under subparagraph (E).

(E) Judicial review

(i) Filing of action for review

Any entity against whom an order imposing a civil money penalty has been entered after an agency hearing under this paragraph may obtain review by the United States district court for any district in which such entity is located or the United States District Court for the District of Columbia by filing a notice of appeal in such court within 30 days from the date of such order, and simultaneously sending a copy of such notice by registered mail to the Secretary.

(ii) Certification of administrative record

The Secretary shall promptly certify and file in such court the record upon which the penalty was imposed.

(iii) Standard for review

The findings of the Secretary shall be set aside only if found to be unsupported by substantial evidence as provided by section 706(2)(E) of title 5.

(iv) Appeal

Any final decision, order, or judgment of the district court concerning such review shall be subject to appeal as provided in chapter 83 of title 28.

(F) Failure to pay assessment; maintenance of action

(i) Failure to pay assessment

If any entity fails to pay an assessment after it has become a final and unappealable order, or after the court has entered final judgment in favor of the Secretary, the Secretary shall refer the matter to the Attorney General who shall recover the amount assessed by action in the appropriate United States district court.

(ii) Nonreviewability

In such action the validity and appropriateness of the final order imposing the penalty shall not be subject to review.

(G) Payment of penalties

Except as otherwise provided, penalties collected under this paragraph shall be paid to the Secretary (or other officer) imposing the penalty and shall be available without appropriation and until expended for the purpose of enforcing the provisions with respect to which the penalty was imposed.

(3) Enforcement authority relating to genetic discrimination

(A) General rule

In the cases described in paragraph (1), notwithstanding the provisions of paragraph (2)(C), the succeeding subparagraphs of this paragraph shall apply with respect to an action under this subsection by the Secretary with respect to any failure of a health insurance issuer in connection with a group health plan, to meet the requirements of subsection (a)(1)(F), (b)(3), (c), or (d) of section 2702[1] or section 2701[1] or 2702(b)(1)[1] with respect to genetic information in connection with the plan.

(B) Amount

(i) In general

The amount of the penalty imposed under this paragraph shall be $100 for each day in the noncompliance period with respect to each participant or beneficiary to whom such failure relates.

(ii) Noncompliance period

For purposes of this paragraph, the term ''noncompliance period'' means, with respect to any failure, the period—

(I) beginning on the date such failure first occurs; and

(II) ending on the date the failure is corrected.

(C) Minimum penalties where failure discovered

Notwithstanding clauses (i) and (ii) of subparagraph (D):

(i) In general

In the case of 1 or more failures with respect to an individual—

(I) which are not corrected before the date on which the plan receives a notice from the Secretary of such violation; and

(II) which occurred or continued during the period involved;

the amount of penalty imposed by subparagraph (A) by reason of such failures with respect to such individual shall not be less than $2,500.

(ii) Higher minimum penalty where violations are more than de minimis

To the extent violations for which any person is liable under this paragraph for any year are more than de minimis, clause (i) shall be applied by substituting ''$15,000'' for ''$2,500'' with respect to such person.

(D) Limitations

(i) Penalty not to apply where failure not discovered exercising reasonable diligence

No penalty shall be imposed by subparagraph (A) on any failure during any period for which it is established to the satisfaction of the Secretary that the person

otherwise liable for such penalty did not know, and exercising reasonable diligence would not have known, that such failure existed.

(ii) Penalty not to apply to failures corrected within certain periods

No penalty shall be imposed by subparagraph (A) on any failure if—

(I) such failure was due to reasonable cause and not to willful neglect; and

(II) such failure is corrected during the 30-day period beginning on the first date the person otherwise liable for such penalty knew, or exercising reasonable diligence would have known, that such failure existed.

(iii) Overall limitation for unintentional failures

In the case of failures which are due to reasonable cause and not to willful neglect, the penalty imposed by subparagraph (A) for failures shall not exceed the amount equal to the lesser of—

(I) 10 percent of the aggregate amount paid or incurred by the employer (or predecessor employer) during the preceding taxable year for group health plans; or

(II) $500,000.

(E) Waiver by Secretary

In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the penalty imposed by subparagraph (A) to the extent that the payment of such penalty would be excessive relative to the failure involved.

(July 1, 1944, ch. 373, title XXVII, §2723, formerly §2722, as added Pub. L. 104–191, title I, §102(a), Aug. 21, 1996, 110 Stat. 1968; amended Pub. L. 110–233, title I, §102(a)(5), May 21, 2008, 122 Stat. 891; renumbered §2736, renumbered §2723, and amended Pub. L. 111–148, title I, §§1001(4), 1563(c)(13), formerly §1562(c)(13), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 269, 911.)

