

SENATE BILL NO. 356—SENATOR TOWNSEND

MARCH 10, 1999

Referred to Committee on Commerce and Labor

SUMMARY—Revises provisions governing parity for insurance benefits for treatment of conditions relating to mental health. (BDR 57-682)

FISCAL NOTE: Effect on Local Government: Yes.
Effect on the State or on Industrial Insurance: Yes.

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EXPLANATION – Matter in ***bolded italics*** is new; matter between brackets ~~[omitted material]~~ is material to be omitted.

AN ACT relating to insurance; providing in skeleton form for the revision of the provisions governing parity for insurance benefits for the treatment of conditions relating to mental health; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE
AND ASSEMBLY, DO ENACT AS FOLLOWS:

- 1 **Section 1.** Chapter 689A of NRS is hereby amended by adding thereto
2 a new section to read as follows:
3 ***1. Notwithstanding any provision of this Title to the contrary, a***
4 ***policy of health insurance issued or delivered for issuance in this state***
5 ***pursuant to this chapter must provide coverage for the treatment of***
6 ***conditions relating to mental health and must not establish any rate, term***
7 ***or condition that places a greater financial burden on the insured person***
8 ***for access to treatment for conditions relating to mental health than for***
9 ***access to treatment for conditions relating to physical health. Any limits***
10 ***required under the policy of health insurance for deductibles and out-of-***
11 ***pocket expenses must be comprehensive for coverage of both conditions***
12 ***relating to mental health and conditions relating to physical health.***
13 ***2. A policy of health insurance that does not otherwise provide for***
14 ***managed care, or that does not provide for the same degree of managed***
15 ***care for all health conditions, may provide coverage for the treatment of***
16 ***conditions relating to mental health through a managed care***
17 ***organization if the managed care organization is in compliance with***

1 regulations adopted by the commissioner which ensure that the system
2 for delivery of the treatment for conditions relating to mental health does
3 not diminish or negate the purpose of this section. The regulations
4 adopted by the commissioner must ensure that:

5 (a) Timely and appropriate access to care is available;

6 (b) The distribution of providers of health care who provide services
7 relating to mental health is adequate to serve the needs of persons in this
8 state, considering the quality, location and area of specialization of such
9 providers; and

10 (c) Administrative or clinical protocols do not reduce access to
11 medically necessary treatment for the insured person.

12 3. A policy of health insurance shall be deemed to be in compliance
13 with this section if the policy provides to the insured person at least one
14 option for treatment of conditions relating to mental health which has
15 rates, terms and conditions that impose no greater financial burden on
16 the insured person than that imposed for treatment of conditions relating
17 to the physical health of the insured person. The commissioner may
18 disapprove any policy of health insurance if he determines that the policy
19 is inconsistent with this section.

20 4. Benefits provided pursuant to this section by a policy of health
21 insurance for conditions relating to mental health must be paid in the
22 same manner as benefits for any other illness covered by the policy.

23 5. Benefits for conditions relating to mental health are not required
24 by this section if the treatment for the condition relating to mental health
25 is not provided:

26 (a) By a person who is licensed or certified to provide treatment for
27 conditions relating to mental health; or

28 (b) In a mental health facility or institution designated as a division
29 facility pursuant to NRS 433.233, or in a medical or other facility
30 licensed by the state board of health pursuant to chapter 449 of NRS that
31 provides programs for the treatment of conditions relating to mental
32 health, and pursuant to an individualized written plan developed for the
33 insured person. A nonprofit hospital or medical service corporation may
34 require a mental health facility or a person who is licensed or certified to
35 provide treatment for conditions relating to mental health to enter into a
36 contract as a condition of providing benefits in accordance with this
37 section.

38 6. The provisions of this section must not be construed to:

39 (a) Limit the provision of specialized services covered by Medicaid for
40 persons with conditions relating to mental health or substance abuse.

