(a) Group health plan

For purposes of this part—

(1) In general

The term “group health plan” means an employee welfare benefit plan to the extent that the plan provides medical care (as defined 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) Medical care

The term “medical care” means amounts paid for—

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

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

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

(b) Definitions relating to health insurance

For purposes of this part—

(1) Health insurance coverage

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

(2) Health insurance issuer

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

(3) Health maintenance organization

The term “health maintenance organization” means—

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

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

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

(4) Group health insurance coverage

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

(c) Excepted benefits

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

(1) Benefits not subject to requirements

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

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

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

(D) Workers’ compensation or similar insurance.
(E) Automobile medical payment insurance.
(F) Credit-only insurance.
(G) Coverage for on-site medical clinics.
(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(2) Benefits not subject to requirements if offered separately
(A) Limited scope dental or vision benefits.
(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.
(C) Such other similar, limited benefits as are specified in regulations.

(3) Benefits not subject to requirements if offered as independent, noncoordinated benefits
(A) Coverage only for a specified disease or illness.
(B) Hospital indemnity or other fixed indemnity insurance.

(4) Benefits not subject to requirements if offered as separate insurance policy
Medicare supplemental health insurance (as defined under section 1395ss(g)(1) of title 42), coverage supplemental to the coverage provided under chapter 55 of title 10, and similar supplemental coverage provided to coverage under a group health plan.

(d) Other definitions
For purposes of this part—

(1) COBRA continuation provision
The term “COBRA continuation provision” means any of the following:
(A) Part 6 of this subtitle.
(B) Section 4980B of title 26, other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines.
(C) Title XXII of the Public Health Service Act [42 U.S.C. 300bb-1 et seq.].

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

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

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

(5) Family member
The term “family member” means, with respect to an individual—
(A) a dependent (as such term is used for purposes of section 1381(f)(2) of this title) of such individual, and
(B) any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual or of an individual described in subparagraph (A).

(6) Genetic information
(A) In general
The term “genetic information” means, with respect to any individual, information about—
(i) such individual’s genetic tests,
(ii) the genetic tests of family members of such individual, and
(iii) the manifestation of a disease or disorder in family members of such individual.

(B) Inclusion of genetic services and participation in genetic research
Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual.

(C) Exclusions
The term “genetic information” shall not include information about the sex or age of any individual.

(7) Genetic test
(A) In general
The term “genetic test” means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detects genotypes, mutations, or chromosomal changes.

(B) Exceptions
The term “genetic test” does not mean—
(i) an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or
(ii) an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(8) Genetic services
The term “genetic services” means—
(A) a genetic test;
(B) genetic counseling (including obtaining, interpreting, or assessing genetic information); or
(C) genetic education.

(9) Underwriting purposes
The term “underwriting purposes” means, with respect to any group health plan, or health insurance coverage offered in connection with a group health plan—
(A) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the plan or coverage;
(B) the computation of premium or contribution amounts under the plan or coverage;
(C) the application of any pre-existing condition exclusion under the plan or coverage; and
(D) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.


REFERENCES IN TEXT

The Public Health Service Act, referred to in subsec. (d)(1)(C), is act July 1, 1944, ch. 373, 58 Stat. 682, as amended. Title XXII of the Act is classified generally to subchapter XX (§ 300bb–1 et seq.) of chapter 6A of Title 42, The Public Health and Welfare. For complete classification of this Act to the Code, see Short Title note set out under section 421 of Title 42 and Tables.

AMENDMENTS


EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by Pub. L. 110–233 applicable with respect to group health plans for plan years beginning after the date that is one year after May 21, 2008, see section 101(f)(2) of Pub. L. 110–233, set out as a note under section 1132 of this title.

EFFECTIVE DATE

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

§ 1191c. Regulations

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


REFERENCES IN TEXT


EFFECTIVE DATE

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

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

(a) Additional material required of applicants

Before issuing an advance determination of whether a pension, profit-sharing, or stock bonus plan, a trust which is a part of such a plan, or an annuity or bond purchase plan meets the requirements of part I of subchapter D of chapter 1 of title 26, the Secretary of the Treasury shall require the person applying for the determination to provide, in addition to any material and information necessary for such determination, such other material and information as may reasonably be made available at the time such application is made as the Secretary of Labor may require under subchapter I of this chapter for the administration of that subchapter. The Secretary of the Treasury shall also require that the applicant provide evidence satisfactory to the Secretary that the applicant has notified each employee who qualifies as an interested party (within the meaning of regulations prescribed under section 7476(b)(1) of title 26 (relating to declaratory judgments in connection with the qualification of certain retirement plans)) of the application for a determination.

(b) Opportunity to comment on application

(1) Whenever an application is made to the Secretary of the Treasury for a determination of whether a pension, profit-sharing, or stock bonus plan, a trust which is a part of such a plan, or an annuity or bond purchase plan meets the requirements of part I of subchapter D of chapter 1 of title 26, the Secretary of the Treasury shall request a determination letter by the Secretary of the Treasury covering qualifications under Internal Revenue Code

(2) The Secretary of Labor may not request an opportunity to comment upon such an application unless he has been requested in writing to do so by the Pension Benefit Guaranty Corporation or by the lesser of—

(A) 10 employees, or

(B) 10 percent of the employees

who qualify as interested parties within the meaning of the regulations referred to in subsection (a) of this section.

(1) Any employee or class of employee qualifying as an interested party within the meaning of the regulations referred to in subsection (a) of this section, the Secretary of Labor, and the Pension Benefit Guaranty Corporation.

(2) The Secretary of Labor may not request an opportunity to comment upon such an application unless he has been requested in writing to do so by the Pension Benefit Guaranty Corporation or by the lesser of—

(A) 10 employees, or

(B) 10 percent of the employees

who qualify as interested parties within the meaning of the regulations referred to in subsection (a) of this section. Upon receiving such a request, the Secretary of Labor shall furnish a copy of the request to the Secretary of the Treasury within 5 days (excluding Saturdays, Sundays, and legal public holidays (as set forth in section 6103 of title 5)).