

## **Subtitle B**

### **Part 6**

#### **Continuation Coverage and Additional Standards for Group Health Plans**

##### **1161. Plans must provide continuation coverage to certain individuals**

###### **(a) In general**

The plan sponsor of each group health plan shall provide, in accordance with this part, that each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled, under the plan, to elect, within the election period, continuation coverage under the plan.

###### **(b) Exception for certain plans**

Subsection (a) of this section shall not apply to any group health plan for any calendar year if all employers maintaining such plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year.

##### **1162. Continuation coverage**

###### **How Current is This?**

For purposes of section 1161 of this title, the term “continuation coverage” means coverage under the plan which meets the following requirements:

###### **(1) Type of benefit coverage**

The coverage must consist of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred. If coverage is modified under the plan for any group of similarly situated beneficiaries, such coverage shall also be modified in the same manner for all individuals who are qualified beneficiaries under the plan pursuant to this part in connection with such group.

###### **(2) Period of coverage**

The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:

###### **(A) Maximum required period**

(i) General rule for terminations and reduced hours In the case of a qualifying event described in section 1163 (2) of this title, except as provided in clause (ii), the date which is 18 months after the date of the qualifying event.

(ii) Special rule for multiple qualifying events If a qualifying event (other than a qualifying event described in section 1163 (6) of this title) occurs during the 18 months after the date of a qualifying event described in section 1163 (2) of this title, the date which is 36 months after the date of the qualifying event described in section 1163 (2) of this title.

(iii) Special rule for certain bankruptcy proceedings In the case of a qualifying event described in section 1163 (6) of this title (relating to bankruptcy proceedings), the date of the death of the covered employee or qualified

beneficiary (described in section 1167 (3)(C)(iii) of this title), or in the case of the surviving spouse or dependent children of the covered employee, 36 months after the date of the death of the covered employee.

(iv) General rule for other qualifying events In the case of a qualifying event not described in section 1163 (2) or 1163 (6) of this title, the date which is 36 months after the date of the qualifying event.

(v) Medicare entitlement followed by qualifying event In the case of a qualifying event described in section 1163 (2) of this title that occurs less than 18 months after the date the covered employee became entitled to benefits under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], the period of coverage for qualified beneficiaries other than the covered employee shall not terminate under this subparagraph before the close of the 36-month period beginning on the date the covered employee became so entitled.

In the case of a qualified beneficiary who is determined, under title II or XVI of the Social Security Act [42 U.S.C. 401 et seq., 1381 et seq.], to have been disabled at any time during the first 60 days of continuation coverage under this part, any reference in clause (i) or (ii) to 18 months is deemed a reference to 29 months (with respect to all qualified beneficiaries), but only if the qualified beneficiary has provided notice of such determination under section 1166 (3) <sup>[1]</sup> of this title before the end of such 18 months.

(B) End of plan

The date on which the employer ceases to provide any group health plan to any employee.

(C) Failure to pay premium

The date on which coverage ceases under the plan by reason of a failure to make timely payment of any premium required under the plan with respect to the qualified beneficiary. The payment of any premium (other than any payment referred to in the last sentence of paragraph (3)) shall be considered to be timely if made within 30 days after the date due or within such longer period as applies to or under the plan.

(D) Group health plan coverage or medicare entitlement

The date on which the qualified beneficiary first becomes, after the date of the election—

(i) covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary (other than such an exclusion or limitation which does not apply to (or is satisfied by) such beneficiary by reason of chapter 100 of title 26, part 7 of this subtitle, or title XXVII of the Public Health Service Act [42 U.S.C. 300gg et seq.]), or

(ii) in the case of a qualified beneficiary other than a qualified beneficiary described in section 1167 (3)(C) of this title, entitled to benefits under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].

(E) Termination of extended coverage for disability

In the case of a qualified beneficiary who is disabled at any time during the first 60 days of continuation coverage under this part, the month that begins more than 30 days after the date of the final determination under title II or XVI of the

Social Security Act [42 U.S.C. 401 et seq., 1381 et seq.] that the qualified beneficiary is no longer disabled.

