

section do not apply with respect to health insurance coverage offered in connection with a group health plan if there is a State law regulating the coverage that meets any of the following criteria:

(i) The State law requires the coverage to provide for at least a 48-hour hospital length of stay following a vaginal delivery and at least a 96-hour hospital length of stay following a delivery by caesarean section.

(ii) The State law requires the 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 any other established professional medical association.

(iii) The State law requires, in connection with the coverage for maternity care, that the hospital length of stay for such care is left to the decision of (or is required to be made by) the attending provider in consultation with the mother. State laws that require the decision to be made by the attending provider with the consent of the mother satisfy the criterion of this paragraph (e)(1)(iii).

(2) *Group health plans*—(i) *Fully-insured plans*. For a group health plan that provides benefits solely through health insurance coverage, if the State law regulating the health insurance coverage meets any of the criteria in paragraph (e)(1) of this section, then the requirements of section 711 of the Act and this section do not apply.

(ii) *Self-insured plans*. For a group health plan that provides all benefits for hospital lengths of stay in connection with childbirth other than through health insurance coverage, the requirements of section 711 of the Act and this section apply.

(iii) *Partially-insured plans*. For a group health plan that provides some benefits through health insurance coverage, if the State law regulating the health insurance coverage meets any of the criteria in paragraph (e)(1) of this section, then the requirements of section 711 of the Act and this section apply only to the extent the plan provides benefits for hospital lengths of stay in connection with childbirth

other than through health insurance coverage.

(3) *Relation to section 731(a) of the Act*. The preemption provisions contained in section 731(a)(1) of the Act and § 2590.731(a) do not supersede a State law described in paragraph (e)(1) of this section.

(4) *Examples*. The rules of this paragraph (e) are illustrated by the following examples:

Example 1. (i) A group health plan buys group health insurance coverage in a State that requires that the coverage provide for at least a 48-hour hospital length of stay following a vaginal delivery and at least a 96-hour hospital length of stay following a delivery by caesarean section.

(ii) In this *Example 1*, the coverage is subject to State law, and the requirements of section 711 of the Act and this section do not apply.

Example 2. (i) A self-insured group health plan covers hospital lengths of stay in connection with childbirth in a State that requires health insurance coverage to provide for maternity care in accordance with guidelines established by the American College of Obstetricians and Gynecologists and to provide for pediatric care in accordance with guidelines established by the American Academy of Pediatrics.

(ii) In this *Example 2*, even though the State law satisfies the criterion of paragraph (e)(1)(ii) of this section, because the plan provides benefits for hospital lengths of stay in connection with childbirth other than through health insurance coverage, the plan is subject to the requirements of section 711 of the Act and this section.

(f) *Effective date*. Section 711 of the Act applies to group health plans, and health insurance issuers offering group health insurance coverage, for plan years beginning on or after January 1, 1998. This section applies to group health plans, and health insurance issuers offering group health insurance coverage, for plan years beginning on or after January 1, 1999.

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§ 2590.712 Parity in the application of certain limits to mental health benefits.

(a) *Definitions*. For purposes of this section, except where the context clearly indicates otherwise, the following definitions apply:

Aggregate lifetime limit means a dollar limitation on the total amount of specified benefits that may be paid under a group health plan (or group health insurance coverage offered in connection with such a plan) for an individual (or for a group of individuals considered a single unit in applying this dollar limitation, such as a family or an employee plus spouse).

Annual limit means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a plan (or group health insurance coverage offered in connection with such a plan) for an individual (or for a group of individuals considered a single unit in applying this dollar limitation, such as a family or an employee plus spouse).

Medical/surgical benefits means benefits for medical or surgical services, as defined under the terms of the plan or group health insurance coverage, but does not include mental health benefits.

Mental health benefits means benefits for mental health services, as defined under the terms of the plan or group health insurance coverage, but does not include benefits for treatment of substance abuse or chemical dependency.

(b) *Requirements regarding limits on benefits—(1)—general—(i) General parity requirement.* A group health plan (or health insurance coverage offered by an issuer in connection with a group health plan) that provides both medical/surgical benefits and mental health benefits must comply with paragraph (b)(2), (3), or (6) of this section.

(ii) *Exception.* The rule in paragraph (b)(1)(i) of this section does not apply if a plan, or coverage, satisfies the requirements of paragraph (e) or (f) of this section.

