§ 156.125 Review of coverage determination.

(a) An issuer must review a request for exception based on exigent circumstances and notify the enrollee or the enrollee’s designee and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than 24 hours after it receives the request.

(i) A health plan that grants an exception based on exigent circumstances must provide coverage of the non-formulary drug for the duration of the exigency.

(ii) For other than self-only coverage—twice the dollar limit for self-only coverage described in paragraph (a)(2)(i) of this section.

(b) [Reserved]

§ 156.125 Prohibition on discrimination.

(a) An issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual’s age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.

(b) An issuer providing EHB must comply with the requirements of §156.200(e) of this subchapter; and

(c) Nothing in this section shall be construed to prevent an issuer from appropriately utilizing reasonable medical management techniques.

§ 156.130 Cost-sharing requirements.

(a) Annual limitation on cost sharing.

(1) For a plan year beginning in the calendar year 2014, cost sharing may not exceed the following:

(i) For self-only coverage—the annual dollar limit as described in section 223(c)(2)(A)(I) of the Internal Revenue Code of 1986 as amended, for self-only coverage that is in effect for 2014; or

(ii) For other than self-only coverage—the annual dollar limit in section 223(c)(2)(A)(II) of the Internal Revenue Code of 1986 as amended, for non-self-only coverage that is in effect for 2014.

(2) For a plan year beginning in a calendar year after 2014, cost sharing may not exceed the following:

(i) For self-only coverage—the dollar limit for calendar year 2014 increased by an amount equal to the product of that amount and the premium adjustment percentage, as defined in paragraph (e) of this section.

(ii) For other than self-only coverage—twice the dollar limit for self-only coverage described in paragraph (a)(2)(i) of this section.

(b) [Reserved]

(c) Special rule for network plans. In the case of a plan using a network of providers, cost-sharing paid by, or on behalf of, an enrollee for benefits provided outside of such network shall not count toward the annual limitation on cost-sharing (as defined in paragraph (a) of this section).

(d) Increase annual dollar limits in multiples of 50. For a plan year beginning in a calendar year after 2014, any increase in the annual dollar limits described in paragraph (a) of this section that does not result in a multiple of 50 dollars will be rounded down, to the next lowest multiple of 50 dollars.

(e) Premium adjustment percentage. The premium adjustment percentage is the percentage (if any) by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance for 2013. HHS will publish the annual premium adjustment percentage in the annual HHS notice of benefits and payment parameters.

(f) Coordination with preventive limits. Nothing in this subpart is in derogation of the requirements of §147.130 of this subchapter.

(g) Coverage of emergency department services. Emergency department services must be provided as follows:

(1) Without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services is out of network that is more restrictive than the requirements or limitations that apply to emergency department services received in network; and

(2) If such services are provided out-of-network, cost-sharing must be limited as provided in §147.138(b)(3) of this subchapter.