(3) Premium requirements

The plan may require payment of a premium for any period of continuation coverage, except that such premium—

(A) shall not exceed 102 percent of the applicable premium for such period, and (B) may, at the election of the payor, be made in monthly installments.

In no event may the plan require the payment of any premium before the day which is 45 days after the day on which the qualified beneficiary made the initial election for continuation coverage. In the case of an individual described in the last sentence of paragraph (2)(A), any reference in subparagraph (A) of this paragraph to “102 percent” is deemed a reference to “150 percent” for any month after the 18th month of continuation coverage described in clause (i) or (ii) of paragraph (2)(A).

(4) No requirement of insurability

The coverage may not be conditioned upon, or discriminate on the basis of lack of, evidence of insurability.

(5) Conversion option

In the case of a qualified beneficiary whose period of continuation coverage expires under paragraph (2)(A), the plan must, during the 180-day period ending on such expiration date, provide to the qualified beneficiary the option of enrollment under a conversion health plan otherwise generally available under the plan.

[1] See References in Text note below.

### **1163. Qualifying event**

For purposes of this part, the term “qualifying event” means, with respect to any covered employee, any of the following events which, but for the continuation coverage required under this part, would result in the loss of coverage of a qualified beneficiary:

(1) The death of the covered employee.

(2) The termination (other than by reason of such employee’s gross misconduct), or reduction of hours, of the covered employee’s employment.

(3) The divorce or legal separation of the covered employee from the employee’s spouse.

(4) The covered employee becoming entitled to benefits under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.].

(5) A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.

(6) A proceeding in a case under title 11, commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time.

In the case of an event described in paragraph (6), a loss of coverage includes a substantial elimination of coverage with respect to a qualified beneficiary

described in section 1167 (3)(C) of this title within one year before or after the date of commencement of the proceeding.

#### **1164. Applicable premium**

For purposes of this part—

(1) In general

The term “applicable premium” means, with respect to any period of continuation coverage of qualified beneficiaries, the cost to the plan for such period of the coverage for similarly situated beneficiaries with respect to whom a qualifying event has not occurred (without regard to whether such cost is paid by the employer or employee).

(2) Special rule for self-insured plans

To the extent that a plan is a self-insured plan—

(A) In general

Except as provided in subparagraph (B), the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to a reasonable estimate of the cost of providing coverage for such period for similarly situated beneficiaries which—

(i) is determined on an actuarial basis, and

(ii) takes into account such factors as the Secretary may prescribe in regulations.

(B) Determination on basis of past cost

If an administrator elects to have this subparagraph apply, the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to—

(i) the cost to the plan for similarly situated beneficiaries for the same period occurring during the preceding determination period under paragraph (3), adjusted by

(ii) the percentage increase or decrease in the implicit price deflator of the gross national product (calculated by the Department of Commerce and published in the Survey of Current Business) for the 12-month period ending on the last day of the sixth month of such preceding determination period.

(C) Subparagraph (B) not to apply where significant change

An administrator may not elect to have subparagraph (B) apply in any case in which there is any significant difference, between the determination period and the preceding determination period, in coverage under, or in employees covered by, the plan. The determination under the preceding sentence for any determination period shall be made at the same time as the determination under paragraph (3).

(3) Determination period

The determination of any applicable premium shall be made for a period of 12 months and shall be made before the beginning of such period.

#### **1165. Election**

(a) In general

For purposes of this part—

(1) Election period

The term “election period” means the period which—

(A) begins not later than the date on which coverage terminates under the plan by reason of a qualifying event,

(B) is of at least 60 days’ duration, and

(C) ends not earlier than 60 days after the later of—

(i) the date described in subparagraph (A), or

(ii) in the case of any qualified beneficiary who receives notice under section 1166 (4) <sup>[1]</sup> of this title, the date of such notice.