(2) *Plan with no limit or limits on less than one-third of all medical/surgical benefits.* If a plan (or group health insurance coverage) does not include an aggregate lifetime or annual limit on any medical/surgical benefits or includes aggregate lifetime or annual limits that apply to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual limit, respectively, on mental health benefits.

(3) *Plan with a limit on at least two-thirds of all medical/surgical benefits.* If a plan (or group health insurance coverage) includes an aggregate lifetime or annual limit on at least two-thirds of all medical/surgical benefits, it must either—

(i) Apply the aggregate lifetime or annual limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health benefits in a manner that does not distinguish between the medical/surgical and mental health benefits; or

(ii) Not include an aggregate lifetime or annual limit on mental health benefits that is less than the aggregate lifetime or annual limit, respectively, on the medical/surgical benefits.

(4) *Examples.* The rules of paragraphs (b)(2) and (3) of this section are illustrated by the following examples:

Example 1. (i) Prior to the effective date of the mental health parity provisions, a group health plan had no annual limit on medical/surgical benefits and had a \$10,000 annual limit on mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Eliminating the plan's annual limit on mental health benefits;

(B) Replacing the plan's previous annual limit on mental health benefits with a \$500,000 annual limit on all benefits (including medical/surgical and mental health benefits); and

(C) Replacing the plan's previous annual limit on mental health benefits with a \$250,000 annual limit on medical/surgical benefits and a \$250,000 annual limit on mental health benefits.

(ii) In this *Example 1*, each of the three options being considered by the plan sponsor would comply with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

Example 2. (i) Prior to the effective date of the mental health parity provisions, a group health plan had a \$100,000 annual limit on medical/surgical inpatient benefits, a \$50,000 annual limit on medical/surgical outpatient benefits, and a \$100,000 annual limit on all mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Replacing the plan's previous annual limit on mental health benefits with a \$150,000 annual limit on mental health benefits; and

(B) Replacing the plan's previous annual limit on mental health benefits with a \$100,000 annual limit on mental health inpatient benefits and a \$50,000 annual limit on mental health outpatient benefits.

(ii) In this *Example 2*, each option under consideration by the plan sponsor would comply with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

Example 3. (i) A group health plan that is subject to the requirements of this section has no aggregate lifetime or annual limit for either medical/surgical benefits or mental health benefits. While the plan provides medical/surgical benefits with respect to both network and out-of-network providers, it does not provide mental health benefits with respect to out-of-network providers.

(ii) In this *Example 3*, the plan complies with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

Example 4. (i) Prior to the effective date of the mental health parity provisions, a group health plan had an annual limit on medical/surgical benefits and a separate but identical annual limit on mental health benefits. The plan included benefits for treatment of substance abuse and chemical dependency in its definition of mental health benefits. Accordingly, claims paid for treatment of substance abuse and chemical dependency were counted in applying the annual limit on mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Making no change in the plan so that claims paid for treatment of substance abuse and chemical dependency continue to count in applying the annual limit on mental health benefits;

(B) Amending the plan to count claims paid for treatment of substance abuse and chemical dependency in applying the annual limit on medical/surgical benefits (rather than counting those claims in applying the annual limit on mental health benefits);

(C) Amending the plan to provide a new category of benefits for treatment of chemical dependency and substance abuse that is subject to a separate, lower limit and under which claims paid for treatment of substance abuse and chemical dependency are counted only in applying the annual limit on this separate category; and

(D) Amending the plan to eliminate distinctions between medical/surgical benefits and mental health benefits and establishing an overall limit on benefits offered under the plan under which claims paid for treatment of substance abuse and chemical dependency are counted with medical/surgical benefits

and mental health benefits in applying the overall limit.

(ii) In this *Example 4*, the group health plan is described in paragraph (b)(3) of this section. Because mental health benefits are defined in paragraph (a) of this section as excluding benefits for treatment of substance abuse and chemical dependency, the inclusion of benefits for treatment of substance abuse and chemical dependency in applying an aggregate lifetime limit or annual limit on mental health benefits under option (A) of this *Example 4* would not comply with the requirements of paragraph (b)(3) of this section. However, options (B), (C), and (D) of this *Example 4* would comply with the requirements of paragraph (b)(3) of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

(5) *Determining one-third and two-thirds of all medical/surgical benefits.* For purposes of this paragraph (b), the determination of whether the portion of medical/surgical benefits subject to a limit represents one-third or two-thirds of all medical/surgical benefits is based on the dollar amount of all plan payments for medical/surgical benefits expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the aggregate lifetime or annual limits). Any reasonable method may be used to determine whether the dollar amounts expected to be paid under the plan will constitute one-third or two-thirds of the dollar amount of all plan payments for medical/surgical benefits.

