

ommended by United States Preventive Services Task Force or to deny coverage for services that are not recommended by such Task Force.

(b) Interval

(1) In general

The Secretary shall establish a minimum interval between the date on which a recommendation described in subsection (a)(1) or (a)(2) or a guideline under subsection (a)(3) is issued and the plan year with respect to which the requirement described in subsection (a) is effective with respect to the service described in such recommendation or guideline.

(2) Minimum

The interval described in paragraph (1) shall not be less than 1 year.

(c) Value-based insurance design

The Secretary may develop guidelines to permit a group health plan and a health insurance issuer offering group or individual health insurance coverage to utilize value-based insurance designs.

(July 1, 1944, ch. 373, title XXVII, §2713, as added Pub. L. 111-148, title I, §1001(5), Mar. 23, 2010, 124 Stat. 131.)

Editorial Notes

PRIOR PROVISIONS

A prior section 300gg-13, act July 1, 1944, ch. 373, title XXVII, §2713, as added Pub. L. 104-191, title I, §102(a), Aug. 21, 1996, 110 Stat. 1966, was renumbered section 2709 of act July 1, 1944, and transferred to section 300gg-9 of this title by Pub. L. 111-148, title I, §§1001(3), 1563(c)(10)(C), formerly §1562(c)(10)(C), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 268, 911.

Another prior section 2713 of act July 1, 1944, was successively renumbered by subsequent acts and transferred, see section 238l of this title.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section effective for plan years beginning on or after the date that is 6 months after Mar. 23, 2010, see section 1004 of Pub. L. 111-148, set out as a note under section 300gg-11 of this title.

RAPID COVERAGE OF PREVENTIVE SERVICES AND VACCINES FOR CORONAVIRUS

Pub. L. 116-136, div. A, title III, §3203, Mar. 27, 2020, 134 Stat. 367, provided that:

“(a) IN GENERAL.—Notwithstanding [section] 2713(b) of the Public Health Service Act (42 U.S.C. 300gg-13[(b)]), the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury shall require group health plans and health insurance issuers offering group or individual health insurance to cover (without cost-sharing) any qualifying coronavirus preventive service, pursuant to section 2713(a) of the Public Health Service Act (42 U.S.C. 300gg-13(a)) (including the regulations under sections 2590.715-2713 of title 29, Code of Federal Regulations, section 54.9815-2713 of title 26, Code of Federal Regulations, and section 147.130 of title 45, Code of Federal Regulations (or any successor regulations)). The requirement described in this subsection shall take effect with respect to a qualifying coronavirus preventive service on the specified date described in subsection (b)(2).

“(b) DEFINITIONS.—For purposes of this section:

“(1) QUALIFYING CORONAVIRUS PREVENTIVE SERVICE.—The term ‘qualifying coronavirus preventive

service’ means an item, service, or immunization that is intended to prevent or mitigate coronavirus disease 2019 and that is—

“(A) an evidence-based item or service that has in effect a rating of ‘A’ or ‘B’ in the current recommendations of the United States Preventive Services Task Force; or

“(B) an immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

“(2) SPECIFIED DATE.—The term ‘specified date’ means the date that is 15 business days after the date on which a recommendation is made relating to the qualifying coronavirus preventive service as described in such paragraph.

“(3) ADDITIONAL TERMS.—In this section, the terms ‘group health plan’, ‘health insurance issuer’, ‘group health insurance coverage’, and ‘individual health insurance coverage’ have the meanings given such terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg-91), section 733 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b), and section 9832 of the Internal Revenue Code [26 U.S.C. 9832], as applicable.”

§ 300gg-14. Extension of dependent coverage

(a) In general

A group health plan and a health insurance issuer offering group or individual health insurance coverage that provides dependent coverage of children shall continue to make such coverage available for an adult child until the child turns 26 years of age. Nothing in this section shall require a health plan or a health insurance issuer described in the preceding sentence to make coverage available for a child of a child receiving dependent coverage.

(b) Regulations

The Secretary shall promulgate regulations to define the dependents to which coverage shall be made available under subsection (a).

(c) Rule of construction

Nothing in this section shall be construed to modify the definition of “dependent” as used in title 26 with respect to the tax treatment of the cost of coverage.