1 (b) *Supersede any provision of federal law, any federal or state policy*
2 *relating to Medicaid, or the terms and conditions imposed on any*
3 *Medicaid waiver granted to this state with respect to the provision of*
4 *services to persons with conditions relating to mental health or substance*
5 *abuse.*

6 (c) *Affect any existing policy of health insurance until its date of*
7 *renewal or, if the policy of health insurance is governed by a collective*
8 *bargaining agreement or employment contract, until the expiration of*
9 *that agreement or contract.*

10 7. *As used in this section:*

11 (a) *“Condition relating to mental health” means a condition or*
12 *disorder involving mental illness that falls within any of the diagnostic*
13 *categories listed in the section on mental disorders in the International*
14 *Classification of Diseases published by the United States Department of*
15 *Health and Human Services.*

16 (b) *“Managed care” has the meaning ascribed to it in NRS 695G.040.*

17 (c) *“Managed care organization” has the meaning ascribed to it in*
18 *NRS 695G.050.*

19 (d) *“Rate, term or condition” means any lifetime or annual limit on*
20 *payments, any requirement concerning deductibles, copayments,*
21 *coinsurance or other forms of cost sharing, any limit on out-of-pocket*
22 *costs or on visits to a provider of treatment, and any other financial*
23 *component of health insurance coverage that affects the insured person.*

24 **Sec. 2.** NRS 689A.040 is hereby amended to read as follows:

25 689A.040 1. Except as *otherwise* provided in subsections 2 and 3,
26 each such policy delivered or issued for delivery to any person in this state
27 must contain the provisions specified in NRS 689A.050 to 689A.170,
28 inclusive, *and section 1 of this act*, in the words in which the provisions
29 appear, except that the insurer may, at its option, substitute for one or more
30 of the provisions corresponding provisions of different wording approved
31 by the commissioner which are in each instance not less favorable in any
32 respect to the insured or the beneficiary. Each such provision must be
33 preceded individually by the applicable caption shown, or, at the option of
34 the insurer, by such appropriate individual or group captions or subcaptions
35 as the commissioner may approve.

36 2. Each policy delivered or issued for delivery in this state after
37 November 1, 1973, must contain a provision, if applicable, setting forth the
38 provisions of NRS 689A.045.

39 3. If any such provision is in whole or in part inapplicable to or
40 inconsistent with the coverage provided by a particular form of policy, the
41 insurer, with the approval of the commissioner, may omit from the policy
42 any inapplicable provision or part of a provision, and shall modify any

1 inconsistent provision or part of a provision in such a manner as to make
2 the provision as contained in the policy consistent with the coverage
3 provided by the policy.

4 **Sec. 3.** Chapter 689B of NRS is hereby amended by adding thereto a
5 new section to read as follows:

6 *1. Notwithstanding any provision of this Title to the contrary, a*
7 *policy of group health insurance issued or delivered for issuance in this*
8 *state pursuant to this chapter must provide coverage for the treatment of*
9 *conditions relating to mental health and must not establish any rate, term*
10 *or condition that places a greater financial burden on the insured person*
11 *for access to treatment for conditions relating to mental health than for*
12 *access to treatment for conditions relating to physical health. Any limits*
13 *required under the policy of group health insurance for deductibles and*
14 *out-of-pocket expenses must be comprehensive for coverage of both*
15 *conditions relating to mental health and conditions relating to physical*
16 *health.*

17 *2. A policy of group health insurance that does not otherwise provide*
18 *for managed care, or that does not provide for the same degree of*
19 *managed care for all health conditions, may provide coverage for the*
20 *treatment of conditions relating to mental health through a managed*
21 *care organization if the managed care organization is in compliance with*
22 *regulations adopted by the commissioner which ensure that the system*
23 *for delivery of the treatment for conditions relating to mental health does*
24 *not diminish or negate the purpose of this section. The regulations*
25 *adopted by the commissioner must ensure that:*

26 *(a) Timely and appropriate access to care is available;*

27 *(b) The distribution of providers of health care who provide services*
28 *relating to mental health is adequate to serve the needs of persons in this*
29 *state, considering the quality, location and area of specialization of such*
30 *providers; and*

31 *(c) Administrative or clinical protocols do not reduce access to*
32 *medically necessary treatment for the insured person.*