(6) *Plan not described in paragraph (b)(2) or (3) of this section—(i) In general.* A group health plan (or group health insurance coverage) that is not described in paragraph (b)(2) or (3) of this section, must either—

(A) Impose no aggregate lifetime or annual limit, as appropriate, on mental health benefits; or

(B) Impose an aggregate lifetime or annual limit on mental health benefits that is no less than an average limit calculated for medical/surgical benefits in the following manner. The average limit is calculated by taking into account the weighted average of the aggregate lifetime or annual limits, as appropriate, that are applicable to the categories of medical/surgical benefits. Limits based on delivery systems, such

as inpatient/outpatient treatment or normal treatment of common, low-cost conditions (such as treatment of normal births), do not constitute categories for purposes of this paragraph (b)(6)(i)(B). In addition, for purposes of determining weighted averages, any benefits that are not within a category that is subject to a separately-designated limit under the plan are taken into account as a single separate category by using an estimate of the upper limit on the dollar amount that a plan may reasonably be expected to incur with respect to such benefits, taking into account any other applicable restrictions under the plan.

(ii) *Weighting.* For purposes of this paragraph (b)(6), the weighting applicable to any category of medical/surgical benefits is determined in the manner set forth in paragraph (b)(5) of this section for determining one-third or two-thirds of all medical/surgical benefits.

(iii) *Example.* The rules of this paragraph (b)(6) are illustrated by the following example:

Example. (i) A group health plan that is subject to the requirements of this section includes a \$100,000 annual limit on medical/surgical benefits related to cardio-pulmonary diseases. The plan does not include an annual limit on any other category of medical/surgical benefits. The plan determines that 40% of the dollar amount of plan payments for medical/surgical benefits are related to cardio-pulmonary diseases. The plan determines that \$1,000,000 is a reasonable estimate of the upper limit on the dollar amount that the plan may incur with respect to the other 60% of payments for medical/surgical benefits.

(ii) In this *Example*, the plan is not described in paragraph (b)(3) of this section because there is not one annual limit that applies to at least two-thirds of all medical/surgical benefits. Further, the plan is not described in paragraph (b)(2) of this section because more than one-third of all medical/surgical benefits are subject to an annual limit. Under this paragraph (b)(6), the plan sponsor can choose either to include no annual limit on mental health benefits, or to include an annual limit on mental health benefits that is not less than the weighted average of the annual limits applicable to each category of medical/surgical benefits. In this example, the minimum weighted average annual limit that can be applied to mental health benefits is

\$640,000

(40%×\$100,000+60%×\$1,000,000=\$640,000).

(c) *Rule in the case of separate benefit packages.* If a group health plan offers two or more benefit packages, the requirements of this section, including the exemption provisions in paragraph (f) of this section, apply separately to each benefit package. Examples of a group health plan that offers two or more benefit packages include a group health plan that offers employees a choice between indemnity coverage or HMO coverage, and a group health plan that provides one benefit package for retirees and a different benefit package for current employees.

(d) *Applicability—(1) Group health plans.* The requirements of this section apply to a group health plan offering both medical/surgical benefits and mental health benefits regardless of whether the mental health benefits are administered separately under the plan.

(2) *Health insurance issuers.* The requirements of this section apply to a health insurance issuer offering health insurance coverage for both medical/surgical benefits and mental health benefits in connection with a group health plan.

(3) *Scope.* This section does not—

(i) Require a group health plan (or health insurance issuer offering coverage in connection with a group health plan) to provide any mental health benefits; or

(ii) Affect the terms and conditions (including cost sharing, limits on the number of visits or days of coverage, requirements relating to medical necessity, requiring prior authorization for treatment, or requiring primary care physicians' referrals for treatment) relating to the amount, duration, or scope of the mental health benefits under the plan (or coverage) except as specifically provided in paragraph (b) of this section.

