

**42. THE PUBLIC HEALTH AND WELFARE**  
**CHAPTER 6A--PUBLIC HEALTH SERVICE**  
**SUBCHAPTER XXV--REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE**  
**PART C--DEFINITIONS; MISCELLANEOUS PROVISIONS**

§ 300gg-91. Definitions

(a) Group health plan

(1) Definition

The term "group health plan" means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. § 1002(1)]) to the extent that the plan provides medical care (as defined in paragraph (2)) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(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).

(3) Treatment of certain plans as group health plan for notice provision

A program under which creditable coverage described in subparagraph (C), (D), (E), or (F) of section 300gg(c)(1) of this title is provided shall be treated as a group health plan for purposes of applying section 300gg(e) of this title.

(b) Definitions relating to health insurance

(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 514(b)(2) of the Employee Retirement Income Security Act of 1974) [29 U.S.C.A. § 1144(b)(2)]. 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 300e(a) of this title),

(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.

(5) Individual health insurance coverage

The term "individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.

(c) Excepted benefits

For purposes of this subchapter, 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 this title), 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

(1) Applicable State authority

The term "applicable State authority" means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this title for the State involved with respect to such issuer.

(2) Beneficiary

The term "beneficiary" has the meaning given such term under section 3(8) of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. § 1002(8)].

(3) Bona fide association

The term "bona fide association" means, with respect to health insurance coverage offered in a State, an association which--

(A) has been actively in existence for at least 5 years;

(B) has been formed and maintained in good faith for purposes other than obtaining insurance;

(C) does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

(D) makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member);

(E) does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

(F) meets such additional requirements as may be imposed under State law.

(4) COBRA continuation provision

The term "COBRA continuation provision" means any of the following:

(A) Section 4980B of Title 26, other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines.

(B) Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. § 1161 et seq.], other than section 609 of such Act [29 U.S.C.A. § 1169].

(C) Subchapter XX of this chapter.

(5) Employee

The term "employee" has the meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. § 1002(6)].

(6) Employer

The term "employer" has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. § 1002(5)], except that such term shall include only employers of two or more employees.

(7) Church plan

The term "church plan" has the meaning given such term under section 3(33) of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. § 1002(33)].

(8) Governmental plan

(A) The term "governmental plan" has the meaning given such term under section 3(32) of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. § 1002(32)] and any Federal governmental plan.

**(B) Federal governmental plan**

The term "Federal governmental plan" means a governmental plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of such Government.

**(C) Non-Federal governmental plan**

The term "non-Federal governmental plan" means a governmental plan that is not a Federal governmental plan.

(9) Health status-related factor

The term "health status-related factor" means any of the factors described in section 300gg-1(a)(1) of this title.

(10) Network plan

The term "network plan" means health insurance coverage of 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.

(11) Participant

The term "participant" has the meaning given such term under section 3(7) of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. § 1002(7)].

(12) Placed for adoption defined

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

(13) Plan sponsor

The term "plan sponsor" has the meaning given such term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. § 1002(16)(B)].

(14) State

The term "State" means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

(e) Definitions relating to markets and small employers

For purposes of this subchapter:

(1) Individual market

(A) In general

The term "individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(B) Treatment of very small groups

(i) In general

Subject to clause (ii), such terms [FN1] includes coverage offered in connection with a group health plan that has fewer than two participants as current employees on the first day of the plan year.

(ii) State exception

Clause (i) shall not apply in the case of a State that elects to regulate the coverage described in such clause as coverage in the small group market.

(2) Large employer

The term "large 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 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

(3) Large group market

The term "large group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer.

(4) Small employer

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 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

(5) Small group market

The term "small group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer.

(6) Application of certain rules in determination of employer size

For purposes of this subsection--

(A) Application of aggregation rule for employers

all [FN2] persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of Title 26 shall be treated as 1 employer.

(B) Employers not in existence in preceding year

In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(C) Predecessors

Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.