

Internal Revenue Service

26 CFR Chapter 1

Accordingly, 26 CFR Parts 54 and 602 are amended as follows:

PART 54 -- PENSION EXCISE TAXES

Paragraph 1. The authority citation for part 54 continues to read in part as follows:

Authority: 26 U.S.C. 7805. * * *

Section 54.9812-1T also issued under 26 U.S.C. 9833. * * *

2. Section 54.9812-1T is revised to read as follows:

§54.9812 Parity in mental health and substance use disorder benefits (temporary).

(a) Meaning of terms. For purposes of this section, except where the context clearly indicates otherwise, the following terms have the meanings indicated:

Aggregate lifetime dollar limit means a dollar limitation on the total amount of specified benefits that may be paid under a group health plan for any coverage unit.

Annual dollar limit means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a group health plan for any coverage unit.

Coverage unit means coverage unit as described in paragraph (c)(1)(iv) of this section.

Cumulative financial requirements are financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums. (However, cumulative financial requirements do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements.)

Cumulative quantitative treatment limitations are treatment limitations that determine whether or to what extent benefits are provided based on accumulated amounts, such as annual or lifetime day or visit limits.

Financial requirements include deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits.

Medical/surgical benefits means benefits for medical or surgical services, as defined under the terms of the plan, but does not include mental health or substance use disorder benefits.

Mental health benefits means benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law. Any condition defined by the plan as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the International Classification of Diseases (ICD), and State guidelines).

Substance use disorder benefits means benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, and State guidelines).

Treatment limitations include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations,

which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations, which otherwise limit the scope or duration of benefits for treatment under a plan. (See paragraph (c)(4)(ii) of this section for an illustrative list of nonquantitative treatment limitations.) A permanent exclusion of all benefits for particular conditions or disorders, however, is not a treatment limitation.

(b) Parity requirements with respect to aggregate lifetime and annual dollar limits—(1)—General—(i) General parity requirement. A group health plan that provides both medical/surgical benefits and mental health or substance use disorder benefits must comply with paragraph (b)(2), (b)(3), or (b)(6) of this section.

(ii) Exception. The rule in paragraph (b)(1)(i) of this section does not apply if a plan satisfies the requirements of paragraph (f) or (g) of this section (relating to exemptions for small employers and for increased cost).

(2) Plan with no limit or limits on less than one-third of all medical/surgical benefits. If a plan does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.

(3) Plan with a limit on at least two-thirds of all medical/surgical benefits. If a plan includes an aggregate lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits, it must either—

(i) Apply the aggregate lifetime or annual dollar limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health or substance use disorder

benefits in a manner that does not distinguish between the medical/surgical benefits and mental health or substance use disorder benefits; or

(ii) Not include an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is less than the aggregate lifetime or annual dollar limit, respectively, on medical/surgical benefits. (For cumulative limits other than aggregate lifetime or annual dollar limits, see paragraph (c)(3)(v) of this section prohibiting separately accumulating cumulative financial requirements or cumulative quantitative treatment limitations.)

(4) Examples. The rules of paragraphs (b)(2) and (b)(3) of this section are illustrated by the following examples:

Example 1. (i) Facts. A group health plan has no annual limit on medical/surgical benefits and a \$10,000 annual limit on mental health and substance use disorder benefits. To comply with the requirements of this paragraph (b), the plan sponsor is considering each of the following options: (A) Eliminating the plan's annual dollar limit on mental health and substance use disorder benefits; (B) Replacing the plan's annual dollar limit on mental health and substance use disorder benefits with a \$500,000 annual limit on all benefits (including medical/surgical and mental health and substance use disorder benefits); and (C) Replacing the plan's annual dollar limit on mental health and substance use disorder benefits with a \$250,000 annual limit on medical/surgical benefits and a \$250,000 annual limit on mental health and substance use disorder benefits.

(ii) Conclusion. In this Example 1, each of the three options being considered by the plan sponsor would comply with the requirements of this paragraph (b).

Example 2. (i) Facts. A plan has a \$100,000 annual limit on medical/surgical inpatient benefits and a \$50,000 annual limit on medical/surgical outpatient benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options: (A) Imposing a \$150,000 annual limit on mental health and substance use disorder benefits; and (B) Imposing a \$100,000 annual limit on mental health and substance use disorder inpatient benefits and a \$50,000 annual limit on mental health and substance use disorder outpatient benefits.

(ii) Conclusion. In this Example 2, each option under consideration by the plan sponsor would comply with the requirements of this section.