REFERENCES IN TEXT

Section 300gg–23 of this title, referred to in subsec. (a)(1), was in the original section ''2723'', and was translated as meaning section 2724 of act July 1, 1944, to reflect the probable intent of Congress and the renumbering of section 2723 as 2724 by Pub. L. 111–148, title I, §§1001(4), 1563(c)(14)(B), formerly §1562(c)(14)(B), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 269, 911.

Section 2702, referred to in subsec. (b)(3)(A), is a reference to section 2702 of act July 1, 1944. Section 2702, which was classified to section 300gg–1 of this title, was amended by Pub. L. 111–148, title I, §1201(3), Mar. 23, 2010, 124 Stat. 154, and was transferred to subsecs. (b) to (f) of section 300gg–4 of this title, effective for plan years beginning on or after Jan. 1, 2014. A new section 2702, related to guaranteed availability of coverage, was added by Pub. L. 111–148, title I, §1201(4), Mar. 23, 2010, 124 Stat. 156, effective for plan years beginning on or after Jan. 1, 2014, and is classified to section 300gg–1 of this title.

Section 2701, referred to in subsec. (b)(3)(A), is a reference to section 2701 of act July 1, 1944. Section 2701, which was classified to section 300gg of this title, was renumbered section 2704, effective for plan years beginning on or after Jan. 1, 2014, with certain exceptions, and amended, by Pub. L. 111–148, title I, §§1201(2), 1563(c)(1), formerly §1562(c)(1), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911, and was transferred to section 300gg–3 of this title. A new section 2701 of act July 1, 1944, related to fair health insurance premiums, was added, effective for plan years beginning on or after Jan. 1, 2014, and amended, by Pub. L. 111–148, title I, §1201(4), title X, §10103(a), Mar. 23, 2010, 124 Stat. 155, 892, and is classified to section 300gg of this title.

PRIOR PROVISIONS

A prior section 2723 of act July 1, 1944, was renumbered section 2724 and is classified to section 300gg–23 of this title.

AMENDMENTS

2010—Subsec. (a)(1). Pub. L. 111–148, §1563(c)(13)(A)(i), formerly §1562(c)(13)(A)(i), as renumbered by Pub. L. 111–148, §10107(b)(1), substituted ''individual or group market'' for ''small or large group markets''.

Subsec. (a)(2). Pub. L. 111–148, §1563(c)(13)(a)(ii), formerly §1562(c)(13)(A)(ii), as renumbered by Pub. L. 111–148, §10107(b)(1), inserted ''or individual health insurance coverage'' after ''group health plans''.

Subsec. (b)(1)(B). Pub. L. 111–148, §1563(c)(13)(B), formerly §1562(c)(13)(B), as renumbered by Pub. L. 111–148, §10107(b)(1), inserted ''individual health insurance coverage or'' after ''with respect to''.

2008—Subsec. (b)(3). Pub. L. 110–233 added par. (3).

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by Pub. L. 110–233 applicable, with respect to group health plans and health insurance coverage offered in connection with group health plans, for plan years beginning after the date that is one year after May 21, 2008, and, with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market, after the date that is one year after May 21, 2008, see section 102(d)(2) of Pub. L. 110–233, set out as a note under section 300gg–21 of this title.

EFFECTIVE DATE

Section applicable with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning after June 30, 1997, except as otherwise provided, see section 102(c) of Pub. L. 104–191, set out as a note under section 300gg of this title.

§ 300gg–23. 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 and part C of this subchapter insofar as it relates to 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 individual or 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 title 29 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 701[1] 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—

(i) substitutes for the reference to ''6-month period'' in section 2701(a)(1)[1] a reference to any shorter period of time;

(ii) substitutes for the reference to ''12 months'' and ''18 months'' in section 2701(a)(2)[1] a reference to any shorter period of time;

(iii) substitutes for the references to ''63'' days in sections 2701(c)(2)(A)[1] and 2701(d)(4)(A)[1] a reference to any greater number of days;

(iv) substitutes for the reference to ''30-day period'' in sections 2701(b)(2)[1] and 2701(d)(1)[1] a reference to any greater period;

(v) prohibits the imposition of any preexisting condition exclusion in cases not described in section 2701(d)[1] or expands the exceptions described in such section;

(vi) requires special enrollment periods in addition to those required under section 2701(f)[1]; or

(vii) reduces the maximum period permitted in an affiliation period under section 2701(g)(1)(B)[1].