33 *3. A policy of group health insurance shall be deemed to be in*
34 *compliance with this section if the policy provides to the insured person*
35 *at least one option for treatment of conditions relating to mental health*
36 *which has rates, terms and conditions that impose no greater financial*
37 *burden on the insured person than that imposed for treatment of*
38 *conditions relating to the physical health of the insured person. The*
39 *commissioner may disapprove any policy of group health insurance if he*
40 *determines that the policy is inconsistent with this section.*

41 *4. Benefits provided pursuant to this section by a policy of group*
42 *health insurance for conditions relating to mental health must be paid in*
43 *the same manner as benefits for any other illness covered by the policy.*

1 5. *Benefits for conditions relating to mental health are not required*
2 *by this section if the treatment for the condition relating to mental health*
3 *is not provided:*

4 (a) *By a person who is licensed or certified to provide treatment for*
5 *conditions relating to mental health; or*

6 (b) *In a mental health facility or institution designated as a division*
7 *facility pursuant to NRS 433.233, or in a medical or other facility*
8 *licensed by the state board of health pursuant to chapter 449 of NRS that*
9 *provides programs for the treatment of conditions relating to mental*
10 *health, and pursuant to an individualized written plan developed for the*
11 *insured person. A nonprofit hospital or medical service corporation may*
12 *require a mental health facility or a person who is licensed or certified to*
13 *provide treatment for conditions relating to mental health to enter into a*
14 *contract as a condition of providing benefits in accordance with this*
15 *section.*

16 6. *The provisions of this section must not be construed to:*

17 (a) *Limit the provision of specialized services covered by Medicaid for*
18 *persons with conditions relating to mental health or substance abuse.*

19 (b) *Supersede any provision of federal law, any federal or state policy*
20 *relating to Medicaid, or the terms and conditions imposed on any*
21 *Medicaid waiver granted to this state with respect to the provision of*
22 *services to persons with conditions relating to mental health or substance*
23 *abuse.*

24 (c) *Affect any existing policy of group health insurance until its date*
25 *of renewal or, if the policy of group health insurance is governed by a*
26 *collective bargaining agreement or employment contract, until the*
27 *expiration of that agreement or contract.*

28 7. *As used in this section:*

29 (a) *“Condition relating to mental health” means a condition or*
30 *disorder involving mental illness that falls within any of the diagnostic*
31 *categories listed in the section on mental disorders in the International*
32 *Classification of Diseases published by the United States Department of*
33 *Health and Human Services.*

34 (b) *“Managed care” has the meaning ascribed to it in NRS 695G.040.*

35 (c) *“Managed care organization” has the meaning ascribed to it in*
36 *NRS 695G.050.*

37 (d) *“Rate, term or condition” means any lifetime or annual limit on*
38 *payments, any requirement concerning deductibles, copayments,*
39 *coinsurance or other forms of cost sharing, any limit on out-of-pocket*
40 *costs or on visits to a provider of treatment, and any other financial*
41 *component of health insurance coverage that affects the insured person.*

1 **Sec. 4.** NRS 689B.030 is hereby amended to read as follows:

2 689B.030 Each group health insurance policy must contain in
3 substance the following provisions:

4 1. A provision that, in the absence of fraud, all statements made by
5 applicants or the policyholders or by an insured person are representations
6 and not warranties, and that no statement made for the purpose of effecting
7 insurance voids the insurance or reduces its benefits unless the statement is
8 contained in a written instrument signed by the policyholder or the insured
9 person, a copy of which has been furnished to him or his beneficiary.

10 2. A provision that the insurer will furnish to the policyholder for
11 delivery to each employee or member of the insured group a statement in
12 summary form of the essential features of the insurance coverage of that
13 employee or member and to whom benefits thereunder are payable. If
14 dependents are included in the coverage, only one statement need be issued
15 for each family.

16 3. A provision that to the group originally insured may be added from
17 time to time eligible new employees or members or dependents, as the case
18 may be, in accordance with the terms of the policy.