(5) Determining one-third and two-thirds of all medical/surgical benefits. For purposes of this paragraph (b), the determination of whether the portion of medical/surgical benefits

subject to an aggregate lifetime or annual dollar limit represents one-third or two-thirds of all medical/surgical benefits is based on the dollar amount of all plan payments for medical/surgical benefits expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the aggregate lifetime or annual dollar limits). Any reasonable method may be used to determine whether the dollar amount expected to be paid under the plan will constitute one-third or two-thirds of the dollar amount of all plan payments for medical/surgical benefits.

(6) Plan not described in paragraph (b)(2) or (b)(3) of this section—(i) In general. A group health plan that is not described in paragraph (b)(2) or (b)(3) of this section, must either—

(A) Impose no aggregate lifetime or annual dollar limit, as appropriate, on mental health or substance use disorder benefits; or

(B) Impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no less than an average limit calculated for medical/surgical benefits in the following manner. The average limit is calculated by taking into account the weighted average of the aggregate lifetime or annual dollar limits, as appropriate, that are applicable to the categories of medical/surgical benefits. Limits based on delivery systems, such as

inpatient/outpatient treatment or normal treatment of common, low-cost conditions (such as treatment of normal births), do not constitute categories for purposes of this paragraph (b)(6)(i)

(B). In addition, for purposes of determining weighted averages, any benefits that are not within a category that is subject to a separately-designated dollar limit under the plan are taken into account as a single separate category by using an estimate of the upper limit on the dollar amount that a plan may reasonably be expected to incur with respect to such benefits, taking into account any other applicable restrictions under the plan.

(ii) Weighting. For purposes of this paragraph (b)(6), the weighting applicable to any category of medical/surgical benefits is determined in the manner set forth in paragraph (b)(5) of this section for determining one-third or two-thirds of all medical/surgical benefits.

(iii) Example. The rules of this paragraph (b)(6) are illustrated by the following example:

Example. (i) Facts. A group health plan that is subject to the requirements of this section includes a \$100,000 annual limit on medical/surgical benefits related to cardio-pulmonary diseases. The plan does not include an annual dollar limit on any other category of medical/surgical benefits. The plan determines that 40% of the dollar amount of plan payments for medical/surgical benefits are related to cardio-pulmonary diseases. The plan determines that \$1,000,000 is a reasonable estimate of the upper limit on the dollar amount that the plan may incur with respect to the other 60% of payments for medical/surgical benefits.

(ii) Conclusion. In this Example, the plan is not described in paragraph (b)(3) of this section because there is not one annual dollar limit that applies to at least two-thirds of all medical/surgical benefits. Further, the plan is not described in paragraph (b)(2) of this section because more than one-third of all medical/surgical benefits are subject to an annual dollar limit. Under this paragraph (b)(6), the plan sponsor can choose either to include no annual dollar limit on mental health or substance use disorder benefits, or to include an annual dollar limit on mental health or substance use disorder benefits that is not less than the weighted average of the annual dollar limits applicable to each category of medical/surgical benefits. In this example, the minimum weighted average annual dollar limit that can be applied to mental health or substance use disorder benefits is \$640,000 ($40\% \times \$100,000 + 60\% \times \$1,000,000 = \$640,000$).

(c) Parity requirements with respect to financial requirements and treatment limitations --

(1) Clarification of terms -- (i) Classification of benefits. When reference is made in this paragraph (c) to a classification of benefits, the term “classification” means a classification as described in paragraph (c)(2)(ii) of this section.

(ii) Type of financial requirement or treatment limitation. When reference is made in this paragraph (c) to a type of financial requirement or treatment limitation, the reference to type means its nature. Different types of financial requirements include deductibles, copayments, coinsurance, and out-of-pocket maximums. Different types of quantitative treatment limitations include annual, episode, and lifetime day and visit limits. See paragraph (c)(4)(ii) of this section for an illustrative list of nonquantitative treatment limitations.

(iii) Level of a type of financial requirement or treatment limitation. When reference is made in this paragraph (c) to a level of a type of financial requirement or treatment limitation, level refers to the magnitude of the type of financial requirement or treatment limitation. For example, different levels of coinsurance include 20% and 30%; different levels of a copayment include \$15 and \$20; different levels of a deductible include \$250 and \$500; and different levels of an episode limit include 21 inpatient days per episode and 30 inpatient days per episode.