(e) *Small employer exemption—(1) In general.* The requirements of this section do not apply to a group health plan (or health insurance issuer offering coverage in connection with a group health plan) for a plan year of a small employer. For purposes of this paragraph (e), the term *small employer* means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who

employed an average of at least two but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. See section 732(a) of the Act and § 2590.732(a), which provide that this section (and certain other sections) does not apply to any group health plan (and health insurance issuer offering coverage in connection with a group health plan) for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees.

(2) *Rules in determining employer size.* For purposes of paragraph (e)(1) of this section—

(i) All persons treated as a single employer under subsections (b), (c), (m), and (o) of section 414 of the Internal Revenue Code of 1986 (26 U.S.C. 414) are treated as one employer;

(ii) If an employer was not in existence throughout the preceding calendar year, whether it is a small employer is determined based on the average number of employees the employer reasonably expects to employ on business days during the current calendar year; and

(iii) Any reference to an employer for purposes of the small employer exemption includes a reference to a predecessor of the employer.

(f) *Increased cost exemption—(1) In general.* A group health plan (or health insurance coverage offered in connection with a group health plan) is not subject to the requirements of this section if the requirements of this paragraph (f) are satisfied. If a plan offers more than one benefit package, this paragraph (f) applies separately to each benefit package. Except as provided in paragraph (h) of this section, a plan must comply with the requirements of paragraph (b)(1)(i) of this section for the first plan year beginning on or after

January 1, 1998, and must continue to comply with the requirements of paragraph (b)(1)(i) of this section until the plan satisfies the requirements in this paragraph (f). In no event is the exemption of this paragraph (f) effective until 30 days after the notice requirements in paragraph (f)(3) of this section are satisfied. If the requirements of this paragraph (f) are satisfied with respect to a plan, the exemption continues in effect (at the plan's discretion) until December 31, 2005, even if the plan subsequently purchases a different policy from the same or a different issuer and regardless of any other changes to the plan's benefit structure.

(2) *Calculation of the one-percent increase—(i) Ratio.* A group health plan (or group health insurance coverage) satisfies the requirements of this paragraph (f)(2) if the application of paragraph (b)(1)(i) of this section to the plan (or to such coverage) results in an increase in the cost under the plan (or for such coverage) of at least one percent. The application of paragraph (b)(1)(i) of this section results in an increased cost of at least one percent under a group health plan (or for such coverage) only if the ratio below equals or exceeds 1.01000. The ratio is determined as follows:

(A) The incurred expenditures during the base period, divided by,

(B) The incurred expenditures during the base period, reduced by—

(1) The claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section; and

(2) Administrative expenses attributable to complying with the requirements of this section.

(ii) *Formula.* The ratio of paragraph (f)(2)(i) of this section is expressed mathematically as follows:

$$\frac{IE}{IE - (CE + AE)} \geq 1.01000$$

(A) *IE* means the incurred expenditures during the base period.

(B) *CE* means the claims incurred during the base period that would have been denied under the terms of the plan

absent plan amendments required to comply with this section

(C) *AE* means administrative costs related to claims in *CE* and other administrative costs attributable to complying with the requirements of this section.

(iii) *Incurred expenditures*. *Incurred expenditures* means actual claims incurred during the base period and reported within two months following the base period, and administrative costs for all benefits under the group health plan, including mental health benefits and medical/surgical benefits, during the base period. Incurred expenditures do not include premiums.

(iv) *Base period*. *Base period* means the period used to calculate whether the plan may claim the one-percent increased cost exemption in this paragraph (f). The base period must begin on the first day in any plan year that the plan complies with the requirements of paragraph (b)(1)(i) of this section and must extend for a period of at least six consecutive calendar months. However, in no event may the base period begin prior to September 26, 1996 (the date of enactment of the Mental Health Parity Act (Pub. L. 104-204, 110 Stat. 2944)).

(v) *Rating pools*. For plans that are combined in a pool for rating purposes, the calculation under this paragraph (f)(2) for each plan in the pool for the base period is based on the incurred expenditures of the pool, whether or not all the plans in the pool have participated in the pool for the entire base period. (However, only the plans that have complied with paragraph (b)(1)(i) of this section for at least six months as a member of the pool satisfy the requirements of this paragraph (f)(2).) Otherwise, the calculation under this paragraph (f)(2) for each plan is calculated by the plan administrator (or issuer) based on the incurred expenditures of the plan.