(c) Rules of construction

Nothing in this part (other than section 2704)[1] 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 (including the Northern Mariana Islands), any political subdivisions of a State or such Islands, or any agency or instrumentality of either.

(July 1, 1944, ch. 373, title XXVII, § 2724, formerly § 2723, as added Pub. L. 104–191, title I, § 102(a), Aug. 21, 1996, 110 Stat. 1971; amended Pub. L. 104–204, title VI, § 604(b)(2), Sept. 26, 1996, 110 Stat. 2941; renumbered § 2737, renumbered § 2724, and amended Pub. L. 111–148, title I, §§ 1001(4), 1563(c)(14), formerly § 1562(c)(14), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 269, 911.)

[1] See References in Text note below.

REFERENCES IN TEXT

Section 2701, referred to in subsec. (b), is a reference to section 2701 of act July 1, 1944. Section 2701, which was classified to section 300gg of this title, was renumbered section 2704, effective for plan years beginning on or after Jan. 1, 2014, with certain exceptions, and amended, by Pub. L. 111–148, title I, §§ 1201(2), 1563(c)(1), formerly § 1562(c)(1), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911, and was transferred to section 300gg–3 of this title. A new section 2701 of act July 1, 1944, related to fair health insurance premiums, was added, effective for plan years beginning on or after Jan. 1, 2014, and amended, by Pub. L. 111–148, title I, § 1201(4), title X, § 10103(a), Mar. 23, 2010, 124 Stat. 155, 892, and is classified to section 300gg of this title.

Section 701, referred to in subsec. (b)(1), probably means ''section 2701'' of act July 1, 1944. See note above.

Section 2704, referred to in subsec. (c), is a reference to section 2704 of act July 1, 1944. Section 2704, which was classified to section 300gg–4 of this title, was renumbered section 2725, and amended by Pub. L. 111–148, title I, §§ 1001(2), 1563(c)(3), formerly § 1562(c)(3), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 265, 911, and was transferred to section 300gg–25 of this title. A new section 2704 of act July 1, 1944, related to prohibition of preexisting condition exclusions or other discrimination based on health status, was added, effective for plan years beginning on or after Jan. 1, 2014, with certain exceptions, and amended, by Pub. L. 111–148, title I, §§ 1201(2), 1563(c)(1), formerly § 1562(c)(1), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911, and is classified to section 300gg–3 of this title.

AMENDMENTS

2010—Subsec. (a)(1). Pub. L. 111–148, § 1563(c)(14)(A), formerly § 1562(c)(14)(A), as renumbered by Pub. L. 111–148, § 10107(b)(1), inserted ''individual or'' before ''group health insurance''.

1996—Subsec. (c). Pub. L. 104–204 inserted ''(other than section 2704)'' after ''part''.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–204 applicable with respect to group health plans for plan years beginning on or after Jan. 1, 1998, see section 604(c) of Pub. L. 104–204 set out as an Effective Date note under section 300gg–25 of this title.

EFFECTIVE DATE

Section applicable with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning after June 30, 1997, except as otherwise provided, see section 102(c) of Pub. L. 104–191, set out as a note under section 300gg of this title.

§ 300gg–25. 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 or individual 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 child-

birth 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 or individual health insurance coverage, 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 or coverage, 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 health insurance issuer offering group or individual health insurance coverage, 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 health insurance 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

A group health plan under this part shall comply with the notice requirement under section 1185(d) of title 29 with respect to the requirements of this section as if such section applied to such plan.

(e) Level and type of reimbursements

Nothing in this section shall be construed to prevent a group health plan or a health insurance issuer offering group or individual 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 300gg–23(d)(1)[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 300gg–23(a)(1)[1] of this title shall not be construed as superseding a State law described in paragraph (1).

(July 1, 1944, ch. 373, title XXVII, § 2725, formerly § 2704, as added Pub. L. 104–204, title VI, § 604(a)(3), Sept. 26, 1996, 110 Stat. 2939; renumbered § 2725 and amended Pub. L. 111–148, title I, §§ 1001(2), 1563(c)(3), formerly § 1562(c)(3), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 265, 911.)

REFERENCES IN TEXT

Section 300gg–23 of this title, referred to in subsec. (f), was in the original section ''2723'', and was translated as meaning section 2724 of act July 1, 1944, to reflect the probable intent of Congress and the renumbering of section 2723 as 2724 by Pub. L. 111–148, title I, §§ 1001(4), 1563(c)(14)(B), formerly § 1562(c)(14)(B), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 269, 911.

CODIFICATION

Section was formerly classified to section 300gg–4 of this title prior to renumbering by Pub. L. 111–148.

[1] See References in Text note below.

