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Reg. Section 54.9815-2711(d)(2)(ii)(D)

No lifetime or annual limits

(a) Prohibition.

(1) Lifetime limits. Except as provided in paragraph (b) of this section, a group health plan, or a health insurance issuer offering group health insurance coverage, may not establish any lifetime limit on the dollar amount of essential health benefits for any individual, whether provided in-network or out-of-network.

(2) Annual limits.

(i) General rule. Except as provided in paragraphs (a)(2)(ii) and (b) of this section, a group health plan, or a health insurance issuer offering group health insurance coverage, may not establish any annual limit on the dollar amount of essential health benefits for any individual, whether provided in-network or out-of-network.

(ii) Exception for health flexible spending arrangements. A health flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code) offered through a cafeteria plan pursuant to section 125 of the Internal Revenue Code is not subject to the requirement in paragraph (a)(2)(i) of this section.

(b) Construction.

(1) Permissible limits on specific covered benefits. The rules of this section do not prevent a group health plan, or a health insurance issuer offering group health insurance coverage, from placing annual or lifetime dollar limits with respect to any individual on specific covered benefits that are not essential health benefits to the extent that such limits are otherwise permitted under applicable Federal or State law. (The scope of essential health benefits is addressed in paragraph (c) of this section).

(2) Condition-based exclusions. The rules of this section do not prevent a group health plan, or a health insurance issuer offering group health insurance coverage, from excluding all benefits for a condition. However, if any benefits are provided for a condition, then the requirements of this section apply. Other requirements of Federal or State law may require coverage of certain benefits.

(c) Definition of essential health benefits. The term "essential health benefits" means essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations. For this purpose, a group health plan or a health insurance issuer that is not required to provide essential health benefits under section 1302(b) must define "essential health benefits" in a manner that is consistent with-

(1) One of the EHB-benchmark plans applicable in a State under 45 CFR 156.110, and includes coverage of any additional required benefits that are considered essential health benefits consistent with 45 CFR 155.170(a)(2); or

(2) One of the three Federal Employees Health Benefits Program (FEHBP) plan options as defined by 45 CFR 156.100(a)(3), supplemented, as necessary, to meet the standards in 45 CFR 156.110.

(d) Special rule for health reimbursement arrangements (HRAs) and other account-based plans.

(1) In general. If an HRA or other account-based plan is integrated with other coverage under a group health plan and the other group health plan coverage alone satisfies the requirements in paragraph (a)(2) of this section, the fact that the benefits under the HRA or other account-based plan are limited does not mean that the HRA or other account-based plan fails to meet the requirements of paragraph (a)(2) of this section. Similarly, if an HRA or other account-based plan is integrated with other coverage under a group health plan and the other group health plan coverage alone satisfies the requirements in PHS Act section 2713 and section 54.9815-2713(a)(1), the HRA or other account-based plan will not fail to meet the requirements of PHS Act section 2713 and §54.9815-2713(a)(1).

(2) Integration requirements. An HRA or other account-based plan is integrated with a group health plan for purposes of paragraph (a)(2) of this section if it meets the requirements under either the integration method set forth in paragraph (d)(2)(i) of this section or the integration method set forth in paragraph (d)(2)(ii) of this section. Integration does not require that the HRA (or other account-based plan) and the group health plan with which it is integrated share the same plan sponsor, the same plan document, or governing instruments, or file a single Form 5500, if applicable. The term "excepted benefits" is used throughout the integration methods; for a definition of the term "excepted benefits" see Code section 9832(c), ERISA section 733(c), and PHS Act section 2791(c).

(i) Integration Method: Minimum value not required. An HRA or other account-based plan is integrated with another group health plan for purposes of this paragraph if:

(A) The plan sponsor offers a group health plan (other than the HRA or other account-based plan) to the employee that does not consist solely of excepted benefits;

(B) The employee receiving the HRA or other account-based plan is actually enrolled in a group health plan (other than the HRA or other account-based plan) that does not consist solely of excepted benefits, regardless of whether the plan is offered by the same plan sponsor (referred to as non-HRA group coverage);

(C) The HRA or other account-based plan is available only to employees who are enrolled in non-HRA group coverage, regardless of whether the non-HRA group coverage is offered by the plan sponsor of the HRA or other account-based plan (for example, the HRA may be offered only to employees who do not enroll in an employer's group health plan but are

enrolled in other non-HRA group coverage, such as a group health plan maintained by the employer of the employee's spouse);

(D) The benefits under the HRA or other account-based plan are limited to reimbursement of one or more of the following-co-payments, co-insurance, deductibles, and premiums under the non-HRA group coverage, as well as medical care (as defined under section 213(d) of the Code) that does not constitute essential health benefits as defined in paragraph (c) of this section; and

(E) Under the terms of the HRA or other account-based plan, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based plan at least annually and, upon termination of employment, either the remaining amounts in the HRA or other account-based plan are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based plan.