(vi) *Examples*. The rules of this paragraph (f)(2) are illustrated by the following examples:

Example 1. (i) A group health plan has a plan year that is the calendar year. The plan satisfies the requirements of paragraph (b)(1)(i) of this section as of January 1, 1998. On September 15, 1998, the plan determines that \$1,000,000 in claims have been incurred

during the period between January 1, 1998 and June 30, 1998 and reported by August 30, 1998. The plan also determines that \$100,000 in administrative costs have been incurred for all benefits under the group health plan, including mental health benefits. Thus, the plan determines that its incurred expenditures for the base period are \$1,100,000. The plan also determines that the claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section are \$40,000 and that administrative expenses attributable to complying with the requirements of this section are \$10,000. Thus, the total amount of expenditures for the base period had the plan not been amended to comply with the requirements of paragraph (b)(1)(i) of this section are \$1,050,000 ($\$1,100,000 - (\$40,000 + \$10,000) = \$1,050,000$).

(ii) In this *Example 1*, the plan satisfies the requirements of this paragraph (f)(2) because the application of this section results in an increased cost of at least one percent under the terms of the plan ($\$1,050,000/\$1,050,000 = 1.04762$).

Example 2. (i) A health insurance issuer sells a group health insurance policy that is rated on a pooled basis and is sold to 30 group health plans. One of the group health plans inquires whether it qualifies for the one-percent increased cost exemption. The issuer performs the calculation for the pool as a whole and determines that the application of this section results in an increased cost of 0.500 percent (for a ratio under this paragraph (f)(2) of 1.00500) for the pool. The issuer informs the requesting plan and the other plans in the pool of the calculation.

(ii) In this *Example 2*, none of the plans satisfy the requirements of this paragraph (f)(2) and a plan that purchases a policy not complying with the requirements of paragraph (b)(1)(i) of this section violates the requirements of this section. In addition, an issuer that issues to any of the plans in the pool a policy not complying with the requirements of paragraph (b)(1)(i) of this section violates the requirements of this section.

Example 3. (i) A partially insured plan is collecting the information to determine whether it qualifies for the exemption. The plan administrator determines the incurred expenses for the base period for the self-funded portion of the plan to be \$2,000,000 and the administrative expenses for the base period for the self-funded portion to be \$200,000. For the insured portion of the plan, the plan administrator requests data from the insurer. For the insured portion of the plan, the plan's own incurred expenses for the base period are \$1,000,000 and the administrative expenses for the base period are \$100,000. The plan administrator determines that under the self-funded portion of the plan, the claims incurred for the base period that

would have been denied under the terms of the plan absent the amendment are \$0 because the self-funded portion does not cover mental health benefits and the plan's administrative costs attributable to complying with the requirements of this section are \$1,000. The issuer determines that under the insured portion of the plan, the claims incurred for the base period that would have been denied under the terms of the plan absent the amendment are \$25,000 and the administrative costs attributable to complying with the requirements of this section are \$1,000. Thus, the total incurred expenditures for the plan for the base period are \$3,300,000 (\$2,000,000 + \$200,000 + \$1,000,000 + \$100,000 = \$3,300,000) and the total amount of expenditures for the base period had the plan not been amended to comply with the requirements of paragraph (b)(1)(i) of this section are \$3,273,000 (\$3,300,000 - (\$0 + \$1,000 + \$25,000 + \$1,000) = \$3,273,000).

(ii) In this *Example 3*, the plan does not satisfy the requirements of this paragraph (f)(2) because the application of this section does not result in an increased cost of at least one percent under the terms of the plan ($\$3,300,000/\$3,273,000 = 1.00825$).

(3) *Notice of exemption—(i) Participants and beneficiaries—(A) In general.* A group health plan must notify participants and beneficiaries of the plan's decision to claim the one-percent increased cost exemption. The notice must include the following information:

(1) A statement that the plan is exempt from the requirements of this section and a description of the basis for the exemption;

(2) The name and telephone number of the individual to contact for further information;

(3) The plan name and plan number (PN);

(4) The plan administrator's name, address, and telephone number;

(5) For single-employer plans, the plan sponsor's name, address, and telephone number (if different from paragraph (f)(3)(i)(A)(3) of this section) and the plan sponsor's employer identification number (EIN);

(6) The effective date of the exemption;

(7) The ability of participants and beneficiaries to contact the plan administrator to see how benefits may be affected as a result of the plan's claim of the exemption; and

(8) The availability, upon request and free of charge, of a summary of the in-

formation required under paragraph (f)(4) of this section.