19 4. A provision for benefits for ~~[expense]~~ *expenses* arising from care at
20 home or health supportive services if the care or service was prescribed by
21 a physician and would have been covered by the policy if performed in a
22 medical facility or facility for the dependent as defined in chapter 449 of
23 NRS.

24 5. A provision for benefits ~~[payable]~~ for expenses incurred for the
25 treatment of the abuse of alcohol or drugs, as provided in NRS 689B.036.

26 6. A provision for benefits for expenses arising from hospice care.

27 *7. A provision for benefits for expenses incurred for the treatment of*
28 *conditions relating to mental health, as provided in section 3 of this act.*

29 **Sec. 5.** NRS 689B.340 is hereby amended to read as follows:

30 689B.340 As used in NRS 689B.340 to ~~[689B.600,]~~ *689B.590,*
31 inclusive, unless the context otherwise requires, the words and terms
32 defined in NRS 689B.350 to 689B.460, inclusive, have the meanings
33 ascribed to them in those sections.

34 **Sec. 6.** Chapter 689C of NRS is hereby amended by adding thereto a
35 new section to read as follows:

36 *1. Notwithstanding any provision of this Title to the contrary, a*
37 *health benefit plan issued or delivered for issuance in this state pursuant*
38 *to this chapter must provide coverage for the treatment of conditions*
39 *relating to mental health and must not establish any rate, term or*
40 *condition that places a greater financial burden on the insured person*
41 *for access to treatment for conditions relating to mental health than for*

1 access to treatment for conditions relating to physical health. Any limits
2 required under the health benefit plan for deductibles and out-of-pocket
3 expenses must be comprehensive for coverage of both conditions relating
4 to mental health and conditions relating to physical health.

5 2. A health benefit plan that does not otherwise provide for managed
6 care, or that does not provide for the same degree of managed care for
7 all health conditions, may provide coverage for the treatment of
8 conditions relating to mental health through a managed care
9 organization if the managed care organization is in compliance with
10 regulations adopted by the commissioner which ensure that the system
11 for delivery of the treatment for conditions relating to mental health does
12 not diminish or negate the purpose of this section. The regulations
13 adopted by the commissioner must ensure that:

14 (a) Timely and appropriate access to care is available;

15 (b) The distribution of providers of health care who provide services
16 relating to mental health is adequate to serve the needs of persons in this
17 state, considering the quality, location and area of specialization of such
18 providers; and

19 (c) Administrative or clinical protocols do not reduce access to
20 medically necessary treatment for the insured person.

21 3. A health benefit plan shall be deemed to be in compliance with
22 this section if the health benefit plan provides to the insured person at
23 least one option for treatment of conditions relating to mental health
24 which has rates, terms and conditions that impose no greater financial
25 burden on the insured person than that imposed for treatment of
26 conditions relating to the physical health of the insured person. The
27 commissioner may disapprove any health benefit plan if he determines
28 that the plan is inconsistent with this section.

29 4. Benefits provided pursuant to this section by a health benefit plan
30 for conditions relating to mental health must be paid in the same manner
31 as benefits for any other illness covered by the health benefit plan.

32 5. Benefits for conditions relating to mental health are not required
33 by this section if the treatment for the condition relating to mental health
34 is not provided:

35 (a) By a person who is licensed or certified to provide treatment for
36 conditions relating to mental health; or

37 (b) In a mental health facility or institution designated as a division
38 facility pursuant to NRS 433.233, or in a medical or other facility
39 licensed by the state board of health pursuant to chapter 449 of NRS that
40 provides programs for the treatment of conditions relating to mental
41 health, and pursuant to an individualized written plan developed for the
42 insured person. A nonprofit hospital or medical service corporation may

1 *require a mental health facility or a person who is licensed or certified to*
2 *provide treatment for conditions relating to mental health to enter into a*
3 *contract as a condition of providing benefits in accordance with this*
4 *section.*

5 *6. The provisions of this section must not be construed to:*

6 *(a) Limit the provision of specialized services covered by Medicaid for*
7 *persons with conditions relating to mental health or substance abuse.*

