self-funded group health plan with a plan year beginning on September 1. The plan sponsor elected under §146.180 of this part to exempt the plan from the requirements of this section and "§146.111 (limitations on preexisting condition exclusion periods) for the plan year beginning September 1, 2002, and renews the exemption election for the plan years beginning September 1, 2003, September 1, 2004, September 1, 2005, and September 1, 2006. Under the terms of the plan while the exemption was in effect, employees and their dependents were allowed to enroll when the employee was first hired without regard to any health factor. If an individual declined to enroll when first eligible, the individual could enroll effective September 1 of any plan year if the individual could pass a physical examination. Also under the terms of the plan, all enrollees were subject to a 12-month preexisting condition exclusion period, regardless of whether they had creditable coverage. *E* chose not to enroll for coverage when first hired. In June of 2006, *E* is diagnosed as having multiple sclerosis (MS). With the plan year beginning September 1, 2007, the plan sponsor chooses to bring the plan into compliance with this section, but renews its exemption election with regard to limitations on preexisting condition exclusion periods. The plan notifies *E* of her opportunity to enroll, without a physical examination, effective September 1, 2007. The plan gives *E* 30 days to enroll. *E* is subject to a 12-month preexisting condition exclusion period with respect to any treatment *E* receives that is related to *E*'s MS, without regard to any prior creditable coverage *E* may have. Beginning September 1, 2008, the plan will cover treatment of *E*'s MS.

(ii) *Conclusion.* In this *Example 2,* the plan complies with the requirements of this section. (The plan is not required to comply with the requirements of §146.111 because the plan continues to be exempted from those requirements in accordance with the plan sponsor's election under §146.180.)

[71 FR 75046, Dec. 13, 2006]

§146.125 Applicability dates.

Section 144.103, §§146.111 through 146.119, §146.143, and §146.145 are applicable for plan years beginning on or after July 1, 2005. Until the applicability date for this regulation, plans and issuers are required to continue to comply with the corresponding sections of 45 CFR parts 144 and 146, contained in the 45 CFR, parts 1 to 199, edition revised as of October 1, 2004.

[69 FR 78797, Dec. 30, 2004; 70 FR 21147, Apr. 25, 2005]

Subpart C—Requirements Related to Benefits

§146.130 Standards relating to benefits for mothers and newborns.

(a) *Hospital length of stay*—(1) *General rule.* Except as provided in paragraph (a)(5) of this section, a group health plan, or a health insurance issuer offering group health insurance coverage, that provides benefits for a hospital length of stay in connection with childbirth for a mother or her newborn may not restrict benefits for the stay to less than—

(i) 48 hours following a vaginal delivery; or

(ii) 96 hours following a delivery by cesarean section.

(2) *When stay begins*—(i) *Delivery in a hospital.* If delivery occurs in a hospital, the hospital length of stay for the mother or newborn child begins at the time of delivery (or in the case of multiple births, at the time of the last delivery).

(ii) *Delivery outside a hospital.* If delivery occurs outside a hospital, the hospital length of stay begins at the time the mother or newborn is admitted as a hospital inpatient in connection with childbirth. The determination of whether an admission is in connection with childbirth is a medical decision to be made by the attending provider.

(3) *Examples.* The rules of paragraphs (a)(1) and (a)(2) of this section are illustrated by the following examples. In each example, the group health plan provides benefits for hospital lengths of stay in connection with childbirth and is subject to the requirements of this section, as follows:

Example 1. (i) A pregnant woman covered under a group health plan goes into labor and is admitted to the hospital at 10 p.m. on June 11. She gives birth by vaginal delivery at 6 a.m. on June 12.

(ii) In this *Example 1,* the 48-hour period described in paragraph (a)(1)(i) of this section ends at 6 a.m. on June 14.

Example 2. (i) A woman covered under a group health plan gives birth at home by vaginal delivery. After the delivery, the woman begins bleeding excessively in connection with the childbirth and is admitted to the hospital for treatment of the excessive bleeding at 7 p.m. on October 1.