(iv) Coverage unit. When reference is made in this paragraph (c) to a coverage unit, coverage unit refers to the way in which a plan groups individuals for purposes of determining benefits, or premiums or contributions. For example, different coverage units include self-only, family, and employee-plus-spouse.

(2) General parity requirement – (i) General rule. A group health plan that provides both medical/surgical benefits and mental health or substance use disorder benefits may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. Whether a financial requirement or treatment limitation is a predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in a classification is determined separately for each type of financial requirement or treatment limitation. The application of the rules of this paragraph (c)(2) to financial requirements and quantitative treatment limitations is addressed in paragraph (c)(3) of this section; the application of the rules of this paragraph (c)(2) to nonquantitative treatment limitations is addressed in paragraph (c)(4) of this section.

(ii) Classifications of benefits used for applying rules – (A) In general. If a plan provides mental health or substance use disorder benefits in any classification of benefits described in this paragraph (c)(2)(ii), mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided. Plans must apply the same standards to medical/surgical benefits and mental health or substance use disorder benefits for determining the classification in which a particular benefit belongs. To the extent that a plan provides benefits in a classification and imposes any separate financial requirement or treatment limitation (or separate level of a financial requirement or treatment limitation) for benefits in the classification, the rules of this paragraph (c) apply separately with respect to that classification for all financial requirements or treatment limitations. The following classifications of benefits are the only classifications used in applying the rules of this paragraph (c):

(1) Inpatient, in-network. Benefits furnished on an inpatient basis and within a network of providers established or recognized under a plan.

(2) Inpatient, out-of-network. Benefits furnished on an inpatient basis and outside any network of providers established or recognized under a plan. This classification includes inpatient benefits under a plan that has no network of providers.

(3) Outpatient, in-network. Benefits furnished on an outpatient basis and within a network of providers established or recognized under a plan.

(4) Outpatient, out-of-network. Benefits furnished on an outpatient basis and outside any network of providers established or recognized under a plan. This classification includes outpatient benefits under a plan that has no network of providers.

(5) Emergency care. Benefits for emergency care.

(6) Prescription drugs. Benefits for prescription drugs. See special rules for multi-tiered prescription drug benefits in paragraph (c)(3)(iii) of this section.

(B) Application to out-of-network providers. See paragraph (c)(2)(ii)(A) of this section, under which a plan that provides mental health or substance use disorder benefits in any classification of benefits must provide mental health or substance use disorder benefits in every classification in which medical/surgical benefits are provided, including out-of-network classifications.

(C) Examples. The rules of this paragraph (c)(2)(ii) are illustrated by the following examples. In each example, the group health plan is subject to the requirements of this section and provides both medical/surgical benefits and mental health and substance use disorder benefits.

Example 1. (i) Facts. A plan offers inpatient and outpatient benefits and does not contract with a network of providers. The plan imposes a \$500 deductible on all benefits. For inpatient medical/surgical benefits, the plan imposes a coinsurance requirement. For outpatient medical/surgical benefits, the plan imposes copayments. The plan imposes no other financial requirements or treatment limitations.

(ii) Conclusion. In this Example 1, because the plan has no network of providers, all benefits provided are out-of-network. Because inpatient, out-of-network medical/surgical benefits are subject to separate financial requirements from outpatient, out-of-network medical/surgical benefits, the rules of this paragraph (c) apply separately with respect to any financial requirements and treatment limitations, including the deductible, in each classification.

Example 2. (i) Facts. A plan imposes a \$500 deductible on all benefits. The plan has no network of providers. The plan generally imposes a 20 percent coinsurance requirement with respect to all benefits, without distinguishing among inpatient, outpatient, emergency, or prescription drug benefits. The plan imposes no other financial requirements or treatment limitations.

(ii) Conclusion. In this Example 2, because the plan does not impose separate financial requirements (or treatment limitations) based on classification, the rules of this paragraph (c) apply with respect to the deductible and the coinsurance across all benefits.

Example 3. (i) Facts. Same facts as Example 2, except the plan exempts emergency care benefits from the 20 percent coinsurance requirement. The plan imposes no other financial requirements or treatment limitations.

(ii) Conclusion. In this Example 3, because the plan imposes separate financial requirements based on classifications, the rules of this paragraph (c) apply with respect to the deductible and the coinsurance separately with respect to (A) benefits in the emergency classification and (B) all other benefits.

Example 4. (i) Facts. Same facts as Example 2, except the plan also imposes a preauthorization requirement for all inpatient treatment in order for benefits to be paid. No such requirement applies to outpatient treatment.