(B) *Use of summary of material reductions in covered services or benefits.* A plan may satisfy the requirements of paragraph (f)(3)(i)(A) of this section by providing participants and beneficiaries (in accordance with paragraph (f)(3)(i)(C) of this section) with a summary of material reductions in covered services or benefits required under § 2520.104b-3(d) that also includes the information of this paragraph (f)(3)(i). However, in all cases, the exemption is not effective until 30 days after notice has been sent.

(C) *Delivery.* The notice described in this paragraph (f)(3)(i) is required to be provided to all participants and beneficiaries. The notice may be furnished by any method of delivery that satisfies the requirements of section 104(b)(1) of ERISA (e.g., first-class mail). If the notice is provided to the participant at the participant's last known address, then the requirements of this paragraph (f)(3)(i) are satisfied with respect to the participant and all beneficiaries residing at that address. If a beneficiary's last known address is different from the participant's last known address, a separate notice is required to be provided to the beneficiary at the beneficiary's last known address.

(D) *Example.* The rules of this paragraph (f)(3)(i) are illustrated by the following example:

Example. (i) A group health plan has a plan year that is the calendar year and has an open enrollment period every November 1 through November 30. The plan determines on September 15 that it satisfies the requirements of paragraph (f)(2) of this section. As part of its open enrollment materials, the plan mails, on October 15, to all participants and beneficiaries a notice satisfying the requirements of this paragraph (f)(3)(i).

(ii) In this *Example*, the plan has sent the notice in a manner that complies with this paragraph (f)(3)(i).

(ii) *Federal agencies—(A) Church plans.* A church plan (as defined in section 414(e) of the Internal Revenue Code) claiming the exemption of this paragraph (f) for any benefit package must provide notice to the Department of the Treasury. This requirement is satisfied if the plan sends a copy, to

the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies.

(B) *Group health plans subject to Part 7 of Subtitle B of Title I of ERISA.* A group health plan subject to Part 7 of Subtitle B of Title I of ERISA, and claiming the exemption of this paragraph (f) for any benefit package, must provide notice to the Department of Labor. This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies.

(C) *Nonfederal governmental plans.* A group health plan that is a nonfederal governmental plan claiming the exemption of this paragraph (f) for any benefit package must provide notice to the Department of Health and Human Services (HHS). This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies.

(4) *Availability of documentation.* The plan (or issuer) must make available to participants and beneficiaries (or their representatives), on request and at no charge, a summary of the information on which the exemption was based. An individual who is not a participant or beneficiary and who presents a notice described in paragraph (f)(3)(i) of this section is considered to be a representative. A representative may request the summary of information by providing the plan a copy of the notice provided to the participant under paragraph (f)(3)(i) of this section with any individually identifiable information redacted. The summary of information must include the incurred expenditures, the base period, the dollar amount of claims incurred during the base period that would have been denied under the terms of the plan absent amendments required to comply with paragraph (b)(1)(i) of this section, the

administrative costs related to those claims, and other administrative costs attributable to complying with the requirements of this section. In no event should the summary of information include any individually identifiable information.

(g) *Special rules for group health insurance coverage—(1) Sale of nonparity policies.* An issuer may sell a policy without parity (as described in paragraph (b) of this section) only to a plan that meets the requirements of paragraphs (e) or (f) of this section.

(2) *Duration of exemption.* After a plan meets the requirements of paragraph (f) of this section, the plan may change issuers without having to meet the requirements of paragraph (f) of this section again before December 31, 2005.

(h) *Effective dates—(1) In general.* The requirements of this section are applicable for plan years beginning on or after January 1, 1998.

(2) *Limitation on actions.* (i) Except as provided in paragraph (h)(3) of this section, no enforcement action is to be taken by the Secretary against a group health plan that has sought to comply in good faith with the requirements of section 712 of the Act, with respect to a violation that occurs before the earlier of—

(A) The first day of the first plan year beginning on or after April 1, 1998; or

(B) January 1, 1999.

