### § 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

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.

**(e) Preemption**

The standards developed under subsection (a) shall preempt any related State standards that require a summary of benefits and coverage that provides less information to consumers than that required to be provided under this section, as determined by the Secretary.

**(f) Failure to provide**

An entity described in subsection (d)(3) that willfully fails to provide the information required under this section shall be subject to a fine of not more than $1,000 for each such fail-

ure. Such failure with respect to each enrollee shall constitute a separate offense for purposes of this subsection.

**(g) Development of standard definitions**

**(1) In general**

The Secretary shall, by regulation, provide for the development of standards for the definitions of terms used in health insurance coverage, including the insurance-related terms described in paragraph (2) and the medical terms described in paragraph (3).

**(2) Insurance-related terms**

The insurance-related terms described in this paragraph are premium, deductible, co-insurance, co-payment, out-of-pocket limit, preferred provider, non-preferred provider, out-of-network co-payments, UCR (usual, customary and reasonable) fees, excluded services, grievance and appeals, and such other terms as the Secretary determines are important to define so that consumers may compare health insurance coverage and understand the terms of their coverage.

**(3) Medical terms**

The medical terms described in this paragraph are hospitalization, hospital outpatient care, emergency room care, physician services, prescription drug coverage, durable medical equipment, home health care, skilled nursing care, rehabilitation services, hospice services, emergency medical transportation, and such other terms as the Secretary determines are important to define so that consumers may compare the medical benefits offered by health insurance and understand the extent of those medical benefits (or exceptions to those benefits).

(July 1, 1944, ch. 373, title XXVII, §2715, as added and amended Pub. L. 111–148, title I, §1001(5), title X, §10101(b), Mar. 23, 2010, 124 Stat. 132, 884.)

AMENDMENTS

2010—Subsec. (a). Pub. L. 111–148, §10101(b), substituted ''and providing to applicants, enrollees, and policyholders or certificate holders'' for ''and providing to enrollees''.

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–15a. Provision of additional information

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall comply with the provisions of section 18031(e)(3) of this title, except that a plan or coverage that is not offered through an Exchange shall only be required to submit the information required to the Secretary and the State insurance commissioner, and make such information available to the public.

(July 1, 1944, ch. 373, title XXVII, §2715A, as added Pub. L. 111–148, title X, §10101(c), Mar. 23, 2010, 124 Stat. 884.)

## § 300gg–16. Prohibition on discrimination in favor of highly compensated individuals

**(a) In general**

A group health plan (other than a self-insured plan) shall satisfy the requirements of section 105(h)(2) of title 26 (relating to prohibition on discrimination in favor of highly compensated individuals).

**(b) Rules and definitions**

For purposes of this section—

**(1) Certain rules to apply**

Rules similar to the rules contained in paragraphs (3), (4), and (8) of section 105(h) of title 26 shall apply.

**(2) Highly compensated individual**

The term ''highly compensated individual'' has the meaning given such term by section 105(h)(5) of title 26.

(July 1, 1944, ch. 373, title XXVII, §2716, as added and amended Pub. L. 111–148, title I, §1001(5), title X, §10101(d), Mar. 23, 2010, 124 Stat. 135, 884.)

AMENDMENTS

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

''(a) IN GENERAL.—The plan sponsor of a group health plan (other than a self-insured plan) may not establish rules relating to the health insurance coverage eligibility (including continued eligibility) of any full-time employee under the terms of the plan that are based on the total hourly or annual salary of the employee or otherwise establish eligibility rules that have the effect of discriminating in favor of higher wage employees.

''(b) LIMITATION.—Subsection (a) shall not be construed to prohibit a plan sponsor from establishing contribution requirements for enrollment in the plan or coverage that provide for the payment by employees with lower hourly or annual compensation of a lower dollar or percentage contribution than the payment required of similarly situated employees with a higher hourly or annual compensation.''

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–17. Ensuring the quality of care

**(a) Quality reporting**

**(1) In general**

Not later than 2 years after March 23, 2010, the Secretary, in consultation with experts in health care quality and stakeholders, shall develop reporting requirements for use by a group health plan, and a health insurance issuer offering group or individual health insurance coverage, with respect to plan or coverage benefits and health care provider reimbursement structures that—

(A) improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model as defined for purposes of section 3602[1] of the Patient Protection and

[1] See References in Text note below.