8 *(b) Supersede any provision of federal law, any federal or state policy*
9 *relating to Medicaid, or the terms and conditions imposed on any*
10 *Medicaid waiver granted to this state with respect to the provision of*
11 *services to persons with conditions relating to mental health or substance*
12 *abuse.*

13 *(c) Affect any existing health benefit plan until its date of renewal or,*
14 *if the health benefit plan is governed by a collective bargaining*
15 *agreement or employment contract, until the expiration of that*
16 *agreement or contract.*

17 *7. As used in this section:*

18 *(a) "Condition relating to mental health" means a condition or*
19 *disorder involving mental illness that falls within any of the diagnostic*
20 *categories listed in the section on mental disorders in the International*
21 *Classification of Diseases published by the United States Department of*
22 *Health and Human Services.*

23 *(b) "Managed care" has the meaning ascribed to it in NRS 695G.040.*

24 *(c) "Managed care organization" has the meaning ascribed to it in*
25 *NRS 695G.050.*

26 *(d) "Rate, term or condition" means any lifetime or annual limit on*
27 *payments, any requirement concerning deductibles, copayments,*
28 *coinsurance or other forms of cost sharing, any limit on out-of-pocket*
29 *costs or on visits to a provider of treatment, and any other financial*
30 *component of health insurance coverage that affects the insured person.*

31 **Sec. 7.** NRS 689C.155 is hereby amended to read as follows:

32 689C.155 The commissioner may adopt regulations to carry out the
33 provisions of **section 6 of this act and** NRS 689C.107 to 689C.145,
34 inclusive, 689C.156 to 689C.159, inclusive, 689C.165, 689C.183,
35 689C.187, 689C.191 to 689C.198, inclusive, 689C.203, 689C.207,
36 689C.265, 689C.283, 689C.287, 689C.325, 689C.342 to 689C.348,
37 inclusive, 689C.355 and 689C.610 to 689C.980, inclusive, and to ensure
38 that rating practices used by carriers serving small employers are consistent
39 with those sections, including regulations that:

1 1. Ensure that differences in rates charged for health benefit plans by
2 such carriers are reasonable and reflect only differences in the designs of
3 the plans, the terms of the coverage, the amount contributed by the
4 employers to the cost of coverage and differences based on the rating
5 factors established by the carrier.

6 2. Prescribe the manner in which characteristics may be used by such
7 carriers.

8 **Sec. 8.** NRS 689C.156 is hereby amended to read as follows:

9 689C.156 1. As a condition of transacting business in this state with
10 small employers, a carrier shall actively market to a small employer each
11 health benefit plan which is actively marketed in this state by the carrier to
12 any small employer in this state. The health insurance plans marketed
13 pursuant to this section by the carrier must include, without limitation, a
14 basic health benefit plan and a standard health benefit plan. A carrier shall
15 be deemed to be actively marketing a health benefit plan when it makes
16 available any of its plans to a small employer that is not currently receiving
17 coverage under a health benefit plan issued by that carrier.

18 2. A carrier shall issue to a small employer any health benefit plan
19 marketed in accordance with this section if the eligible small employer
20 applies for the plan and agrees to make the required premium payments and
21 satisfy the other reasonable provisions of the health benefit plan that are not
22 inconsistent with NRS 689C.015 to 689C.355, inclusive, **and section 6 of**
23 **this act**, and **NRS** 689C.610 to 689C.980, inclusive, except that a carrier is
24 not required to issue a health benefit plan to a self-employed person who is
25 covered by, or is eligible for coverage under, a health benefit plan offered
26 by another employer.

27 **Sec. 9.** NRS 695B.180 is hereby amended to read as follows:

28 695B.180 A contract for hospital, medical or dental services must not
29 be entered into between a corporation proposing to furnish or provide any
30 one or more of the services authorized under this chapter and a subscriber:

31 1. Unless the entire consideration therefor is expressed in the contract.

32 2. Unless the times at which the benefits or services to the subscriber
33 take effect and terminate are stated in a portion of the contract above the
34 evidence of its execution.

