

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, 2006.

[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; 71 FR 13939, Mar. 20, 2006]

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,

the provisions of part 7 of subtitle B of Title I of the Act 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 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) Shortens the period of time from the “6-month period” described in section 701(a)(1) of the Act and § 2590.701-3(a)(2)(i) (for purposes of identifying a preexisting condition);

(ii) Shortens the period of time from the “12 months” and “18 months” described in section 701(a)(2) of the Act and § 2590.701-3(a)(2)(ii) (for purposes of applying a preexisting condition exclusion period);

(iii) Provides for a greater number of days than the “63-day period” described in sections 701(c)(2)(A) and (d)(4)(A) of the Act and §§ 2590.701-3(a)(2)(iii) and 2590.701-4 (for purposes of applying the break in coverage rules);

(iv) Provides for a greater number of days than the “30-day period” described in sections 701(b)(2) and (d)(1) of the Act and § 2590.701-3(b) (for purposes of the enrollment period and preexisting condition exclusion periods for certain newborns and children that are adopted or placed for adoption);

(v) Prohibits the imposition of any preexisting condition exclusion in cases not described in section 701(d) of the Act or expands the exceptions described therein;

(vi) Requires special enrollment periods in addition to those required under section 701(f) of the Act; or

(vii) Reduces the maximum period permitted in an affiliation period under section 701(g)(1)(B) of the Act.

(d) *Definitions*—(1) *State law.* For purposes of this section 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 is treated as a State law rather than a law of the United States.

(2) *State.* For purposes of this section the term *State* includes a State (as defined in § 2590.701-2), any political subdivisions of a State, or any agency or instrumentality of either.

[69 FR 78778, Dec. 30, 2004; 70 FR 21147, Apr. 25, 2005]

§ 2590.732 Special rules relating to group health plans.

(a) *Group health plan*—(1) *Defined.* A group health plan means an employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees (including both current and former employees) or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(2) *Determination of number of plans.* [Reserved]

(b) *General exception for certain small group health plans.* The requirements of this part, other than § 2590.711, do not apply to any group health plan (and group health insurance coverage) for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees.

(c) *Excepted benefits*—(1) *In general.* The requirements of this Part do not apply to any group health plan (or any group health insurance coverage) in relation to its provision of the benefits described in paragraph (c)(2), (3), (4), or (5) of this section (or any combination of these benefits).

(2) *Benefits excepted in all circumstances.* The following benefits are excepted in all circumstances—

(i) Coverage only for accident (including accidental death and dismemberment);

(ii) Disability income coverage;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Coverage issued as a supplement to liability insurance;

(v) Workers’ compensation or similar coverage;