(2) Effect of election on other beneficiaries

Except as otherwise specified in an election, any election of continuation coverage by a qualified beneficiary described in subparagraph (A)(i) or (B) of section 1167 (3) of this title shall be deemed to include an election of continuation coverage on behalf of any other qualified beneficiary who would lose coverage under the plan by reason of the qualifying event. If there is a choice among types of coverage under the plan, each qualified beneficiary is entitled to make a separate selection among such types of coverage.

(b) Temporary extension of COBRA election period for certain individuals

(1) In general

In the case of a nonelecting TAA-eligible individual and notwithstanding subsection (a) of this section, such individual may elect continuation coverage under this part during the 60-day period that begins on the first day of the month in which the individual becomes a TAA-eligible individual, but only if such election is made not later than 6 months after the date of the TAA-related loss of coverage.

(2) Commencement of coverage; no reach-back

Any continuation coverage elected by a TAA-eligible individual under paragraph

(1) shall commence at the beginning of the 60-day election period described in such paragraph and shall not include any period prior to such 60-day election period.

(3) Preexisting conditions

With respect to an individual who elects continuation coverage pursuant to paragraph (1), the period—

(A) beginning on the date of the TAA-related loss of coverage, and

(B) ending on the first day of the 60-day election period described in paragraph (1),

shall be disregarded for purposes of determining the 63-day periods referred to in section 1181 (c)(2) of this title, section 300gg (c)(2) of title 42, and section 9801 (c)(2) of title 26.

(4) Definitions

For purposes of this subsection:

(A) Nonelecting TAA-eligible individual

The term “nonelecting TAA-eligible individual” means a TAA-eligible individual who—

(i) has a TAA-related loss of coverage; and

(ii) did not elect continuation coverage under this part during the TAA-related election period.

(B) TAA-eligible individual

The term “TAA-eligible individual” means—

(i) an eligible TAA recipient (as defined in paragraph (2) of section 35 (c) of title 26), and

(ii) an eligible alternative TAA recipient (as defined in paragraph (3) of such section).

(C) TAA-related election period

The term “TAA-related election period” means, with respect to a TAA-related loss of coverage, the 60-day election period under this part which is a direct consequence of such loss.

(D) TAA-related loss of coverage

The term “TAA-related loss of coverage” means, with respect to an individual whose separation from employment gives rise to being an TAA-eligible individual, the loss of health benefits coverage associated with such separation.

## **1166. Notice requirements**

(a) In general

In accordance with regulations prescribed by the Secretary—

(1) the group health plan shall provide, at the time of commencement of coverage under the plan, written notice to each covered employee and spouse of the employee (if any) of the rights provided under this subsection,

(2) the employer of an employee under a plan must notify the administrator of a qualifying event described in paragraph (1), (2), (4), or (6) of section 1163 of this title within 30 days (or, in the case of a group health plan which is a multiemployer plan, such longer period of time as may be provided in the terms of the plan) of the date of the qualifying event,

(3) each covered employee or qualified beneficiary is responsible for notifying the administrator of the occurrence of any qualifying event described in paragraph (3) or (5) of section 1163 of this title within 60 days after the date of the qualifying event and each qualified beneficiary who is determined, under title II or XVI of the Social Security Act [42 U.S.C. 401 et seq., 1381 et seq.], to have been disabled at any time during the first 60 days of continuation coverage under this part is responsible for notifying the plan administrator of such determination within 60 days after the date of the determination and for notifying the plan administrator within 30 days after the date of any final determination under such title or titles that the qualified beneficiary is no longer disabled, and

(4) the administrator shall notify—

(A) in the case of a qualifying event described in paragraph (1), (2), (4), or (6) of section 1163 of this title, any qualified beneficiary with respect to such event, and

(B) in the case of a qualifying event described in paragraph (3) or (5) of section 1163 of this title where the covered employee notifies the administrator under paragraph (3), any qualified beneficiary with respect to such event,

of such beneficiary's rights under this subsection.

(b) Alternative means of compliance with requirements for notification of multiemployer plans by employers

The requirements of subsection (a)(2) of this section shall be considered satisfied in the case of a multiemployer plan in connection with a qualifying event described in paragraph (2) of section 1163 of this title if the plan provides that the determination of the occurrence of such qualifying event will be made by the plan administrator.