(ii) Compliance with the requirements of this section is deemed to be good faith compliance with the requirements of section 712 of Part 7 of Subtitle B of Title I of ERISA.

(iii) The rules of this paragraph (h)(2) are illustrated by the following examples:

Example 1. (i) A group health plan has a plan year that is the calendar year. The plan complies with section 712 of Part 7 of Subtitle B of Title I of ERISA in good faith using assumptions inconsistent with paragraph (b)(6) of this section relating to weighted averages for categories of benefits.

(ii) In this *Example 1*, no enforcement action may be taken against the plan with respect to a violation resulting solely from those assumptions and occurring before January 1, 1999.

Example 2. (i) A group health plan has a plan year that is the calendar year. For the entire 1998 plan year, the plan applies a \$1,000,000 annual limit on medical/surgical

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benefits and a \$100,000 annual limit on mental health benefits.

(ii) In this *Example 2*, the plan has not sought to comply with the requirements of section 712 of the Act in good faith and this paragraph (h)(2) does not apply.

(3) *Transition period for increased cost exemption*—(i) *In general.* No enforcement action will be taken against a group health plan that is subject to the requirements of this section based on a violation of this section that occurs before April 1, 1998 solely because the plan claims the increased cost exemption under section 712(c)(2) of Part 7 of Subtitle B of Title I of ERISA based on assumptions inconsistent with the rules under paragraph (f) of this section, provided that a plan amendment that complies with the requirements of paragraph (b)(1)(i) of this section is adopted and effective no later than March 31, 1998 and the plan complies with the notice requirements in paragraph (h)(3)(ii) of this section.

(ii) *Notice of plan's use of transition period.* (A) A group health plan satisfies the requirements of this paragraph (h)(3)(ii) only if the plan provides notice to the applicable federal agency and posts such notice at the location(s) where documents must be made available for examination by participants and beneficiaries under section 104(b)(2) of ERISA and the regulations thereunder (29 CFR 2520.104b-1(b)(3)). The notice must indicate the plan's decision to use the transition period in paragraph (h)(3)(i) of this section by 30 days after the first day of the plan year beginning on or after January 1, 1998, but in no event later than March 31, 1998. For a group health plan that is a church plan, the applicable federal agency is the Department of the Treasury. For a group health plan that is subject to Part 7 of Subtitle B of Title I of ERISA, the applicable federal agency is the Department of Labor. For a group health plan that is a non-federal governmental plan, the applicable federal agency is the Department of Health and Human Services. The notice must include—

(1) The name of the plan and the plan number (PN);

(2) The name, address, and telephone number of the plan administrator;

(3) For single-employer plans, the name, address, and telephone number of the plan sponsor (if different from the plan administrator) and the plan sponsor's employer identification number (EIN);

(4) The name and telephone number of the individual to contact for further information; and

(5) The signature of the plan administrator and the date of the signature.

(B) The notice must be provided at no charge to participants or their representative within 15 days after receipt of a written or oral request for such notification, but in no event before the notice has been sent to the applicable federal agency.

(i) *Sunset.* This section does not apply to benefits for services furnished on or after December 31, 2005.

[62 FR 66957, Dec. 22, 1997. Redesignated at 65 FR 82142, Dec. 27, 2000; as amended at 67 FR 60861, Sept. 27, 2002; 68 FR 18049, Apr. 14, 2003; 69 FR 3817, Jan. 26, 2004; 69 FR 75799, Dec. 17, 2004]

Subpart D—General Provisions Related to Subparts B and C

SOURCE: 62 FR 16941, Apr. 8, 1997, unless otherwise noted. Redesignated at 65 FR 82142, Dec. 27, 2000.

§ 2590.731 Preemption; State flexibility; construction.

(a) *Continued applicability of State law with respect to health insurance issuers.* Subject to paragraph (b) of this section and except as provided in paragraph (c) of this section, part 7 of subtitle B of Title I of the Act is not to 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 group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part.

(b) *Continued preemption with respect to group health plans.* Nothing in part 7 of subtitle B of Title I of the Act affects or modifies the provisions of section 514 of the Act with respect to group health plans.

(c) *Special rules*—(1) *In general.* Subject to paragraph (c)(2) of this section,