AMENDMENTS

2010—Subsec. (a)(1). Pub. L. 111–148, § 1563(c)(3)(A), formerly § 1562(c)(3)(A), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''group or individual health insurance coverage'' for ''group health insurance coverage'' in introductory provisions.

Subsec. (b). Pub. L. 111–148, § 1563(c)(3)(B)(i), formerly § 1562(c)(3)(B)(i), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''group or individual health insurance coverage'' for ''group health insurance coverage in connection with a group health plan'' in introductory provisions.

Subsec. (b)(1). Pub. L. 111–148, § 1563(c)(3)(B)(ii), formerly § 1562(c)(3)(B)(ii), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''plan or coverage'' for ''plan''.

Subsec. (c)(2). Pub. L. 111–148, § 1563(c)(3)(C)(i), formerly § 1562(c)(3)(C)(i), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''health insurance issuer offering group or individual health insurance coverage'' for ''group health insurance coverage offered by a health insurance issuer''.

Subsec. (c)(3). Pub. L. 111–148, § 1563(c)(3)(C)(ii), formerly § 1562(c)(3)(C)(ii), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''health insurance issuer'' for ''issuer''.

Subsec. (e). Pub. L. 111–148, § 1563(c)(3)(D), formerly § 1562(c)(3)(D), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''group or individual health insurance coverage'' for ''group health insurance coverage''.

EFFECTIVE DATE

Pub. L. 104–204, title VI, § 604(c), Sept. 26, 1996, 110 Stat. 2941, provided that: ''The amendments made by this section [enacting this section and amending sections 300gg–21 and 300gg–23 of this title] shall apply with respect to group health plans for plan years beginning on or after January 1, 1998.''

CONGRESSIONAL FINDINGS

Pub. L. 104–204, title VI, § 602, Sept. 26, 1996, 110 Stat. 2935, provided that: ''Congress finds that—

''(1) the length of post-delivery hospital stay should be based on the unique characteristics of each mother and her newborn child, taking into consideration the health of the mother, the health and stability of the newborn, the ability and confidence of the mother and the father to care for their newborn, the adequacy of support systems at home, and the access of the mother and her newborn to appropriate follow-up health care; and

''(2) the timing of the discharge of a mother and her newborn child from the hospital should be made by the attending provider in consultation with the mother.''

§ 300gg–26. Parity in mental health and substance use disorder benefits

(a) In general

(1) Aggregate lifetime limits

In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder 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 or substance use disorder 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 and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or

(ii) not include any aggregate lifetime limit on mental health or substance use disorder 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 and substance use disorder 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 a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder 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 or substance use disorder 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 and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or

(ii) not include any annual limit on mental health or substance use disorder 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 and substance use disorder 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.

(3) Financial requirements and treatment limitations

(A) In general

In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that—

(i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

(ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

(B) Definitions

In this paragraph:

(i) Financial requirement

The term ''financial requirement'' includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit subject to paragraphs (1) and (2).

(ii) Predominant

A financial requirement or treatment limit is considered to be predominant if it is the most common or frequent of such type of limit or requirement.

(iii) Treatment limitation

The term ''treatment limitation'' includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

(4) Availability of plan information

The criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits (or the health insurance coverage offered in connection with the plan with respect to such benefits) shall be made available by the plan administrator (or the health insurance issuer offering such coverage) in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request. The reason for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary shall, on request or as otherwise required, be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary in accordance with regulations.

(5) Out-of-network providers

In the case of a plan or coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, if the plan or coverage provides coverage for medical or surgical benefits provided by out-of-network providers, the plan or coverage shall provide coverage for mental health or substance use disorder benefits provided by out-of-network providers in a manner that is consistent with the requirements of this section.

(b) Construction

Nothing in this section shall be construed—

(1) as requiring a group health plan or a health insurance issuer offering group or individual health insurance coverage to provide any mental health or substance use disorder benefits; or

(2) in the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides mental health or substance use disorder benefits, as affecting the terms and conditions of the plan or coverage relating to such benefits under the plan or coverage, except as provided in subsection (a).

(c) Exemptions

(1) Small employer exemption

This section shall not apply to any group health plan and a health insurance issuer offering group or individual health insurance coverage for any plan year of a small employer (as defined in section 300gg–91(e)(4) of this title, except that for purposes of this paragraph such term shall include employers with 1 employee in the case of an employer residing in a State that permits small groups to include a single individual).

