

covered under the plan, the plan must provide the child, not later than January 1, 2011, an opportunity to enroll (including written notice to the employee of an opportunity to enroll the child) that continues for at least 30 days, with enrollment effective not later than January 1, 2011.

(g) *Special rule for grandfathered group health plans*—(1) For plan years beginning before January 1, 2014, a group health plan that qualifies as a grandfathered health plan under section 1251 of the Patient Protection and Affordable Care Act and that makes available dependent coverage of children may exclude an adult child who has not attained age 26 from coverage only if the adult child is eligible to enroll in an eligible employer-sponsored health plan (as defined in section 5000A(f)(2) of the Internal Revenue Code) other than a group health plan of a parent.

(2) For plan years beginning on or after January 1, 2014, a group health plan that qualifies as a grandfathered health plan under section 1251 of the Patient Protection and Affordable Care Act must comply with the requirements of paragraphs (a) through (f) of this section.

(h) *Applicability date*. The provisions of this section apply for plan years (in the individual market, policy years) beginning on or after September 23, 2010. See § 147.140 of this part for determining the application of this section to grandfathered health plans.

[75 FR 27138, May 13, 2010, as amended at 75 FR 34566, June 17, 2010]

§ 147.126 No lifetime or annual limits.

(a) *Prohibition*—(1) *Lifetime limits*. Except as provided in paragraph (b) of this section, a group health plan, or a health insurance issuer offering group or individual health insurance coverage, may not establish any lifetime limit on the dollar amount of benefits for any individual.

(2) *Annual limits*—(i) *General rule*. Except as provided in paragraphs (a)(2)(ii), (b), and (d) of this section, a group health plan, or a health insurance issuer offering group or individual health insurance coverage, may not establish any annual limit on the dollar amount of benefits for any individual.

(ii) *Exception for health flexible spending arrangements*. A health flexible

spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code) is not subject to the requirement in paragraph (a)(2)(i) of this section.

(b) *Construction*—(1) *Permissible limits on specific covered benefits*. The rules of this section do not prevent a group health plan, or a health insurance issuer offering group or individual health insurance coverage, from placing annual or lifetime dollar limits with respect to any individual on specific covered benefits that are not essential health benefits to the extent that such limits are otherwise permitted under applicable Federal or State law. (The scope of essential health benefits is addressed in paragraph (c) of this section).

(2) *Condition-based exclusions*. The rules of this section do not prevent a group health plan, or a health insurance issuer offering group or individual health insurance coverage, from excluding all benefits for a condition. However, if any benefits are provided for a condition, then the requirements of this section apply. Other requirements of Federal or State law may require coverage of certain benefits.

(c) *Definition of essential health benefits*. The term “essential health benefits” means essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations.

(d) *Restricted annual limits permissible prior to 2014*—(1) *In general*. With respect to plan years (in the individual market, policy years) beginning prior to January 1, 2014, a group health plan, or a health insurance issuer offering group or individual health insurance coverage, may establish, for any individual, an annual limit on the dollar amount of benefits that are essential health benefits, provided the limit is no less than the amounts in the following schedule:

(i) For a plan year (in the individual market, policy year) beginning on or after September 23, 2010, but before September 23, 2011, \$750,000.

(ii) For a plan year (in the individual market, policy year) beginning on or after September 23, 2011, but before September 23, 2012, \$1,250,000.

(iii) For plan years (in the individual market, policy years) beginning on or after September 23, 2012, but before January 1, 2014, \$2,000,000.

(2) *Only essential health benefits taken into account.* In determining whether an individual has received benefits that meet or exceed the applicable amount described in paragraph (d)(1) of this section, a plan or issuer must take into account only essential health benefits.

(3) *Waiver authority of the Secretary.* For plan years (in the individual market, policy years) beginning before January 1, 2014, the Secretary may establish a program under which the requirements of paragraph (d)(1) of this section relating to annual limits may be waived (for such period as is specified by the Secretary) for a group health plan or health insurance coverage that has an annual dollar limit on benefits below the restricted annual limits provided under paragraph (d)(1) of this section if compliance with paragraph (d)(1) of this section would result in a significant decrease in access to benefits under the plan or health insurance coverage or would significantly increase premiums for the plan or health insurance coverage.

(e) *Transitional rules for individuals whose coverage or benefits ended by reason of reaching a lifetime limit—(1) In general.* The relief provided in the transitional rules of this paragraph (e) applies with respect to any individual—

(i) Whose coverage or benefits under a group health plan or group or individual health insurance coverage ended by reason of reaching a lifetime limit on the dollar value of all benefits for any individual (which, under this section, is no longer permissible); and

(ii) Who becomes eligible (or is required to become eligible) for benefits not subject to a lifetime limit on the dollar value of all benefits under the group health plan or group or individual health insurance coverage on the first day of the first plan year (in the individual market, policy year) beginning on or after September 23, 2010, by reason of the application of this section.