(ii) Conclusion. In this Example 4, because the plan has no network of providers, all benefits provided are out-of-network. Because the plan imposes a separate treatment limitation based on classifications, the rules of this paragraph (c) apply with respect to the deductible and coinsurance separately with respect to (A) inpatient, out-of-network benefits and (B) all other benefits.

(3) Financial requirements and quantitative treatment limitations – (i) Determining “substantially all” and “predominant” – (A) Substantially all. For purposes of this paragraph (c), a type of financial requirement or quantitative treatment limitation is considered to apply to substantially all medical/surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical/surgical benefits in that classification. (For this purpose, benefits expressed as subject to a zero level of a type of financial requirement or quantitative treatment limitation are treated as benefits not subject to that type of financial requirement or quantitative treatment limitation.) If a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of all medical/surgical benefits in a classification, then that type cannot be applied to mental health or substance use disorder benefits in that classification.

(B) Predominant – (1) If a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical/surgical benefits in a classification as determined under paragraph (c)(3)(i)(A), the level of the financial requirement or quantitative treatment limitation that is considered the predominant level of that type in a classification of

benefits is the level that applies to more than one-half of medical/surgical benefits in that classification subject to the financial requirement or quantitative treatment limitation.

(2) If, with respect to a type of financial requirement or quantitative treatment limitation that applies to at least two-thirds of all medical/surgical benefits in a classification, there is no single level that applies to more than one-half of medical/surgical benefits in the classification subject to the financial requirement or quantitative treatment limitation, the plan may combine levels until the combination of levels applies to more than one-half of medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in the classification. The least restrictive level within the combination is considered the predominant level of that type in the classification. (For this purpose, a plan may combine the most restrictive levels first, with each less restrictive level added to the combination until the combination applies to more than one-half of the benefits subject to the financial requirement or treatment limitation.)

(C) Portion based on plan payments. For purposes of this paragraph (c), the determination of the portion of medical/surgical benefits in a classification of benefits subject to a financial requirement or quantitative treatment limitation (or subject to any level of a financial requirement or quantitative treatment limitation) is based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the financial requirement or quantitative treatment limitation).

(D) Clarifications for certain threshold requirements. For any deductible, the dollar amount of plan payments includes all plan payments with respect to claims that would be subject to the deductible if it had not been satisfied. For any out-of-pocket maximum, the dollar amount of plan payments includes all plan payments associated with out-of-pocket payments that are

taken into account towards the out-of-pocket maximum as well as all plan payments associated with out-of-pocket payments that would have been made towards the out-of-pocket maximum if it had not been satisfied. Similar rules apply for any other thresholds at which the rate of plan payment changes.

(E) Determining the dollar amount of plan payments. Subject to paragraph (c)(3)(i)(D) of this section, any reasonable method may be used to determine the dollar amount expected to be paid under a plan for medical/surgical benefits subject to a financial requirement or quantitative treatment limitation (or subject to any level of a financial requirement or quantitative treatment limitation).

(ii) Application to different coverage units. If a plan applies different levels of a financial requirement or quantitative treatment limitation to different coverage units in a classification of medical/surgical benefits, the predominant level that applies to substantially all medical/surgical benefits in the classification is determined separately for each coverage unit.

(iii) Special rule for multi-tiered prescription drug benefits. If a plan applies different levels of financial requirements to different tiers of prescription drug benefits based on reasonable factors determined in accordance with the rules in paragraph (c)(4) of this section (relating to requirements for nonquantitative treatment limitations) and without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use disorder benefits, the plan satisfies the parity requirements of this paragraph (c) with respect to prescription drug benefits. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up.

(iv) Examples. The rules of paragraphs (c)(3)(i), (c)(3)(ii), and (c)(3)(iii) of this section are illustrated by the following examples. In each example, the group health plan is subject to

the requirements of this section and provides both medical/surgical benefits and mental health and substance use disorder benefits.

Example 1. (i) Facts. For inpatient, out-of-network medical/surgical benefits, a group health plan imposes five levels of coinsurance. Using a reasonable method, the plan projects its payments for the upcoming year as follows:

Coinsurance rate	0 %	10%	15%	20%	30%	Total
Projected payments	\$200x	\$100x	\$450x	\$100x	\$150x	\$1,000x
Percent of total plan costs	20%	10%	45%	10%	15%	
Percent subject to coinsurance level	N/A	12.5% (100x/800x)	56.25% (450x/800x)	12.5% (100x/800x)	18.75% (150x/800x)	

The plan projects plan costs of \$800x to be subject to coinsurance (\$100x + \$450x + \$100x + \$150x = \$800x). Thus, 80 percent (\$800x/\$1,000x) of the benefits are projected to be subject to coinsurance, and 56.25 percent of the benefits subject to coinsurance are projected to be subject to the 15 percent coinsurance level.