(2) Cost exemption

(A) In general

With respect to a group health plan or a health insurance issuer offering group or individual health insurance coverage, if the application of this section to such plan (or coverage) results in an increase for the plan year involved of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan (as determined and certified under subparagraph (C)) by an amount that exceeds the applicable percentage described in subparagraph (B) of the actual total plan costs, the provisions of this section shall not apply to such plan (or coverage) during the following plan year, and such exemption shall apply to the plan (or coverage) for 1 plan year. An

employer may elect to continue to apply mental health and substance use disorder parity pursuant to this section with respect to the group health plan (or coverage) involved regardless of any increase in total costs.

(B) Applicable percentage

With respect to a plan (or coverage), the applicable percentage described in this subparagraph shall be—

(i) 2 percent in the case of the first plan year in which this section is applied; and

(ii) 1 percent in the case of each subsequent plan year.

(C) Determinations by actuaries

Determinations as to increases in actual costs under a plan (or coverage) for purposes of this section shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. All such determinations shall be in a written report prepared by the actuary. The report, and all underlying documentation relied upon by the actuary, shall be maintained by the group health plan or health insurance issuer for a period of 6 years following the notification made under subparagraph (E).

(D) 6-month determinations

If a group health plan (or a health insurance issuer offering coverage in connection with a group health plan) seeks an exemption under this paragraph, determinations under subparagraph (A) shall be made after such plan (or coverage) has complied with this section for the first 6 months of the plan year involved.

(E) Notification

(i) In general

A group health plan (or a health insurance issuer offering coverage in connection with a group health plan) that, based upon a certification described under subparagraph (C), qualifies for an exemption under this paragraph, and elects to implement the exemption, shall promptly notify the Secretary, the appropriate State agencies, and participants and beneficiaries in the plan of such election.

(ii) Requirement

A notification to the Secretary under clause (i) shall include—

(I) a description of the number of covered lives under the plan (or coverage) involved at the time of the notification, and as applicable, at the time of any prior election of the cost-exemption under this paragraph by such plan (or coverage);

(II) for both the plan year upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan; and

(III) for both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage with respect to mental health and substance use disorder benefits under the plan.

(iii) Confidentiality

A notification to the Secretary under clause (i) shall be confidential. The Secretary shall make available, upon request and on not more than an annual basis, an anonymous itemization of such notifications, that includes—

(I) a breakdown of States by the size and type of employers submitting such notification; and

(II) a summary of the data received under clause (ii).

(F) Audits by appropriate agencies

To determine compliance with this paragraph, the Secretary may audit the books and records of a group health plan or health insurance issuer relating to an exemption, including any actuarial reports prepared pursuant to subparagraph (C), during the 6 year period following the notification of such exemption under subparagraph (E). A State agency receiving a notification under subparagraph (E) may also conduct such an audit with respect to an exemption covered by such notification.

(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 or substance use disorder benefits.

(4) Mental health benefits

The term ''mental health benefits'' means benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law.

(5) Substance use disorder benefits

The term ''substance use disorder benefits'' means benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law.

(July 1, 1944, ch. 373, title XXVII, § 2726, formerly § 2705, as added Pub. L. 104–204, title VII, § 703(a), Sept. 26, 1996, 110 Stat. 2947; amended Pub. L. 107–116, title VII, § 701(b), Jan. 10, 2002, 115 Stat. 2228; Pub. L. 107–313, § 2(b), Dec. 2, 2002, 116 Stat. 2457; Pub. L. 108–197, § 2(b), Dec. 19, 2003, 117 Stat. 2898; Pub. L. 108–311, title III, § 302(c), Oct. 4, 2004, 118 Stat. 1179; Pub. L. 109–151, § 1(b), Dec. 30, 2005, 119 Stat. 2886; Pub. L. 109–432, div. A, title I, § 115(c), Dec. 20, 2006, 120 Stat. 2941; Pub. L. 110–245, title IV, § 401(c), June 17, 2008, 122 Stat. 1650; Pub. L. 110–343, div. C, title V, § 512(b), (g)(2), Oct. 3, 2008, 122 Stat. 3885, 3892; renumbered § 2726 and amended Pub. L. 111–148, title I, §§ 1001(2), 1563(c)(4), formerly § 1562(c)(4), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 265, 911.)

CODIFICATION

Section was formerly classified to section 300gg–5 of this title prior to renumbering by Pub. L. 111–148.

AMENDMENTS

2010—Subsecs. (a), (b). Pub. L. 111–148, § 1563(c)(4)(A), (B), formerly § 1562(c)(4)(A), (B), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''or a health insurance issuer offering group or individual health insurance coverage'' for ''(or health insurance coverage offered in connection with such a plan)'' wherever appearing.