(ii) Integration Method: Minimum value required. An HRA or other account-based plan is integrated with another group health plan for purposes of this paragraph if:

(A) The plan sponsor offers a group health plan (other than the HRA or other account-based plan) to the employee that provides minimum value pursuant to Code section 36B(c)(2)(C)(ii) (and its implementing regulations and applicable guidance);

(B) The employee receiving the HRA or other account-based plan is actually enrolled in a group health plan that provides minimum value pursuant to section 36B(c)(2)(C)(ii) of the Code (and applicable guidance), regardless of whether the plan is offered by the plan sponsor of the HRA or other account-based plan (referred to as non-HRA MV group coverage);

(C) The HRA or other account-based plan is available only to employees who are actually enrolled in non-HRA MV group coverage, regardless of whether the non-HRA MV group coverage is offered by the plan sponsor of the HRA or other account-based plan (for example, the HRA may be offered only to employees who do not enroll in an employer's group health plan but are enrolled in other non-HRA MV group coverage, such as a group health plan maintained by an employer of the employee's spouse); and



(D) Under the terms of the HRA or other account-based plan, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based plan at least annually, and, upon termination of employment, either the remaining amounts in the HRA or other account-based plan are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based plan.

(3) Forfeiture. For purpose of integration under paragraphs (d)(2)(i)(E) and (d)(2)(ii)(D) of this section, forfeiture or waiver occurs even if the forfeited or waived amounts may be reinstated upon a fixed date, a participant's death, or the earlier of the two events (the reinstatement event). For this purpose coverage under an HRA or other account-based plan is considered forfeited or waived prior to a reinstatement event only if the participant's election to forfeit or waive is irrevocable, meaning that, beginning on the effective date of the election and through the date of the reinstatement event, the participant and the participant's beneficiaries have no access to amounts credited to the HRA or other account-based plan. This means that upon and after reinstatement, the reinstated amounts under the HRA or other account-based plan may not be used to reimburse or pay medical expenses incurred during the period after forfeiture and prior to reinstatement.

(4) No integration with individual market coverage. A group health plan, including an HRA or other account-based plan, used to purchase coverage on the individual market is not integrated with that individual market coverage for purposes of paragraph (a)(2) of this section (or for purposes of the requirements of PHS Act section 2713).

(5) Integration with Medicare parts B and D. For employers that are not required to offer their non-HRA group health plan coverage to employees who are Medicare beneficiaries, an HRA or other account-based plan that may be used to reimburse premiums under Medicare part B or D may be integrated with Medicare (and deemed to comply with PHS Act sections 2711 and 2713) if the following requirements are satisfied with respect to employees who would be eligible for the employer's non-HRA group health plan but for their eligibility for Medicare (and the integration rules under paragraphs (d)(2)(i) and (ii) of this section continue to apply to employees who are not eligible for Medicare):

(i) The plan sponsor offers a group health plan (other than the HRA or other account-based plan and that does not consist solely of excepted benefits) to employees who are not eligible for Medicare;

(ii) The employee receiving the HRA or other account-based plan is actually enrolled Medicare part B or D;

(iii) The HRA or other account-based plan is available only to employees who are enrolled in Medicare part B or D; and

(iv) The HRA or other account-based plan complies with paragraphs (d)(2)(i)(E) and (d)(2)(ii)(D) of this section.

(6) Account-based plan. An account-based plan for purposes of this section is an employer-provided group health plan that provides reimbursements of medical expenses other than individual market policy premiums with the reimbursement subject to a maximum fixed dollar amount for a period. An HRA is a type of account-based plan.

(e) Applicability date. The provisions of this section are applicable to group health plans and health insurance issuers for plan years beginning on or after January 1, 2017. Until the applicability date for this regulation, plans and issuers are required to continue to comply with

the interim final regulations promulgated by the Department of Labor at 29 CFR part 2590, contained in the 29 CFR, parts 1927 to end, edition revised as of July 1, 2015.