(c) Rules relating to notification of qualified beneficiaries by plan administrator  
For purposes of subsection (a)(4) of this section, any notification shall be made within 14 days (or, in the case of a group health plan which is a multiemployer plan, such longer period of time as may be provided in the terms of the plan) of the date on which the administrator is notified under paragraph (2) or (3), whichever is applicable, and any such notification to an individual who is a qualified beneficiary as the spouse of the covered employee shall be treated as notification to all other qualified beneficiaries residing with such spouse at the time such notification is made.

## **1167. Definitions and special rules**

For purposes of this part—

(1) Group health plan

The term "group health plan" means an employee welfare benefit plan providing medical care (as defined in section 213 (d) of title 26) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise. Such term shall not include any plan substantially all of the coverage under which is for qualified long-term care services (as defined in section 7702B (c) of title 26).

(2) Covered employee

The term "covered employee" means an individual who is (or was) provided coverage under a group health plan by virtue of the performance of services by the individual for 1 or more persons maintaining the plan (including as an employee defined in section 401 (c)(1) of title 26).

(3) Qualified beneficiary

(A) In general

The term "qualified beneficiary" means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan—

(i) as the spouse of the covered employee, or

(ii) as the dependent child of the employee.

Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continuation coverage under this part.

(B) Special rule for terminations and reduced employment

In the case of a qualifying event described in section 1163 (2) of this title, the term "qualified beneficiary" includes the covered employee.

(C) Special rule for retirees and widows

In the case of a qualifying event described in section 1163 (6) of this title, the term “qualified beneficiary” includes a covered employee who had retired on or before the date of substantial elimination of coverage and any other individual who, on the day before such qualifying event, is a beneficiary under the plan—

- (i) as the spouse of the covered employee,
- (ii) as the dependent child of the employee, or
- (iii) as the surviving spouse of the covered employee.

(4) Employer

Subsection (n) (relating to leased employees) and subsection (t) (relating to application of controlled group rules to certain employee benefits) of section 414 of title 26 shall apply for purposes of this part in the same manner and to the same extent as such subsections apply for purposes of section 106 of title 26. Any regulations prescribed by the Secretary pursuant to the preceding sentence shall be consistent and coextensive with any regulations prescribed for similar purposes by the Secretary of the Treasury (or such Secretary’s delegate) under such subsections.

(5) Optional extension of required periods

A group health plan shall not be treated as failing to meet the requirements of this part solely because the plan provides both—

- (A) that the period of extended coverage referred to in section 1162 (2) of this title commences with the date of the loss of coverage, and
- (B) that the applicable notice period provided under section 1166 (a)(2) of this title commences with the date of the loss of coverage

### **1168. Regulations**

The Secretary may prescribe regulations to carry out the provisions of this part.

### **1169. Additional standards for group health plans**

How Current is This?

(a) Group health plan coverage pursuant to medical child support orders

(1) In general

Each group health plan shall provide benefits in accordance with the applicable requirements of any qualified medical child support order. A qualified medical child support order with respect to any participant or beneficiary shall be deemed to apply to each group health plan which has received such order, from which the participant or beneficiary is eligible to receive benefits, and with respect to which the requirements of paragraph (4) are met.

(2) Definitions

For purposes of this subsection—

(A) Qualified medical child support order

The term “qualified medical child support order” means a medical child support order—

- (i) which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a participant or beneficiary is eligible under a group health plan, and
- (ii) with respect to which the requirements of paragraphs (3) and (4) are met.

(B) Medical child support order

The term "medical child support order" means any judgment, decree, or order (including approval of a settlement agreement) which—

- (i) provides for child support with respect to a child of a participant under a group health plan or provides for health benefit coverage to such a child, is made pursuant to a State domestic relations law (including a community property law), and relates to benefits under such plan, or
- (ii) is made pursuant to a law relating to medical child support described in section 1908 of the Social Security Act [42 U.S.C. 1396g–1] (as added by section 13822<sup>[1]</sup> of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan,

if such judgment, decree, or order

- (I) is issued by a court of competent jurisdiction or
- (II) is issued through an administrative process established under State law and has the force and effect of law under applicable State law. For purposes of this subparagraph, an administrative notice which is issued pursuant to an administrative process referred to in subclause (II) of the preceding sentence and which has the effect of an order described in clause (i) or (ii) of the preceding sentence shall be treated as such an order.

