

§ 146.160

available by a health insurance issuer in the small or large group market to employers only through one or more associations, the reference to “plan sponsor” is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

(Approved by the Office of Management and Budget under control number 0938-0702.)

[62 FR 16958, Apr. 8, 1997; 62 FR 31670, June 10, 1997, as amended at 62 FR 35906, July 2, 1997]

§ 146.160 Disclosure of information.

(a) *General rule.* In connection with the offering of any health insurance coverage to a small employer, a health insurance issuer is required to—

(1) Make a reasonable disclosure to the employer, as part of its solicitation and sales materials, of the availability of information described in paragraph (b) of this section; and

(2) Upon request of the employer, provide that information to the employer.

(b) *Information described.* Subject to paragraph (d) of this section, information that must be provided under paragraph (a)(2) of this section is information concerning the following:

(1) Provisions of coverage relating to the following:

(i) The issuer’s right to change premium rates and the factors that may affect changes in premium rates.

(ii) Renewability of coverage.

(iii) Any preexisting condition exclusion, including use of the alternative method of counting creditable coverage.

(iv) Any affiliation periods applied by HMOs.

(v) The geographic areas served by HMOs.

(2) The benefits and premiums available under all health insurance coverage for which the employer is qualified, under applicable State law. See § 146.150(b) through (f) for allowable limitations on product availability.

(c) *Form of information.* The information must be described in language that is understandable by the average small employer, with a level of detail that is sufficient to reasonably inform small employers of their rights and obligations under the health insurance coverage. This requirement is satisfied

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if the issuer provides each of the following with respect to each product offered:

(1) An outline of coverage. For purposes of this section, outline of coverage means a description of benefits in summary form.

(2) The rate or rating schedule that applies to the product (with and without the preexisting condition exclusion or affiliation period).

(3) The minimum employer contribution and group participation rules that apply to any particular type of coverage.

(4) In the case of a network plan, a map or listing of counties served.

(5) Any other information required by the State.

(d) *Exception.* An issuer is not required to disclose any information that is proprietary and trade secret information under applicable law.

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Subpart F—Exclusion of Plans and Enforcement

§ 146.180 Treatment of non-Federal governmental plans.

The plan sponsor of a non-Federal governmental plan may elect to be exempted from any or all of the requirements identified in paragraph (a) of this section with respect to any portion of its plan that is not provided through health insurance coverage, if the election complies with the requirements of paragraphs (b) and (c) of this section. The election remains in effect for the period described in paragraph (d) of this section.

(a) *Exemption from requirements.* The election described in this section exempts a non-Federal governmental plan from the following requirements:

(1) Limitations on preexisting condition exclusion periods (§ 146.111).

(2) Special enrollment periods for individuals and dependents (§ 146.117).

(3) Prohibitions against discriminating against individual participants and beneficiaries based on health status (§ 146.121).