35 3. If the contract purports to entitle more than one person to benefits or
36 services, except for family contracts issued under NRS 695B.190, group
37 contracts issued under NRS 695B.200, and blanket contracts issued under
38 NRS 695B.220.

39 4. Unless every printed portion and any endorsement or attached
40 papers are plainly printed in type of which the face is not smaller than 10
41 points.

1 5. Except for group contracts and blanket contracts issued under NRS
2 695B.220, unless the exceptions of the contract are printed with greater
3 prominence than the benefits to which they apply.

4 6. Except for group contracts and blanket contracts issued under NRS
5 695B.230, unless, if any portion of the contract purports, by reason of the
6 circumstances under which an illness, injury or disablement is incurred to
7 reduce any service to less than that provided for the same illness, injury or
8 disablement incurred under ordinary circumstances, that portion is printed
9 in boldface type and with greater prominence than any other text of the
10 contract.

11 7. If the contract contains any provisions purporting to make any
12 portion of the charter, constitution or bylaws of a nonprofit corporation a
13 part of the contract unless that portion is set forth in full in the contract.

14 8. Unless the contract, if it is a group contract, contains a provision for
15 benefits payable for expenses incurred for the treatment of ~~the~~ :

16 (a) *The* abuse of alcohol or drugs, as provided in NRS 695B.194 ~~H~~ ;
17 *and*

18 (b) *Conditions relating to mental health, as provided in section 3 of*
19 *this act.*

20 9. Unless the contract provides benefits for expenses incurred for
21 hospice care.

22 10. Unless the contract for service in a hospital contains in blackface
23 type, not less than 10 points, the following provisions:

24
25 This contract does not restrict or interfere with the right of any
26 person entitled to service and care in a hospital to select the
27 contracting hospital or to make a free choice of his attending
28 physician, who must be the holder of a valid and unrevoked
29 physician's license and a member of, or acceptable to, the attending
30 staff and board of directors of the hospital in which the services are to
31 be provided.

32 **Sec. 10.** NRS 695C.170 is hereby amended to read as follows:

33 695C.170 1. Every enrollee residing in this state is entitled to
34 evidence of coverage under a health care plan. If the enrollee obtains
35 coverage under a health care plan through an insurance policy, whether by
36 option or otherwise, the insurer shall issue the evidence of coverage.
37 Otherwise, the health maintenance organization shall issue the evidence of
38 coverage.

39 2. Evidence of coverage or amendment thereto must not be issued or
40 delivered to any person in this state until a copy of the form of the evidence
41 of coverage or amendment thereto has been filed with and approved by the
42 commissioner.

- 1 3. An evidence of coverage:
- 2 (a) Must not contain any provisions or statements which are unjust,
- 3 unfair, inequitable, misleading, deceptive, which encourage
- 4 misrepresentation or which are untrue, misleading or deceptive as defined
- 5 in subsection 1 of NRS 695C.300; and
- 6 (b) Must contain a clear and complete statement, if a contract, or a
- 7 reasonably complete summary if a certificate, of:
- 8 (1) The health care services and the insurance or other benefits, if
- 9 any, to which the enrollee is entitled under the health care plan;
- 10 (2) Any limitations on the services, kind of services, benefits, or kind
- 11 of benefits, to be provided, including any deductible or copayment feature;
- 12 (3) Where and in what manner the services may be obtained;
- 13 (4) The total amount of payment for health care services and the
- 14 indemnity or service benefits, if any, which the enrollee is obligated to pay;
- 15 and
- 16 (5) A provision for benefits payable for expenses incurred for the
- 17 treatment of ~~the~~ :
- 18 (I) *The* abuse of alcohol or drugs, as provided in NRS 695C.174 ~~;~~
- 19 ; and
- 20 (II) *Conditions relating to mental health, as provided in section 3*
- 21 *of this act.*
- 22 Any subsequent change may be evidenced in a separate document issued to
- 23 the enrollee.
- 24 4. A copy of the form of the evidence of coverage to be used in this
- 25 state and any amendment thereto is subject to the requirements for filing
- 26 and approval of subsection 2 unless it is subject to the jurisdiction of the
- 27 commissioner under the laws governing health insurance, in which event
- 28 the provisions for filing and approval of those laws apply. To the extent
- 29 that such provisions do not apply to the requirements in subsection 3, such
- 30 provisions are amended to incorporate the requirements of subsection 3 in
- 31 approving or disapproving an evidence of coverage required by subsection
- 32 2.
- 33 **Sec. 11.** NRS 689B.600 is hereby repealed.
- 34 **Sec. 12.** This act becomes effective on July 1, 1999.