Subsec. (c)(1). Pub. L. 111–148, § 1563(c)(4)(C)(i), formerly § 1562(c)(4)(C)(i), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''and a health insurance issuer offering group or individual health insurance coverage'' for ''(and group health insurance coverage offered in connection with a group health plan)''.

Subsec. (c)(2)(A). Pub. L. 111–148, § 1563(c)(4)(C)(ii), formerly § 1562(c)(4)(C)(ii), as renumbered by Pub. L. 111–148, § 10107(b)(1), substituted ''or a health insurance issuer offering group or individual health insurance coverage'' for ''(or health insurance coverage offered in connection with such a plan)''.

2008—Pub. L. 110–343, § 512(g)(2), amended section catchline generally. Prior to amendment, catchline read as follows: ''Parity in application of certain limits to mental health benefits''.

Subsec. (a)(1), (2). Pub. L. 110–343, § 512(b)(7), substituted ''mental health or substance use disorder benefits'' for ''mental health benefits'' wherever appearing in pars. (1)(introductory provisions), (A), and (B)(ii) and (2)(introductory provisions), (A), and (B)(ii).

Pub. L. 110–343, § 512(b)(6), substituted ''mental health and substance use disorder benefits'' for ''mental health benefits'' wherever appearing in pars. (1)(B)(i) and (C) and (2)(B)(i) and (C).

Subsec. (a)(3) to (5). Pub. L. 110–343, § 512(b)(1), added pars. (3) to (5).

Subsec. (b)(1). Pub. L. 110–343, § 512(b)(7), substituted ''mental health or substance use disorder benefits'' for ''mental health benefits''.

Subsec. (b)(2). Pub. L. 110–343, § 512(b)(2), amended par. (2) generally. Prior to amendment, par. (2) read as follows: ''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).''

Subsec. (c)(1). Pub. L. 110–343, § 512(b)(3)(A), inserted ''(as defined in section 300gg–91(e)(4) of this title, except that for purposes of this paragraph such term shall include employers with 1 employee in the case of an employer residing in a State that permits small groups to include a single individual)'' before period at end.

Subsec. (c)(2). Pub. L. 110–343, § 512(b)(3)(B), added par. (2) and struck out former par. (2). Prior to amendment, text read as follows: ''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.''

Subsec. (e)(3). Pub. L. 110–343, § 512(b)(7), substituted ''mental health or substance use disorder benefits'' for ''mental health benefits''.

Subsec. (e)(4). Pub. L. 110–343, § 512(b)(7), which directed substitution of ''mental health or substance use disorder benefits'' for ''mental health benefits'' wherever appearing in this section (other than in any provision amended by section 512(b)(6) of Pub. L. 110–343), was not executed to par. (4) as added by Pub. L. 110–343, § 512(b)(4), to reflect the probable intent of Congress. See below.

Pub. L. 110–343, § 512(b)(4), added par. (4) and struck out former par. (4). Prior to amendment, text read as follows: ''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.''

Subsec. (e)(5). Pub. L. 110–343, § 512(b)(4), added par. (5).

Subsec. (f). Pub. L. 110–343, § 512(b)(5), struck out subsec. (f). Text read as follows: ''This section shall not apply to benefits for services furnished—

''(1) on or after January 1, 2008, and before June 17, 2008, and

''(2) after December 31, 2008..''

Pub. L. 110–245 substituted ''services furnished—'' for ''services furnished after December 31, 2007'' and added pars. (1) and (2).

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 OF 2008 AMENDMENT

Pub. L. 110–343, div. C, title V, § 512(e), Oct. 3, 2008, 122 Stat. 3891, as amended by Pub. L. 110–460, § 1, Dec. 23, 2008, 122 Stat. 5123, provided that:

''(1) IN GENERAL.—The amendments made by this section [amending this section, section 9812 of Title 26, Internal Revenue Code, and section 1185a of Title 29, Labor] shall apply with respect to group health plans for plan years beginning after the date that is 1 year after the date of enactment of this Act [Oct. 3, 2008], regardless of whether regulations have been issued to carry out such amendments by such effective date, except that the amendments made by subsections (a)(5), (b)(5), and (c)(5) [amending this section, section 9812 of Title 26, and section 1185a of Title 29], relating to striking of certain sunset provisions, shall take effect on January 1, 2009.

''(2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enact-

ment of this Act [Oct. 3, 2008], 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) January 1, 2010.

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.''

EFFECTIVE DATE

Pub. L. 104–204, title VII, §703(b), Sept. 26, 1996, 110 Stat. 2950, provided that: ''The amendments made by this section [enacting this section] shall apply with respect to group health plans for plan years beginning on or after January 1, 1998.''