(C) Alternate recipient

The term "alternate recipient" means any child of a participant who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant.

(D) Child

The term "child" includes any child adopted by, or placed for adoption with, a participant of a group health plan.

(3) Information to be included in qualified order

A medical child support order meets the requirements of this paragraph only if such order clearly specifies—

- (A) the name and the last known mailing address (if any) of the participant and the name and mailing address of each alternate recipient covered by the order, except that, to the extent provided in the order, the name and mailing address of an official of a State or a political subdivision thereof may be substituted for the mailing address of any such alternate recipient,
- (B) a reasonable description of the type of coverage to be provided to each such alternate recipient, or the manner in which such type of coverage is to be determined, and
- (C) the period to which such order applies.

(4) Restriction on new types or forms of benefits

A medical child support order meets the requirements of this paragraph only if such order does not require a plan to provide any type or form of benefit, or any option, not otherwise provided under the plan, except to the extent necessary to

meet the requirements of a law relating to medical child support described in section 1908 of the Social Security Act [42 U.S.C. 1396g–1] (as added by section 13822 <sup>[1]</sup> of the Omnibus Budget Reconciliation Act of 1993).

(5) Procedural requirements

(A) Timely notifications and determinations

In the case of any medical child support order received by a group health plan—

(i) the plan administrator shall promptly notify the participant and each alternate recipient of the receipt of such order and the plan's procedures for determining whether medical child support orders are qualified medical child support orders, and

(ii) within a reasonable period after receipt of such order, the plan administrator shall determine whether such order is a qualified medical child support order and notify the participant and each alternate recipient of such determination.

(B) Establishment of procedures for determining qualified status of orders

Each group health plan shall establish reasonable procedures to determine whether medical child support orders are qualified medical child support orders and to administer the provision of benefits under such qualified orders. Such procedures—

(i) shall be in writing,

(ii) shall provide for the notification of each person specified in a medical child support order as eligible to receive benefits under the plan (at the address included in the medical child support order) of such procedures promptly upon receipt by the plan of the medical child support order, and

(iii) shall permit an alternate recipient to designate a representative for receipt of copies of notices that are sent to the alternate recipient with respect to a medical child support order.

(C) National Medical Support Notice deemed to be a qualified medical child support order

(i) In general If the plan administrator of a group health plan which is maintained by the employer of a noncustodial parent of a child or to which such an employer contributes receives an appropriately completed National Medical Support Notice promulgated pursuant to section 401(b) of the Child Support Performance and Incentive Act of 1998 in the case of such child, and the Notice meets the requirements of paragraphs (3) and (4), the Notice shall be deemed to be a qualified medical child support order in the case of such child.

(ii) Enrollment of child in plan In any case in which an appropriately completed National Medical Support Notice is issued in the case of a child of a participant under a group health plan who is a noncustodial parent of the child, and the Notice is deemed under clause (i) to be a qualified medical child support order, the plan administrator, within 40 business days after the date of the Notice, shall—

(l) notify the State agency issuing the Notice with respect to such child whether coverage of the child is available under the terms of the plan and, if so, whether such child is covered under the plan and either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent (or by the official of

a State or political subdivision thereof substituted for the name of such child pursuant to paragraph (3)(A)) to effectuate the coverage; and  
(II) provide to the custodial parent (or such substituted official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

(iii) Rule of construction Nothing in this subparagraph shall be construed as requiring a group health plan, upon receipt of a National Medical Support Notice, to provide benefits under the plan (or eligibility for such benefits) in addition to benefits (or eligibility for benefits) provided under the terms of the plan as of immediately before receipt of such Notice.