TEXT OF REPEALED SECTION

689B.600 Insurance for groups of 51 persons or more which offers medical and surgical benefits and mental health benefits: Aggregate lifetime and annual limits on benefits. [Expires by limitation on September 30,

2001.]

1. Except as otherwise provided in this section, if group health insurance for groups of 51 persons or more which is issued or delivered for issuance in this state and which offers both medical and surgical benefits and mental health benefits:

(a) Does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the group health insurance may not impose an aggregate lifetime limit on the mental health benefits.

(b) Includes an aggregate lifetime limit on substantially all medical and surgical benefits, the aggregate lifetime limit on the mental health benefits offered by the group health insurance must not be less than the aggregate lifetime limit set for the medical and surgical benefits.

(c) Includes no aggregate lifetime limits, or different aggregate lifetime limits, on different categories of medical and surgical benefits, the applicable aggregate lifetime limit that must be applied in accordance with paragraph (b) to the mental health benefits of the group health insurance must be computed by taking into account the weighted average of the aggregate lifetime limits applicable to such categories of medical and surgical benefits offered by the group health insurance. The computation of the aggregate lifetime limit must be consistent with the rules adopted by the Secretary of the United States Department of Labor pursuant to 29 U.S.C. § 1185a.

2. Except as otherwise provided in this section, if group health insurance for groups of 51 persons or more which is issued or delivered for issuance in this state and which offers both medical and surgical benefits and mental health benefits:

(a) Does not include an annual limit on substantially all medical and surgical benefits, the group health insurance may not impose an annual limit on the mental health benefits.

(b) Includes an annual limit on substantially all medical and surgical benefits, the annual limit on the mental health benefits offered by the group health insurance must not be less than the annual limit set for the medical and surgical benefits.

(c) Includes no annual limit, or different annual limits, on different categories of medical and surgical benefits, the applicable annual limit that must be applied in accordance with paragraph (b) to the mental health benefits of the group health insurance must be computed by taking into account the weighted average of the annual limits applicable to such categories of medical and surgical benefits offered by the group health insurance. The computation of the annual limit must be consistent with the rules adopted by the Secretary of the United States Department of Labor pursuant to 29 U.S.C. § 1185a.

3. Nothing in this section:

(a) Requires group health insurance to provide mental health benefits.

(b) Except as specifically provided in subsection 1, affects the terms or conditions of group health insurance that provides mental health benefits, relating to the amount, duration or scope of those benefits, including, but not limited to, cost sharing, limits on numbers of visits or days of coverage and requirements relating to medical necessity.

4. Group health insurance is not required to comply with the provisions of this section if the application of this section would result in an increase in the cost under the group health insurance of 1 percent or more.

5. If the group health insurance offers a participant or beneficiary more than one benefit package option, the provisions of this section must be applied separately to each such option offered.

6. As used in this section:

(a) “Aggregate lifetime limit” means a limitation on the total amount of benefits that may be paid with respect to those benefits under group health insurance with respect to a policyholder or other coverage unit.

(b) “Annual limit” means a limitation on the total amount of benefits that may be paid with respect to those benefits in a 12-month period under group health insurance with respect to an individual or other coverage unit.

(c) “Medical and surgical benefits” means benefits, as defined under the group health insurance, provided by such insurance for medical or surgical services. The term does not include benefits for services relating to mental health.

(d) “Mental health benefits” means benefits, as defined under the group health insurance, provided by such insurance for services relating to mental health. The term does not include benefits provided for the treatment of substance abuse or chemical dependency.