(2) *Notice and enrollment opportunity requirements—(i)* If an individual described in paragraph (e)(1) of this section is eligible for benefits (or is re-

quired to become eligible for benefits) under the group health plan—or group or individual health insurance coverage—described in paragraph (e)(1) of this section, the plan and the issuer are required to give the individual written notice that the lifetime limit on the dollar value of all benefits no longer applies and that the individual, if covered, is once again eligible for benefits under the plan. Additionally, if the individual is not enrolled in the plan or health insurance coverage, or if an enrolled individual is eligible for but not enrolled in any benefit package under the plan or health insurance coverage, then the plan and issuer must also give such an individual an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll). The notices and enrollment opportunity required under this paragraph (e)(2)(i) must be provided beginning not later than the first day of the first plan year (in the individual market, policy year) beginning on or after September 23, 2010.

(ii) The notices required under paragraph (e)(2)(i) of this section may be provided to an employee on behalf of the employee's dependent (in the individual market, to the primary subscriber on behalf of the primary subscriber's dependent). In addition, for a group health plan or group health insurance coverage, the notices may be included with other enrollment materials that a plan distributes to employees, provided the statement is prominent. For either notice, with respect to a group health plan or group health insurance coverage, if a notice satisfying the requirements of this paragraph (e)(2) is provided to an individual, the obligation to provide the notice with respect to that individual is satisfied for both the plan and the issuer.

(3) *Effective date of coverage.* In the case of an individual who enrolls under paragraph (e)(2) of this section, coverage must take effect not later than the first day of the first plan year (in the individual market, policy year) beginning on or after September 23, 2010.

(4) *Treatment of enrollees in a group health plan.* Any individual enrolling in a group health plan pursuant to paragraph (e)(2) of this section must be

treated as if the individual were a special enrollee, as provided under the rules of §146.117(d). Accordingly, the individual (and, if the individual would not be a participant once enrolled in the plan, the participant through whom the individual is otherwise eligible for coverage under the plan) must be offered all the benefit packages available to similarly situated individuals who did not lose coverage by reason of reaching a lifetime limit on the dollar value of all benefits. For this purpose, any difference in benefits or cost-sharing requirements constitutes a different benefit package. The individual also cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of reaching a lifetime limit on the dollar value of all benefits.

(5) *Examples.* The rules of this paragraph (e) are illustrated by the following examples:

Example 1. (i) *Facts.* Employer *Y* maintains a group health plan with a calendar year plan year. The plan has a single benefit package. For plan years beginning before September 23, 2010, the plan has a lifetime limit on the dollar value of all benefits. Individual *B*, an employee of *Y*, was enrolled in *Y*'s group health plan at the beginning of the 2008 plan year. On June 10, 2008, *B* incurred a claim for benefits that exceeded the lifetime limit under *Y*'s plan and ceased to be enrolled in the plan. *B* is still eligible for coverage under *Y*'s group health plan. On or before January 1, 2011, *Y*'s group health plan gives *B* written notice informing *B* that the lifetime limit on the dollar value of all benefits no longer applies, that individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan, and that individuals can request such enrollment through February 1, 2011 with enrollment effective retroactively to January 1, 2011.

(ii) *Conclusion.* In this *Example 1*, the plan has complied with the requirements of this paragraph (e) by providing a timely written notice and enrollment opportunity to *B* that lasts at least 30 days.

Example 2. (i) *Facts.* Employer *Z* maintains a group health plan with a plan year beginning October 1 and ending September 30. Prior to October 1, 2010, the group health plan has a lifetime limit on the dollar value of all benefits. Individual *D*, an employee of *Z*, and Individual *E*, *D*'s child, were enrolled in family coverage under *Z*'s group health plan for the plan year beginning on October 1, 2008. On May 1, 2009, *E* incurred a claim for benefits that exceeded the lifetime limit

under *Z*'s plan. *D* dropped family coverage but remains an employee of *Z* and is still eligible for coverage under *Z*'s group health plan.

(ii) *Conclusion.* In this *Example 2*, not later than October 1, 2010, the plan must provide *D* and *E* an opportunity to enroll (including written notice of an opportunity to enroll) that continues for at least 30 days, with enrollment effective not later than October 1, 2010.

Example 3. (i) *Facts.* Same facts as *Example 2*, except that *Z*'s plan had two benefit packages (a low-cost and a high-cost option). Instead of dropping coverage, *D* switched to the low-cost benefit package option.