(6) Actions taken by fiduciaries

If a plan fiduciary acts in accordance with part 4 of this subtitle in treating a medical child support order as being (or not being) a qualified medical child support order, then the plan's obligation to the participant and each alternate recipient shall be discharged to the extent of any payment made pursuant to such act of the fiduciary.

(7) Treatment of alternate recipients

(A) Treatment as beneficiary generally

A person who is an alternate recipient under a qualified medical child support order shall be considered a beneficiary under the plan for purposes of any provision of this chapter.

(B) Treatment as participant for purposes of reporting and disclosure requirements

A person who is an alternate recipient under any medical child support order shall be considered a participant under the plan for purposes of the reporting and disclosure requirements of part 1 of this subtitle.

(8) Direct provision of benefits provided to alternate recipients

Any payment for benefits made by a group health plan pursuant to a medical child support order in reimbursement for expenses paid by an alternate recipient or an alternate recipient's custodial parent or legal guardian shall be made to the alternate recipient or the alternate recipient's custodial parent or legal guardian.

(9) Payment to State official treated as satisfaction of plan's obligation to make payment to alternate recipient

Payment of benefits by a group health plan to an official of a State or a political subdivision thereof whose name and address have been substituted for the address of an alternate recipient in a qualified medical child support order, pursuant to paragraph (3)(A), shall be treated, for purposes of this subchapter, as payment of benefits to the alternate recipient.

(b) Rights of States with respect to group health plans where participants or beneficiaries thereunder are eligible for medicaid benefits

(1) Compliance by plans with assignment of rights

A group health plan shall provide that payment for benefits with respect to a participant under the plan will be made in accordance with any assignment of rights made by or on behalf of such participant or a beneficiary of the participant as required by a State plan for medical assistance approved under title XIX of the

Social Security Act [42 U.S.C. 1396 et seq.] pursuant to section 1912(a)(1)(A) of such Act [42 U.S.C. 1396k (a)(1)(A)] (as in effect on August 10, 1993).

(2) Enrollment and provision of benefits without regard to medicaid eligibility  
A group health plan shall provide that, in enrolling an individual as a participant or beneficiary or in determining or making any payments for benefits of an individual as a participant or beneficiary, the fact that the individual is eligible for or is provided medical assistance under a State plan for medical assistance approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] will not be taken into account.

(3) Acquisition by States of rights of third parties

A group health plan shall provide that, to the extent that payment has been made under a State plan for medical assistance approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] in any case in which a group health plan has a legal liability to make payment for items or services constituting such assistance, payment for benefits under the plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to a participant to such payment for such items or services.

(c) Group health plan coverage of dependent children in cases of adoption

(1) Coverage effective upon placement for adoption

In any case in which a group health plan provides coverage for dependent children of participants or beneficiaries, such plan shall provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of participants or beneficiaries under the plan, irrespective of whether the adoption has become final.

(2) Restrictions based on preexisting conditions at time of placement for adoption prohibited

A group health plan may not restrict coverage under the plan of any dependent child adopted by a participant or beneficiary, or placed with a participant or beneficiary for adoption, solely on the basis of a preexisting condition of such child at the time that such child would otherwise become eligible for coverage under the plan, if the adoption or placement for adoption occurs while the participant or beneficiary is eligible for coverage under the plan.

(3) Definitions

For purposes of this subsection—

(A) Child

The term “child” means, in connection with any adoption, or placement for adoption, of the child, an individual who has not attained age 18 as of the date of such adoption or placement for adoption.

(B) Placement for adoption

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.

(d) Continued coverage of costs of a pediatric vaccine under group health plans

A group health plan may not reduce its coverage of the costs of pediatric vaccines (as defined under section 1928(h)(6) of the Social Security Act [42 U.S.C. 1396s (h)(6)] as amended by section 13830<sup>[2]</sup> of the Omnibus Budget Reconciliation Act of 1993) below the coverage it provided as of May 1, 1993.

(e) Regulations

Any regulations prescribed under this section shall be prescribed by the Secretary of Labor, in consultation with the Secretary of Health and Human Services.

[1] So in original. Probably should be section "13623".

[2] So in original. Probably should be section "13631".