REGULATIONS

Pub. L. 110–343, div. C, title V, §512(d), Oct. 3, 2008, 122 Stat. 3891, provided that: ''Not later than 1 year after the date of enactment of this Act [Oct. 3, 2008], the Secretaries of Labor, Health and Human Services, and the Treasury shall issue regulations to carry out the amendments made by subsections (a), (b), and (c) [amending this section, section 9812 of Title 26, Internal Revenue Code, and section 1185a of Title 29, Labor], respectively.''

ASSURING COORDINATION

Pub. L. 110–343, div. C, title V, §512(f), Oct. 3, 2008, 122 Stat. 3892, provided that: ''The Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury may ensure, through the execution or revision of an interagency memorandum of understanding among such Secretaries, that—

''(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under this section [amending this section, section 9812 of Title 26, Internal Revenue Code, and section 1185a of Title 29, Labor, and enacting provisions set out as notes under this section] (and the amendments made by this section) are administered so as to have the same effect at all times; and

''(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.''

§ 300gg–27. Required coverage for reconstructive surgery following mastectomies

The provisions of section 1185b of title 29 shall apply to group health plans, and and[1] health insurance issuers offering group or individual health insurance coverage, as if included in this subpart.

(July 1, 1944, ch. 373, title XXVII, §2727, formerly §2706, as added Pub. L. 105–277, div. A, §101(f) [title IX, §903(a)], Oct. 21, 1998, 112 Stat. 2681–337, 2681–438; renumbered §2727 and amended Pub. L. 111–148, title I, §§1001(2), 1563(c)(5), formerly §1562(c)(5), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 266, 911.)

CODIFICATION

Section was formerly classified to section 300gg–6 of this title prior to renumbering by Pub. L. 111–148.

[1] So in original.

AMENDMENTS

2010—Pub. L. 111–148, §1563(c)(5), formerly §1562(c)(5), as renumbered by Pub. L. 111–148, §10107(b)(1), substituted ''and health insurance issuers offering group or individual health insurance coverage'' for ''health insurance issuers providing health insurance coverage in connection with group health plans''.

EFFECTIVE DATE

Pub. L. 105–277, div. A, §101(f) [title IX, §903(c)(1)], Oct. 21, 1998, 112 Stat. 2681–337, 2681–438, provided that:

''(A) IN GENERAL.—The amendment made by subsection (a) [enacting this section] shall apply to group health plans for plan years beginning on or after the date of enactment of this Act [Oct. 21, 1998].

''(B) 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 the amendment made by subsection (a) shall not be treated as a termination of such collective bargaining agreement.''

§ 300gg–28. Coverage of dependent students on medically necessary leave of absence

(a) Medically necessary leave of absence

In this section, the term ''medically necessary leave of absence'' means, with respect to a dependent child described in subsection (b)(2) in connection with a group health plan or individual health insurance coverage, a leave of absence of such child from a postsecondary educational institution (including an institution of higher education as defined in section 1002 of title 20), or any other change in enrollment of such child at such an institution, that—

(1) commences while such child is suffering from a serious illness or injury;

(2) is medically necessary; and

(3) causes such child to lose student status for purposes of coverage under the terms of the plan or coverage.

(b) Requirement to continue coverage

(1) In general

In the case of a dependent child described in paragraph (2), a group health plan, or a health insurance issuer that offers group or individual health insurance coverage, shall not terminate coverage of such child under such plan or health insurance coverage due to a medically necessary leave of absence before the date that is the earlier of—

(A) the date that is 1 year after the first day of the medically necessary leave of absence; or

(B) the date on which such coverage would otherwise terminate under the terms of the plan or health insurance coverage.

(2) Dependent child described

A dependent child described in this paragraph is, with respect to a group health plan or individual health insurance coverage, a beneficiary under the plan who—

(A) is a dependent child, under the terms of the plan or coverage, of a participant or beneficiary under the plan or coverage; and

(B) was enrolled in the plan or coverage, on the basis of being a student at a post-

secondary educational institution (as described in subsection (a)), immediately before the first day of the medically necessary leave of absence involved.

(3) Certification by physician

Paragraph (1) shall apply to a group health plan or individual health insurance coverage only if the plan or issuer of the coverage has received written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) described in subsection (a) is medically necessary.

(c) Notice

A group health plan, and a health insurance issuer that offers group or individual health insurance coverage, shall include, with any notice regarding a requirement for certification of student status for coverage under the plan or coverage, a description of the terms of this section for continued coverage during medically necessary leaves of absence. Such description shall be in language which is understandable to the typical plan participant.

