

§ 147.145

Example 11. (i) *Facts.* A group health plan that is a grandfathered health plan and also a high deductible health plan within the meaning of section 223(c)(2) of the Internal Revenue Code had a \$2,400 deductible for family coverage on March 23, 2010. The plan is subsequently amended after June 15, 2021 to increase the deductible limit by the amount that is necessary to comply with the requirements for a plan to qualify as a high deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code, but that exceeds the maximum percentage increase.

(ii) *Conclusion.* In this *Example 11*, the increase in the deductible at that time does not cause the plan to cease to be a grandfathered health plan because the increase was necessary for the plan to continue to satisfy the definition of a high deductible health plan under section 223(c)(2)(A) of the Internal Revenue Code.

[80 FR 72289, Nov. 18, 2015, as amended at 85 FR 81120, Dec. 15, 2020]

§ 147.145 Student health insurance coverage.

(a) *Definition.* Student health insurance coverage is a type of individual health insurance coverage (as defined in §144.103 of this subchapter) that is provided pursuant to a written agreement between an institution of higher education (as defined in the Higher Education Act of 1965) and a health insurance issuer, and provided to students enrolled in that institution of higher education and their dependents, that meets the following conditions:

(1) Does not make health insurance coverage available other than in connection with enrollment as a student (or as a dependent of a student) in the institution of higher education.

(2) Does not condition eligibility for the health insurance coverage on any health status-related factor (as defined in §146.121(a) of this subchapter) relating to a student (or a dependent of a student).

(3) Meets any additional requirement that may be imposed under State law.

(b) *Exemptions from the Public Health Service Act and the Affordable Care Act—*

(1) *Guaranteed availability and guaranteed renewability.* (i) For purposes of sections 2741(e)(1) and 2742(b)(5) of the Public Health Service Act, student health insurance coverage is deemed to be available only through a bona fide association.

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(ii) For purposes of section 2702 of the Public Health Service Act, a health insurance issuer that offers student health insurance coverage is not required to accept individuals who are not students or dependents of students in such coverage, and, notwithstanding the requirements of §147.104(b), is not required to establish open enrollment periods or coverage effective dates that are based on a calendar policy year or to offer policies on a calendar year basis.

(iii) For purposes of section 2703(a) of the Public Health Service Act, a health insurance issuer that offers student health insurance coverage is not required to renew or continue in force coverage for individuals who are no longer students or dependents of students.

(2) *Levels of coverage.* The requirement to provide a specific level of coverage described in section 1302(d) of the Affordable Care Act does not apply to student health insurance coverage for policy years beginning on or after July 1, 2016. However, the benefits provided by such coverage must provide at least 60 percent actuarial value, as calculated in accordance with §156.135 of this subchapter. The issuer must specify in any plan materials summarizing the terms of the coverage the actuarial value and level of coverage (or next lowest level of coverage) the coverage would otherwise satisfy under §156.140 of this subchapter.

(3) *Single risk pool.* Student health insurance coverage is not subject to the requirements of section 1312(c) of the Affordable Care Act. A health insurance issuer that offers student health insurance coverage may establish one or more separate risk pools for an institution of higher education, if the distinction between or among groups of students (or dependents of students) who form the risk pool is based on a bona fide school-related classification and not based on a health factor (as described in §146.121 of this subchapter). However, student health insurance rates must reflect the claims experience of individuals who comprise the risk pool, and any adjustments to rates within a risk pool must be actuarially justified.

(c) *Student administrative health fees—*
 (1) *Definition.* A student administrative health fee is a fee charged by the institution of higher education on a periodic basis to students of the institution of higher education to offset the cost of providing health care through health clinics regardless of whether the students utilize the health clinics or enroll in student health insurance coverage.

(2) *Preventive services.* Notwithstanding the requirements under section 2713 of the Public Health Service Act and its implementing regulations, student administrative health fees as defined in paragraph (c)(1) of this section are not considered cost-sharing requirements with respect to specified recommended preventive services.

[77 FR 16468, Mar. 21, 2012, as amended at 78 FR 13439, Feb. 27, 2013; 79 FR 13834, Mar. 11, 2014; 81 FR 12334, Mar. 8, 2016]

§ 147.150 Coverage of essential health benefits.

(a) *Requirement to cover the essential health benefits package.* A health insurance issuer offering health insurance coverage in the individual or small group market must ensure that such coverage includes the essential health benefits package as defined in section 1302(a) of the Affordable Care Act effective for plan or policy years beginning on or after January 1, 2014.

(b) *Cost-sharing under group health plans.* [Reserved]

(c) *Child-only plans.* If a health insurance issuer offers health insurance coverage in any level of coverage specified under section 1302(d)(1) of the Affordable Care Act, the issuer must offer coverage in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21.

[78 FR 12865, Feb. 25, 2013]

§ 147.160 Parity in mental health and substance use disorder benefits.

(a) *In general.* The provisions of § 146.136 of this subchapter apply to health insurance coverage offered by health insurance issuer in the individual market in the same manner and to the same extent as such provisions apply to health insurance coverage offered by a health insurance issuer in

connection with a group health plan in the large group market.

(b) *Applicability date.* The provisions of this section apply for policy years beginning on or after the applicability dates set forth in § 146.136(i) of this subchapter. This section applies to non-grandfathered and grandfathered health plans as defined in § 147.140.

[78 FR 68296, Nov. 13, 2013]

§ 147.200 Summary of benefits and coverage and uniform glossary.

(a) *Summary of benefits and coverage—*
 (1) *In general.* A group health plan (and its administrator as defined in section 3(16)(A) of ERISA), and a health insurance issuer offering group or individual health insurance coverage, is required to provide a written summary of benefits and coverage (SBC) for each benefit package without charge to entities and individuals described in this paragraph (a)(1) in accordance with the rules of this section.

(i) *SBC provided by a group health insurance issuer to a group health plan—*
 (A) *Upon application.* A health insurance issuer offering group health insurance coverage must provide the SBC to a group health plan (or its sponsor) upon application for health coverage, as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application. If an SBC was provided before application pursuant to paragraph (a)(1)(i)(D) of this section (relating to SBCs upon request), this paragraph (a)(1)(i)(A) is deemed satisfied, provided there is no change to the information required to be in the SBC. However, if there has been a change in the information required, a new SBC that includes the changed information must be provided upon application pursuant to this paragraph (a)(1)(i)(A).

(B) *By first day of coverage (if there are changes).* If there is any change in the information required to be in the SBC that was provided upon application and before the first day of coverage, the issuer must update and provide a current SBC to the plan (or its sponsor) no later than the first day of coverage.

(C) *Upon renewal, reissuance, or re-enrollment.* If the issuer renews or reissues a policy, certificate, or contract of insurance for a succeeding policy