(ii) Conclusion. In this Example 1, the two-thirds threshold of the substantially all standard is met for coinsurance because 80 percent of all inpatient, out-of-network medical/surgical benefits are subject to coinsurance. Moreover, the 15 percent coinsurance is the predominant level because it is applicable to more than one-half of inpatient, out-of-network medical/surgical benefits subject to the coinsurance requirement. The plan may not impose any level of coinsurance with respect to inpatient, out-of-network mental health or substance use disorder benefits that is more restrictive than the 15 percent level of coinsurance.

Example 2. (i) Facts. For outpatient, in-network medical/surgical benefits, a group health plan imposes five different copayment levels. Using a reasonable method, the plan projects payments for the upcoming year as follows:

Copayment amount	\$0	\$10	\$15	\$20	\$50	Total
Projected payments	\$200x	\$200x	\$200x	\$300x	\$100x	\$1,000x
Percent of total plan costs	20%	20%	20%	30%	10%	
Percent subject to copayments	N/A	25% (200x/800x)	25% (200x/800x)	37.5% (300x/800x)	12.5% (100x/800x)	

The plan projects plan costs of \$800x to be subject to copayments (\$200x + \$200x + \$300x + \$100x = \$800x). Thus, 80 percent (\$800x/\$1,000x) of the benefits are projected to be subject to a copayment.

(ii) Conclusion. In this Example 2, the two-thirds threshold of the substantially all standard is met for copayments because 80 percent of all outpatient, in-network medical/surgical benefits are subject to a copayment. Moreover, there is no single level that applies to more than

one-half of medical/surgical benefits in the classification subject to a copayment (for the \$10 copayment, 25%; for the \$15 copayment, 25%; for the \$20 copayment, 37.5%; and for the \$50 copayment, 12.5%). The plan can combine any levels of copayment, including the highest levels, to determine the predominant level that can be applied to mental health or substance use disorder benefits. If the plan combines the highest levels of copayment, the combined projected payments for the two highest copayment levels, the \$50 copayment and the \$20 copayment, are not more than one-half of the outpatient, in-network medical/surgical benefits subject to a copayment because it is exactly one-half ($\$300x + \$100x = \$400x$; $\$400x/\$800x = 50\%$). The combined projected payments for the three highest copayment levels – the \$50 copayment, the \$20 copayment, and the \$15 copayment – are more than one-half of the outpatient, in-network medical/surgical benefits subject to the copayments ($\$100x + \$300x + \$200x = \$600x$; $\$600x/\$800x = 75\%$). Thus, the plan may not impose any copayment on outpatient, in-network mental health or substance use disorder benefits that is more restrictive than the least restrictive copayment in the combination, the \$15 copayment.

Example 3. (i) Facts. A plan imposes a \$250 deductible on all medical/surgical benefits for self-only coverage and a \$500 deductible on all medical/surgical benefits for family coverage. The plan has no network of providers. For all medical/surgical benefits, the plan imposes a coinsurance requirement. The plan imposes no other financial requirements or treatment limitations.

(ii) Conclusion. In this Example 3, because the plan has no network of providers, all benefits are provided out-of-network. Because self-only and family coverage are subject to different deductibles, whether the deductible applies to substantially all medical/surgical benefits is determined separately for self-only medical/surgical benefits and family medical/surgical benefits. Because the coinsurance is applied without regard to coverage units, the predominant coinsurance that applies to substantially all medical/surgical benefits is determined without regard to coverage units.

Example 4. (i) Facts. A plan applies the following financial requirements for prescription drug benefits. The requirements are applied without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use disorder benefits. Moreover, the process for certifying a particular drug as “generic”, “preferred brand name”, “non-preferred brand name”, or “specialty” complies with the rules of paragraph (c)(4) of this section (relating to requirements for nonquantitative treatment limitations).

