

(6) *Association membership ceases.* For coverage made available in the small or large group market only through one or more bona fide associations, if the employer's membership in the association ceases, but only if the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.

(c) *Discontinuing a particular product.* In any case in which an issuer decides to discontinue offering a particular product offered in the small or large group market, that product may be discontinued by the issuer in accordance with applicable State law in the particular market only if—

(1) The issuer provides notice in writing to each plan sponsor provided that particular product in that market (and to all participants and beneficiaries covered under such coverage) of the discontinuation at least 90 days before the date the coverage will be discontinued;

(2) The issuer offers to each plan sponsor provided that particular product the option, on a guaranteed issue basis, to purchase all (or, in the case of the large group market, any) other health insurance coverage currently being offered by the issuer to a group health plan in that market; and

(3) In exercising the option to discontinue that product and in offering the option of coverage under paragraph (c)(2) of this section, the issuer acts uniformly without regard to the claims experience of those sponsors or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.

(d) *Discontinuing all coverage.* An issuer may elect to discontinue offering all health insurance coverage in the small or large group market or both markets in a State in accordance with applicable State law only if—

(1) The issuer provides notice in writing to the applicable State authority and to each plan sponsor (and all participants and beneficiaries covered under the coverage) of the discontinuation at least 180 days prior to the date the coverage will be discontinued; and

(2) All health insurance policies issued or delivered for issuance in the

State in the market (or markets) are discontinued and not renewed.

(e) *Prohibition on market reentry.* An issuer who elects to discontinue offering all health insurance coverage in a market (or markets) in a State as described in paragraph (d) of this section may not issue coverage in the market (or markets) and State involved during the 5-year period beginning on the date of discontinuation of the last coverage not renewed.

(f) *Exception for uniform modification of coverage.* Only at the time of coverage renewal may issuers modify the health insurance coverage for a product offered to a group health plan in the—

(1) Large group market; and

(2) Small group market if, for coverage available in this market (other than only through one or more bona fide associations), the modification is consistent with State law and is effective uniformly among group health plans with that product.

(g) *Application to coverage offered only through associations.* In the case of health insurance coverage that is made available by a health insurance issuer in the small or large group market to employers only through one or more associations, the reference to "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

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§ 146.160 Disclosure of information.

(a) *General rule.* In connection with the offering of any health insurance coverage to a small employer, a health insurance issuer is required to—

(1) Make a reasonable disclosure to the employer, as part of its solicitation and sales materials, of the availability of information described in paragraph (b) of this section; and

(2) Upon request of the employer, provide that information to the employer.

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(b) *Information described.* Subject to paragraph (d) of this section, information that must be provided under paragraph (a)(2) of this section is information concerning the following:

(1) Provisions of coverage relating to the following:

(i) The issuer's right to change premium rates and the factors that may affect changes in premium rates.

(ii) Renewability of coverage.

(iii) Any preexisting condition exclusion, including use of the alternative method of counting creditable coverage.

(iv) Any affiliation periods applied by HMOs.

(v) The geographic areas served by HMOs.

(2) The benefits and premiums available under all health insurance coverage for which the employer is qualified, under applicable State law. See § 146.150(b) through (f) for allowable limitations on product availability.

(c) *Form of information.* The information must be described in language that is understandable by the average small employer, with a level of detail that is sufficient to reasonably inform small employers of their rights and obligations under the health insurance coverage. This requirement is satisfied if the issuer provides each of the following with respect to each product offered:

(1) An outline of coverage. For purposes of this section, outline of coverage means a description of benefits in summary form.

(2) The rate or rating schedule that applies to the product (with and without the preexisting condition exclusion or affiliation period).

(3) The minimum employer contribution and group participation rules that apply to any particular type of coverage.

(4) In the case of a network plan, a map or listing of counties served.

(5) Any other information required by the State.

(d) *Exception.* An issuer is not required to disclose any information that

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is proprietary and trade secret information under applicable law.

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Subpart F—Exclusion of Plans and Enforcement

§ 146.180 Treatment of non-Federal governmental plans.

(a) *Requirements subject to exemption—*

(1) *Basic rule.* A sponsor of a non-Federal governmental plan may elect to exempt its plan, to the extent that the plan is not provided through health insurance coverage, (that is, it is self-funded), from any or all of the following requirements:

(i) Limitations on preexisting condition exclusion periods described in § 146.111.

(ii) Special enrollment periods for individuals and dependents described in § 146.117.

(iii) Prohibitions against discriminating against individual participants and beneficiaries based on health status described in § 146.121.

(iv) Standards relating to benefits for mothers and newborns described in § 146.130.

(v) Parity in the application of certain limits to mental health benefits described in § 146.136.

(vi) Required coverage for reconstructive surgery and certain other services following a mastectomy under section 2706 of the PHS Act.

(2) *Limitations.* (i) An election under this section cannot circumvent a requirement of this part to the extent the requirement applied to the plan before the effective date of the election.

(A) *Example 1.* A plan is subject to requirements of section 2706 of the PHS Act, under which a plan that covers medical and surgical benefits with respect to a mastectomy must cover reconstructive surgery and certain other services following a mastectomy. An enrollee who has had a mastectomy receives reconstructive surgery on August 24. Claims with respect to the surgery are submitted to and processed by the plan in September. The group health plan commences a new plan