(i) *Notice of renewal of coverage.* If an issuer is renewing grandfathered coverage as described in paragraph (b) of this section, or uniformly modifying grandfathered coverage as described in paragraph (g) of this section, the issuer must provide to each individual written notice of the renewal at least 60 calendar days before the date the coverage will be renewed in a form and manner specified by the Secretary.

(Approved by the Office of Management and Budget under control number 0938–0703)

[62 FR 16998, Apr. 8, 1997; 62 FR 31696, June 10, 1997, as amended at 62 FR 35906, July 2, 1997; 79 FR 30340, May 27, 2014; 79 FR 42986, July 24, 2014; 79 FR 53004, Sept. 5, 2014; 81 FR 94174, Dec. 22, 2016; 84 FR 17561, Apr. 25, 2019]

§ 148.124 Certification and disclosure of coverage.

(a) *General rule.* The rules for providing certificates of creditable coverage and demonstrating creditable coverage have been superseded by the prohibition on preexisting condition exclusions. *See* § 147.108 of this subchapter for rules prohibiting the imposition of a preexisting condition exclusion.

(b) *Applicability.* The provisions of this section apply beginning December 31, 2014.

[79 FR 30341, May 27, 2014]

§ 148.126 Determination of an eligible individual.

The rules for guaranteeing the availability of individual health insurance coverage to certain eligible individuals with prior group coverage have been superseded by the requirements of § 147.104 of this subchapter, which set forth Federal requirements for guaranteed availability of coverage in the group and individual markets.

[79 FR 30341, May 27, 2014]

§ 148.128 State flexibility in individual market reforms—alternative mechanisms.

The rules for a State to implement an acceptable alternative mechanism for purposes of guaranteeing the availability of individual health insurance coverage to certain eligible individuals with prior group coverage have been superseded by the requirements of § 147.104 of this subchapter, which set forth Federal requirements for guaranteed availability of coverage in the group and individual markets.

[79 FR 30341, May 27, 2014]

Subpart C—Requirements Related to Benefits

§ 148.170 Standards relating to benefits for mothers and newborns.

(a) *Hospital length of stay*—(1) *General rule.* Except as provided in paragraph (a)(5) of this section, an issuer offering health insurance coverage in the individual market that provides benefits for a hospital length of stay in connection with childbirth for a mother or her newborn may not restrict benefits for the stay to less than—

(i) 48 hours following a vaginal delivery; or

(ii) 96 hours following a delivery by cesarean section.

(2) *When stay begins*—(i) *Delivery in a hospital.* If delivery occurs in a hospital, the hospital length of stay for the mother or newborn child begins at the time of delivery (or in the case of multiple births, at the time of the last delivery).

(ii) *Delivery outside a hospital.* If delivery occurs outside a hospital, the hospital length of stay begins at the time the mother or newborn is admitted as a hospital inpatient in connection with childbirth. The determination of whether an admission is in connection with childbirth is a medical decision to be made by the attending provider.

(3) *Examples.* The rules of paragraphs (a)(1) and (2) of this section are illustrated by the following examples. In each example, the issuer provides benefits for hospital lengths of stay in connection with childbirth and is subject to the requirements of this section, as follows:

Example 1. (i) *Facts.* A pregnant woman covered under a policy issued in the individual market goes into labor and is admitted to the hospital at 10 p.m. on June 11. She gives birth by vaginal delivery at 6 a.m. on June 12.

(ii) *Conclusion.* In this *Example 1*, the 48-hour period described in paragraph (a)(1)(i) of this section ends at 6 a.m. on June 14.