	Tier 1	Tier 2	Tier 3	Tier 4
Tier description	Generic drugs	Preferred brand name drugs	Non-preferred brand name drugs (which may have Tier 1 or Tier 2 alternatives)	Specialty drugs
Percent paid by plan	90%	80%	60%	50%

(ii) Conclusion. In this Example 4, the financial requirements that apply to prescription drug benefits are applied without regard to whether a drug is generally prescribed with respect to

medical/surgical benefits or with respect to mental health or substance use disorder benefits; the process for certifying drugs in different tiers complies with paragraph (c)(4) of this section; and the bases for establishing different levels or types of financial requirements are reasonable. The financial requirements applied to prescription drug benefits do not violate the parity requirements of this paragraph (c)(3).

(v) No separate cumulative financial requirements or cumulative quantitative treatment limitations – (A) A group health plan may not apply any cumulative financial requirement or cumulative quantitative treatment limitation for mental health or substance use disorder benefits in a classification that accumulates separately from any established for medical/surgical benefits in the same classification.

(B) The rules of this paragraph (c)(3)(v) are illustrated by the following examples:

Example 1. (i) Facts. A group health plan imposes a combined annual \$500 deductible on all medical/surgical, mental health, and substance use disorder benefits.

(ii) Conclusion. In this Example 1, the combined annual deductible complies with the requirements of this paragraph (c)(3)(v).

Example 2. (i) Facts. A group health plan imposes an annual \$250 deductible on all medical/surgical benefits and a separate annual \$250 deductible on all mental health and substance use disorder benefits.

(ii) Conclusion. In this Example 2, the separate annual deductible on mental health and substance use disorder benefits violates the requirements of this paragraph (c)(3)(v).

Example 3. (i) Facts. A group health plan imposes an annual \$300 deductible on all medical/surgical benefits and a separate annual \$100 deductible on all mental health or substance use disorder benefits.

(ii) Conclusion. In this Example 3, the separate annual deductible on mental health and substance use disorder benefits violates the requirements of this paragraph (c)(3)(v).

Example 4. (i) Facts. A group health plan generally imposes a combined annual \$500 deductible on all benefits (both medical/surgical benefits and mental health and substance use disorder benefits) except prescription drugs. Certain benefits, such as preventive care, are provided without regard to the deductible. The imposition of other types of financial requirements or treatment limitations varies with each classification. Using reasonable methods, the plan projects its payments for medical/surgical benefits in each classification for the upcoming year as follows:

Classification	Benefits Subject to Deductible	Total Benefits	Percent Subject to Deductible
Inpatient, in-network	\$1,800x	\$2,000x	90%
Inpatient, out-of-network	\$1,000x	\$1,000x	100%
Outpatient, in-network	\$1,400x	\$2,000x	70%
Outpatient, out-of-network	\$1,880x	\$2,000x	94%
Emergency care	\$300x	\$500x	60%

(ii) Conclusion. In this Example 4, the two-thirds threshold of the substantially all standard is met with respect to each classification except emergency care because in each of those other classifications at least two-thirds of medical/surgical benefits are subject to the \$500 deductible. Moreover, the \$500 deductible is the predominant level in each of those other classifications because it is the only level. However, emergency care mental health and substance use disorder benefits cannot be subject to the \$500 deductible because it does not apply to substantially all emergency care medical/surgical benefits.

(4) Nonquantitative treatment limitations – (i) General rule. A group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference.

(ii) Illustrative list of nonquantitative treatment limitations. Nonquantitative treatment limitations include –

(A) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;

(B) Formulary design for prescription drugs;

(C) Standards for provider admission to participate in a network, including reimbursement rates;

(D) Plan methods for determining usual, customary, and reasonable charges;

(E) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols); and

(F) Exclusions based on failure to complete a course of treatment.

(iii) Examples. The rules of this paragraph (c)(4) are illustrated by the following examples. In each example, the group health plan is subject to the requirements of this section and provides both medical/surgical benefits and mental health and substance use disorder benefits.

Example 1. (i) Facts. A group health plan limits benefits to treatment that is medically necessary. The plan requires concurrent review for inpatient, in-network mental health and substance use disorder benefits but does not require it for any inpatient, in-network medical/surgical benefits. The plan conducts retrospective review for inpatient, in-network medical/surgical benefits.

(ii) Conclusion. In this Example 1, the plan violates the rules of this paragraph (c)(4). Although the same nonquantitative treatment limitation – medical necessity – applies to both mental health and substance use disorder benefits and to medical/surgical benefits for inpatient, in-network services, the concurrent review process does not apply to medical/surgical benefits. The concurrent review process is not comparable to the retrospective review process. While such a difference might be permissible in certain individual cases based on recognized clinically appropriate standards of care, it is not permissible for distinguishing between all medical/surgical benefits and all mental health or substance use disorder benefits.