(July 1, 1944, ch. 373, title XXVII, §2714, as added Pub. L. 111-148, title I, §1001(5), Mar. 23, 2010, 124 Stat. 132; amended Pub. L. 111-152, title II, §2301(b), Mar. 30, 2010, 124 Stat. 1082.)

Editorial Notes

PRIOR PROVISIONS

A prior section 2714 of act July 1, 1944, was successively renumbered by subsequent acts and transferred, see section 238m of this title.

AMENDMENTS

2010—Subsec. (a). Pub. L. 111-152 struck out “(who is not married)” after “adult child”.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section effective for plan years beginning on or after the date that is 6 months after Mar. 23, 2010, see section 1004 of Pub. L. 111-148, set out as a note under section 300gg-11 of this title.

§ 300gg-15. Development and utilization of uniform explanation of coverage documents and standardized definitions

(a) In general

Not later than 12 months after March 23, 2010, the Secretary shall develop standards for use by a group health plan and a health insurance issuer offering group or individual health insurance coverage, in compiling and providing to applicants, enrollees, and policyholders or certificate holders a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage. In developing such standards, the Secretary shall consult with the National Association of Insurance Commissioners (referred to in this section as the “NAIC”), a working group composed of representatives of health insurance-related consumer advocacy organizations, health insurance issuers, health care professionals, patient advocates including those representing individuals with limited English proficiency, and other qualified individuals.

(b) Requirements

The standards for the summary of benefits and coverage developed under subsection (a) shall provide for the following:

(1) Appearance

The standards shall ensure that the summary of benefits and coverage is presented in a uniform format that does not exceed 4 pages in length and does not include print smaller than 12-point font.

(2) Language

The standards shall ensure that the summary is presented in a culturally and linguistically appropriate manner and utilizes terminology understandable by the average plan enrollee.

(3) Contents

The standards shall ensure that the summary of benefits and coverage includes—

(A) uniform definitions of standard insurance terms and medical terms (consistent with subsection (g)) so that consumers may compare health insurance coverage and understand the terms of coverage (or exception to such coverage);

(B) a description of the coverage, including cost sharing for—

(i) each of the categories of the essential health benefits described in subparagraphs (A) through (J) of section 18022(b)(1) of this title; and

(ii) other benefits, as identified by the Secretary;

(C) the exceptions, reductions, and limitations on coverage;

(D) the cost-sharing provisions, including deductible, coinsurance, and co-payment obligations;

(E) the renewability and continuation of coverage provisions;

(F) a coverage facts label that includes examples to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions and related cost

sharing, such scenarios to be based on recognized clinical practice guidelines;

(G) a statement of whether the plan or coverage—

(i) provides minimum essential coverage (as defined under section 5000A(f) of title 26); and

(ii) ensures that the plan or coverage share of the total allowed costs of benefits provided under the plan or coverage is not less than 60 percent of such costs;

(H) a statement that the outline is a summary of the policy or certificate and that the coverage document itself should be consulted to determine the governing contractual provisions; and

(I) a contact number for the consumer to call with additional questions and an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.

(c) Periodic review and updating

The Secretary shall periodically review and update, as appropriate, the standards developed under this section.

(d) Requirement to provide

(1) In general

Not later than 24 months after March 23, 2010, each entity described in paragraph (3) shall provide, prior to any enrollment restriction, a summary of benefits and coverage explanation pursuant to the standards developed by the Secretary under subsection (a) to—

(A) an applicant at the time of application;

(B) an enrollee prior to the time of enrollment or reenrollment, as applicable; and

(C) a policyholder or certificate holder at the time of issuance of the policy or delivery of the certificate.

(2) Compliance

An entity described in paragraph (3) is deemed to be in compliance with this section if the summary of benefits and coverage described in subsection (a) is provided in paper or electronic form.

(3) Entities in general

An entity described in this paragraph is—

(A) a health insurance issuer (including a group health plan that is not a self-insured plan) offering health insurance coverage within the United States; or

(B) in the case of a self-insured group health plan, the plan sponsor or designated administrator of the plan (as such terms are defined in section 1002(16) of title 29).

(4) Notice of modifications

If a group health plan or health insurance issuer makes any material modification in any of the terms of the plan or coverage involved (as defined for purposes of section 1022 of title 29) that is not reflected in the most recently provided summary of benefits and coverage, the plan or issuer shall provide notice of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective.