(B) except as provided in paragraph (2), annual limits on the dollar value of benefits for any participant or beneficiary.

(2) Annual limits prior to 2014

With respect to plan years beginning prior to January 1, 2014, a group health plan and a health insurance issuer offering group or individual health insurance coverage may only establish a restricted annual limit on the dollar value of benefits for any participant or beneficiary with respect to the scope of benefits that are essential health benefits under section 18022(b) of this title, as determined by the Secretary. In defining the term ''restricted annual limit'' for purposes of the preceding sentence, the Secretary shall ensure that access to needed services is made available with a minimal impact on premiums.

(b) Per beneficiary limits

Subsection (a) shall not be construed to prevent a group health plan or health insurance coverage from placing annual or lifetime per beneficiary limits on specific covered benefits that are not essential health benefits under section 18022(b) of this title, to the extent that such limits are otherwise permitted under Federal or State law.

(July 1, 1944, ch. 373, title XXVII, § 2711, as added and amended Pub. L. 111–148, title I, § 1001(5), title X, § 10101(a), Mar. 23, 2010, 124 Stat. 131, 883.)

PRIOR PROVISIONS

A prior section 300gg–11, act July 1, 1944, ch. 373, title XXVII, § 2711, as added Pub. L. 104–191, title I, § 102(a), Aug. 21, 1996, 110 Stat. 1962, which related to guaranteed availability of coverage for employers in a group market, was renumbered section 2731 of act July 1, 1944, amended, and transferred to subsecs. (c) and (d) of section 300gg–1 of this title, by Pub. L. 111–148, title I, §§ 1001(3), 1563(c)(8), formerly § 1562(c)(8), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 266, 911.

Another prior section 2711 of act July 1, 1944, was successively renumbered by subsequent acts and transferred, see section 238j of this title.

AMENDMENTS

2010—Pub. L. 111–148, § 10101(a), amended section generally. Prior to amendment, text read as follows:

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish—

''(1) lifetime limits on the dollar value of benefits for any participant or beneficiary; or

''(2) unreasonable annual limits (within the meaning of section 223 of title 26) on the dollar value of benefits for any participant or beneficiary.

''(b) PER BENEFICIARY LIMITS.—Subsection (a) shall not be construed to prevent a group health plan or health insurance coverage that is not required to provide essential health benefits under section 18022(b) of this title from placing annual or lifetime per beneficiary limits on specific covered benefits to the extent that such limits are otherwise permitted under Federal or State law.''

EFFECTIVE DATE

Pub. L. 111–148, title I, § 1004, Mar. 23, 2010, 124 Stat. 140, provided that:

''(a) IN GENERAL.—Except as provided for in subsection (b), this subtitle [subtitle A (§§ 1001–1004) of title I of Pub. L. 111–148, enacting this section and sections 300gg–12 to 300gg–15, 300gg–16 to 300gg–19, 300gg–93, and 300gg–94 of this title, amending former sections 300gg–11 and 300gg–12 of this title and sections 300gg–21 to 300gg–23 of this title, and transferring section 300gg–13 of this title to section 300gg–9 of this title and sections 300gg–4 to 300gg–7 of this title to sections 300gg–25 to 300gg–28 of this title, respectively] (and the amendments made by this subtitle) shall become effective for plan years beginning on or after the date that is 6 months after the date of enactment of this Act [Mar. 23, 2010], except that the amendments made by sections 1002 and 1003 [enacting sections 300gg–93 and 300gg–94 of this title] shall become effective for fiscal years beginning with fiscal year 2010.

''(b) SPECIAL RULE.—The amendments made by sections 1002 and 1003 [enacting sections 300gg–93 and 300gg–94 of this title] shall take effect on the date of enactment of this Act [Mar. 23, 2010].''

§ 300gg–12. Prohibition on rescissions

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with prior notice to the enrollee, and only as permitted under section 300gg–2(b)[1] or 300gg–42(b) of this title.

(July 1, 1944, ch. 373, title XXVII, § 2712, as added Pub. L. 111–148, title I, § 1001(5), Mar. 23, 2010, 124 Stat. 131.)

REFERENCES IN TEXT

Section 300gg–2(b) of this title, referred to in text, was in the original a reference to section ''2702(c)'' of act July 1, 1944, which was translated as meaning section 2703(b) of act July 1, 1944, to reflect the probable intent of Congress. Section 2702(c), which is classified to section 300gg–1 of this title, relates to special rules for network plans, while section 2703(b) specifies the reasons for which a health insurance issuer may nonrenew or discontinue health insurance coverage offered in connection with a health insurance coverage offering in the group or individual market. Section 300gg–2(b) also parallels section 300gg–42(b) which appears in the same context in this section as the reference to section 300gg–2(b).

PRIOR PROVISIONS

A prior section 300gg–12, act July 1, 1944, ch. 373, title XXVII, § 2712, as added Pub. L. 104–191, title I, § 102(a), Aug. 21, 1996, 110 Stat. 1964, which related to guaranteed renewability of coverage for employers in a group market, was renumbered section 2732 of act July 1, 1944, amended, and transferred to subsecs. (b) to (e) of section 300gg–2 of this title, by Pub. L. 111–148, title I, §§ 1001(3), 1563(c)(9), formerly § 1562(c)(9), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 267, 911.

Another prior section 2712 of act July 1, 1944, was successively renumbered by subsequent acts and transferred, see section 238k of this title.

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.

[1] See References in Text note below.

§ 300gg–13. Coverage of preventive health services

(a) In general

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for—

(1) evidence-based items or services that have in effect a rating of ''A'' or ''B'' in the current recommendations of the United States Preventive Services Task Force;

(2) immunizations that have 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; and[1]

(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.[2]

(4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.[2]

(5) for the purposes of this chapter, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

Nothing in this subsection shall be construed to prohibit a plan or issuer from providing coverage for services in addition to those recommended 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.)

[1] So in original. The word ''and'' probably should not appear.

[2] So in original. The period probably should be a semicolon.

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 238*l* of this title.

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–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.)

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''.

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