(d) No change in benefits

A dependent child whose benefits are continued under this section shall be entitled to the same benefits as if (during the medically necessary leave of absence) the child continued to be a covered student at the institution of higher education and was not on a medically necessary leave of absence.

(e) Continued application in case of changed coverage

If—

(1) a dependent child of a participant or beneficiary is in a period of coverage under a group health plan or individual health insurance coverage, pursuant to a medically necessary leave of absence of the child described in subsection (b);

(2) the manner in which the participant or beneficiary is covered under the plan changes, whether through a change in health insurance coverage or health insurance issuer, a change between health insurance coverage and self-insured coverage, or otherwise; and

(3) the coverage as so changed continues to provide coverage of beneficiaries as dependent children,

this section shall apply to coverage of the child under the changed coverage for the remainder of the period of the medically necessary leave of absence of the dependent child under the plan in the same manner as it would have applied if the changed coverage had been the previous coverage.

(July 1, 1944, ch. 373, title XXVII, §2728, formerly §2707, as added Pub. L. 110–381, §2(b)(1), Oct. 9, 2008, 122 Stat. 4083; renumbered §2728 and amended Pub. L. 111–148, title I, §§1001(2), 1563(c)(6), formerly §1562(c)(6), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 266, 911.)

CODIFICATION

Section was formerly classified to section 300gg–7 of this title prior to renumbering by Pub. L. 111–148.

AMENDMENTS

2010—Subsec. (a). Pub. L. 111–148, §1563(c)(6)(A), formerly §1562(c)(6)(A), as renumbered by Pub. L. 111–148, §10107(b)(1), substituted ''individual health insurance coverage'' for ''health insurance coverage offered in connection with such plan'' in introductory provisions.

Subsec. (b)(1). Pub. L. 111–148, §1563(c)(6)(B)(i), formerly §1562(c)(6)(B)(i), as renumbered by Pub. L. 111–148, §10107(b)(1), substituted ''or a health insurance issuer that offers group or individual health insurance coverage'' for ''or a health insurance issuer that provides health insurance coverage in connection with a group health plan'' in introductory provisions.

Subsec. (b)(2). Pub. L. 111–148, §1563(c)(6)(B)(ii), formerly §1562(c)(6)(B)(ii), as renumbered by Pub. L. 111–148, §10107(b)(1), substituted ''individual health insurance coverage'' for ''health insurance coverage offered in connection with the plan'' in introductory provisions.

Subsec. (b)(3). Pub. L. 111–148, §1563(c)(6)(B)(iii), formerly §1562(c)(6)(B)(iii), as renumbered by Pub. L. 111–148, §10107(b)(1), substituted ''individual health insurance coverage'' for ''health insurance coverage offered by an issuer in connection with such plan''.

Subsec. (c). Pub. L. 111–148, §1563(c)(6)(C), formerly §1562(c)(6)(C), as renumbered by Pub. L. 111–148, §10107(b)(1), substituted ''health insurance issuer that offers group or individual health insurance coverage'' for ''health insurance issuer providing health insurance coverage in connection with a group health plan''.

Subsec. (e)(1). Pub. L. 111–148, §1563(c)(6)(D), formerly §1562(c)(6)(D), as renumbered by Pub. L. 111–148, §10107(b)(1), substituted ''individual health insurance coverage'' for ''health insurance coverage offered in connection with such a plan''.

EFFECTIVE DATE

Section applicable with respect to plan years beginning on or after the date that is one year after Oct. 9, 2008, and to medically necessary leaves of absence beginning during such plan years, see section 2(d) of Pub. L. 110–381, set out as a note under section 9813 of Title 26, Internal Revenue Code.

PART B—INDIVIDUAL MARKET RULES

SUBPART 1—PORTABILITY, ACCESS, AND RENEWABILITY REQUIREMENTS

§300gg–41. Guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage

(a) Guaranteed availability

(1) In general

Subject to the succeeding subsections of this section and section 300gg–44 of this title, each health insurance issuer that offers health insurance coverage (as defined in section 300gg–91(b)(1) of this title) in the individual market in a State may not, with respect to an eligible individual (as defined in subsection (b) of this section) desiring to enroll in individual health insurance coverage—

(A) decline to offer such coverage to, or deny enrollment of, such individual; or

(B) impose any preexisting condition exclusion (as defined in section 2701(b)(1)(A))[1] with respect to such coverage.

(2) Substitution by State of acceptable alternative mechanism

The requirement of paragraph (1) shall not apply to health insurance coverage offered in

[1] See References in Text note below.