(ii) *Conclusion.* In this *Example 3*, not later than October 1, 2010, the plan must provide *D* and *E* an opportunity to enroll in any benefit package available to similarly situated individuals who enroll when first eligible. The plan would have to provide *D* and *E* the opportunity to enroll in any benefit package available to similarly situated individuals who enroll when first eligible, even if *D* had not switched to the low-cost benefit package option.

Example 4. (i) *Facts.* Employer *Q* maintains a group health plan with a plan year beginning October 1 and ending September 30. For the plan year beginning on October 1, 2009, *Q* has an annual limit on the dollar value of all benefits of \$500,000.

(ii) *Conclusion.* In this *Example 4*, *Q* must raise the annual limit on the dollar value of essential health benefits to at least \$750,000 for the plan year beginning October 1, 2010. For the plan year beginning October 1, 2011, *Q* must raise the annual limit to at least \$1.25 million. For the plan year beginning October 1, 2012, *Q* must raise the annual limit to at least \$2 million. *Q* may also impose a restricted annual limit of \$2 million for the plan year beginning October 1, 2013. After the conclusion of that plan year, *Q* cannot impose an overall annual limit.

Example 5. (i) *Facts.* Same facts as *Example 4*, except that the annual limit for the plan year beginning on October 1, 2009, is \$1 million and *Q* lowers the annual limit for the plan year beginning October 1, 2010 to \$750,000.

(ii) *Conclusion.* In this *Example 5*, *Q* complies with the requirements of this paragraph (e). However, *Q*'s choice to lower its annual limit means that under §147.140(g)(1)(vi)(C), the group health plan will cease to be a grandfathered health plan and will be generally subject to all of the provisions of PHS Act sections 2701 through 2719A.

Example 6. (i) *Facts.* For a policy year that began on October 1, 2009, Individual *T* has individual health insurance coverage with a lifetime limit on the dollar value of all benefits of \$1 million. For the policy year beginning October 1, 2010, the issuer of *T*'s health

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insurance coverage eliminates the lifetime limit and replaces it with an annual limit of \$1 million dollars. In the policy year beginning October 1, 2011, the issuer of *T*'s health insurance coverage maintains the annual limit of \$1 million dollars.

(ii) *Conclusion.* In this *Example 6*, the issuer's replacement of a lifetime limit with an equal dollar annual limit allows it to maintain status as a grandfathered health policy under §147.140(g)(1)(vi)(B). Since grandfathered health plans that are individual health insurance coverage are not subject to the requirements of this section relating to annual limits, the issuer does not have to comply with this paragraph (e).

(f) *Applicability date.* The provisions of this section apply for plan years (in the individual market, for policy years) beginning on or after September 23, 2010. See §147.140 of this part for determining the application of this section to grandfathered health plans (providing that the prohibitions on lifetime and annual limits apply to all grandfathered health plans that are group health plans and group health insurance coverage, including the special rules regarding restricted annual limits, and the prohibition on lifetime limits apply to individual health insurance coverage that is a grandfathered health plan but the rules on annual limits do not apply to individual health insurance coverage that is a grandfathered health plan).

[75 FR 37236, June 28, 2010]

§ 147.128 Rules regarding rescissions.

(a) *Prohibition on rescissions*—(1) A group health plan, or a health insurance issuer offering group or individual health insurance coverage, must not rescind coverage under the plan, or under the policy, certificate, or contract of insurance, with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the plan or coverage, unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage. A group health plan, or a health insurance issuer offering group or indi-

vidual health insurance coverage, must provide at least 30 days advance written notice to each participant (in the individual market, primary subscriber) who would be affected before coverage may be rescinded under this paragraph (a)(1), regardless of, in the case of group coverage, whether the coverage is insured or self-insured, or whether the rescission applies to an entire group or only to an individual within the group. (The rules of this paragraph (a)(1) apply regardless of any contestability period that may otherwise apply.)

(2) For purposes of this section, a rescission is a cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats a policy as void from the time of the individual's or group's enrollment is a rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a rescission for this purpose. A cancellation or discontinuance of coverage is not a rescission if—

(i) The cancellation or discontinuance of coverage has only a prospective effect; or

(ii) The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(3) The rules of this paragraph (a) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *A* seeks enrollment in an insured group health plan. The plan terms permit rescission of coverage with respect to an individual if the individual engages in fraud or makes an intentional misrepresentation of a material fact. The plan requires *A* to complete a questionnaire regarding *A*'s prior medical history, which affects setting the group rate by the health insurance issuer. The questionnaire complies with the other requirements of this part and part 146. The questionnaire includes the following question: "Is there anything else relevant to your health that we should know?" *A* inadvertently fails to list that *A* visited a psychologist on two occasions, six years previously. *A* is later diagnosed with breast cancer and seeks benefits under the plan. On or around the same time, the issuer receives information about *A*'s visits to the psychologist, which was not disclosed in the questionnaire.