Example 2. (i) Facts. A plan requires prior approval that a course of treatment is medically necessary for outpatient, in-network medical/surgical, mental health, and substance use disorder benefits. For mental health and substance use disorder treatments that do not have prior approval, no benefits will be paid; for medical/surgical treatments that do not have prior approval, there will only be a 25 percent reduction in the benefits the plan would otherwise pay.

(ii) Conclusion. In this Example 2, the plan violates the rules of this paragraph (c)(4). Although the same nonquantitative treatment limitation – medical necessity – is applied both to mental health and substance use disorder benefits and to medical/surgical benefits for outpatient, in-network services, the penalty for failure to obtain prior approval for mental health and

substance use disorder benefits is not comparable to the penalty for failure to obtain prior approval for medical/surgical benefits.

Example 3. (i) Facts. A plan generally covers medically appropriate treatments. For both medical/surgical benefits and mental health and substance use disorder benefits, evidentiary standards used in determining whether a treatment is medically appropriate (such as the number of visits or days of coverage) are based on recommendations made by panels of experts with appropriate training and experience in the fields of medicine involved. The evidentiary standards are applied in a manner that may differ based on clinically appropriate standards of care for a condition.

(ii) Conclusion. In this Example 3, the plan complies with the rules of this paragraph (c) (4) because the nonquantitative treatment limitation – medical appropriateness – is the same for both medical/surgical benefits and mental health and substance use disorder benefits, and the processes for developing the evidentiary standards and the application of them to mental health and substance use disorder benefits are comparable to and are applied no more stringently than for medical/surgical benefits. This is the result even if, based on clinically appropriate standards of care, the application of the evidentiary standards does not result in similar numbers of visits, days of coverage, or other benefits utilized for mental health conditions or substance use disorders as it does for any particular medical/surgical condition.

Example 4. (i) Facts. A plan generally covers medically appropriate treatments. In determining whether prescription drugs are medically appropriate, the plan automatically excludes coverage for antidepressant drugs that are given a black box warning label by the Food and Drug Administration (indicating the drug carries a significant risk of serious adverse effects). For other drugs with a black box warning (including those prescribed for other mental health conditions and substance use disorders, as well as for medical/surgical conditions), the plan will provide coverage if the prescribing physician obtains authorization from the plan that the drug is medically appropriate for the individual, based on clinically appropriate standards of care.

(ii) Conclusion. In this Example 4, the plan violates the rules of this paragraph (c)(4). Although the same nonquantitative treatment limitation – medical appropriateness – is applied to both mental health and substance use disorder benefits and medical/surgical benefits, the plan's unconditional exclusion of antidepressant drugs given a black box warning is not comparable to the conditional exclusion for other drugs with a black box warning.

Example 5. (i) Facts. An employer maintains both a major medical program and an employee assistance program (EAP). The EAP provides, among other benefits, a limited number of mental health or substance use disorder counseling sessions. Participants are eligible for mental health or substance use disorder benefits under the major medical program only after exhausting the counseling sessions provided by the EAP. No similar exhaustion requirement applies with respect to medical/surgical benefits provided under the major medical program.

(ii) Conclusion. In this Example 5, limiting eligibility for mental health and substance use disorder benefits only after EAP benefits are exhausted is a nonquantitative treatment limitation subject to the parity requirements of this paragraph (c). Because no comparable

requirement applies to medical/surgical benefits, the requirement may not be applied to mental health or substance use disorder benefits.

(5) Exemptions. The rules of this paragraph (c) do not apply if a group health plan satisfies the requirements of paragraph (f) or (g) of this section (relating to exemptions for small employers and for increased cost).

(d) Availability of plan information – (1) Criteria for medical necessity determinations. The criteria for medical necessity determinations made under a group health plan with respect to mental health or substance use disorder benefits must be made available by the plan administrator to any current or potential participant, beneficiary, or contracting provider upon request.

(2) Reason for denial. The reason for any denial under a group health plan of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary must be made available by the plan administrator to the participant or beneficiary in accordance with this paragraph (d)(2).

(i) Plans subject to ERISA. If a plan is subject to ERISA, it must provide the reason for the claim denial in a form and manner consistent with the requirements of 29 CFR 2560.503-1 for group health plans.

(ii) Plans not subject to ERISA. If a plan is not subject to ERISA, upon the request of a participant or beneficiary the reason for the claim denial must be provided within a reasonable time. For this purpose, a plan that follows the requirements of 29 CFR 2560.503-1 for group health plans complies with the requirements of this paragraph (d)(2)(ii).

(e) Applicability – (1) Group health plans. The requirements of this section apply to a group health plan offering medical/surgical benefits and mental health or substance use disorder benefits. If, under an arrangement or arrangements to provide health care benefits by an

employer or employee organization (including for this purpose a joint board of trustees of a multiemployer trust affiliated with one or more multiemployer plans), any participant (or beneficiary) can simultaneously receive coverage for medical/surgical benefits and coverage for mental health or substance use disorder benefits, then the requirements of this section (including the exemption provisions in paragraph (g) of this section) apply separately with respect to each combination of medical/surgical benefits and of mental health or substance use disorder benefits that any participant (or beneficiary) can simultaneously receive from that employer's or employee organization's arrangement or arrangements to provide health care benefits, and all such combinations are considered for purposes of this section to be a single group health plan.

(2) Health insurance issuers. See 29 CFR 2590.712(e)(2) and 45 CFR 146.136(e)(2), under which a health insurance issuer offering health insurance coverage for mental health or substance use disorder benefits is subject to requirements similar to those applicable to group health plans under this section if the health insurance coverage is offered in connection with a group health plan subject to requirements under 29 CFR 2590.712 or 45 CFR 146.136 similar to those applicable to group health plans under this section.

(3) Scope. This section does not –

(i) Require a group health plan to provide any mental health benefits or substance use disorder benefits, and the provision of benefits by a plan for one or more mental health conditions or substance use disorders does not require the plan under this section to provide benefits for any other mental health condition or substance use disorder; or

(ii) Affect the terms and conditions relating to the amount, duration, or scope of mental health or substance use disorder benefits under the plan except as specifically provided in paragraphs (b) and (c) of this section.

(f) Small employer exemption—(1) In general. The requirements of this section do not apply to a group health plan for a plan year of a small employer. For purposes of this paragraph (f), 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 two (or one in the case of an employer residing in a state that permits small groups to include a single individual) but not more than 50 employees on business days during the preceding calendar year. See section 9831(a)(2) and §54.9831-1(b) of this part, which provide that this section (and certain other sections) does not apply to any group health plan for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees.

(2) Rules in determining employer size. For purposes of paragraph (f)(1) of this section

—
(i) All persons treated as a single employer under subsections (b), (c), (m), and (o) of section 414 are treated as one employer;

(ii) If an employer was not in existence throughout the preceding calendar year, whether it is a small employer is determined based on the average number of employees the employer reasonably expects to employ on business days during the current calendar year; and

(iii) Any reference to an employer for purposes of the small employer exemption includes a reference to a predecessor of the employer.

(g) Increased cost exemption—[Reserved]

(h) Sale of nonparity health insurance coverage. See 29 CFR 2590.712(h) and 45 CFR 146.136(h), under which a health insurance issuer may not sell a policy, certificate, or contract of insurance that fails to comply with requirements similar to those under paragraph (b) or (c) of this section, except to a plan for a year for which the plan is exempt from requirements similar to

those under paragraph (b) or (c) of this section because the plan meets requirements under paragraph (f) or (g) of 29 CFR 2590.712 or 45 CFR 146.136 similar to those under paragraph (f) or (g) of this section.

(i) Effective/applicability dates—(1) In general. Except as provided in paragraph (i)(2) of this section, the requirements of this section are applicable for plan years beginning on or after July 1, 2010.

(2) Special effective date for certain collectively-bargained plans. For a group health plan maintained pursuant to one or more collective bargaining agreements ratified before October 3, 2008, the requirements of this section do not apply to the plan for plan years beginning before the later of either –

(i) The date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension agreed to after October 3, 2008); or

(ii) July 1, 2010.

(j) Expiration date. This section expires on or before **[INSERT DATE 3 YEARS AFTER FILING DATE WITH FEDERAL REGISTER]**.

PART 602 -- OMB CONTROL NUMBERS UNDER THE PAPERWORK REDUCTION ACT

Par. 3. The authority citation for part 602 continues to read as follows:

Authority: 26 U.S.C. 7805.

Par. 4. In §602.101, paragraph (b) is amended by adding the following entries in numerical order to the table:

§602.101 OMB Control numbers.

* * * * *

(b) * * *

CFR part or section where
identified and described

Current OMB
control No.

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Deputy Commissioner for Services and Enforcement,
Internal Revenue Service.

Approved:

Acting Assistant Secretary of the Treasury (Tax Policy).