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or the enrollee's prescribing physician (or other prescriber) to request a standard review of a decision that a drug is not covered by the plan.

(ii) A health plan must make its determination on a standard exception 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 72 hours following receipt of the request.

(iii) A health plan that grants a standard exception request must provide coverage of the non-formulary drug for the duration of the prescription, including refills.

(2) *Expedited exception request.* (i) A health plan must have a process for an enrollee, the enrollee's designee, or the enrollee's prescribing physician (or other prescriber) to request an expedited review based on exigent circumstances.

(ii) Exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug.

(iii) A health plan must make its coverage determination on an expedited review request 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 following receipt of the request.

(iv) 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.

(3) *External exception request review.* For plans years beginning on or after January 1, 2016:

(i) If the health plan denies a request for a standard exception under paragraph (c)(1) of this section or for an expedited exception under paragraph (c)(2) of this section, the health plan must have a process for the enrollee, the enrollee's designee, or the enrollee's prescribing physician (or other prescriber) to request that the original exception request and subsequent denial of such request be reviewed by an independent review organization.

(ii) A health plan must make its determination on the external exception request 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 72 hours following its receipt of the request, if the original request was a standard exception request under paragraph (c)(1) of this section, and no later than 24 hours following its receipt of the request, if the original request was an expedited exception request under paragraph (c)(2) of this section.

(iii) If a health plan grants an external exception review of a standard exception request, the health plan must provide coverage of the non-formulary drug for the duration of the prescription. If a health plan grants an external exception review of an expedited exception request, the health plan must provide coverage of the non-formulary drug for the duration of the exigency.

(d)(1) For plan years beginning on or after January 1, 2016, a health plan must publish an up-to-date, accurate, and complete list of all covered drugs on its formulary drug list, including any tiering structure that it has adopted and any restrictions on the manner in which a drug can be obtained, in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Exchange, HHS, the U.S. Office of Personnel Management, and the general public. A formulary drug list is easily accessible when:

(i) It can be viewed on the plan's public Web site through a clearly identifiable link or tab without requiring an individual to create or access an account or enter a policy number; and

(ii) If an issuer offers more than one plan, when an individual can easily discern which formulary drug list applies to which plan.

(2) A QHP in the Federally-facilitated Exchange must make available the information described in paragraph (d)(1) of this section on its Web site in an HHS-specified format and also submit this information to HHS, in a format and at times determined by HHS.

Submitted by Charles Storrow, ICSE Partners, LLP on behalf of Express Scripts, Inc.

(e) For plan years beginning on or after January 1, 2017, a health plan providing essential health benefits must have the following access procedures:

(1) A health plan must allow enrollees to access prescription drug benefits at in-network retail pharmacies, unless:

(i) The drug is subject to restricted distribution by the U.S. Food and Drug Administration; or

(ii) The drug requires special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy.

(2) A health plan may charge enrollees a different cost-sharing amount for obtaining a covered drug at a retail pharmacy, but all cost sharing will count towards the plan's annual limitation on cost sharing under §156.130 and must be accounted for in the plan's actuarial value calculated under §156.135.

[78 FR 12866, Feb. 25, 2013, as amended at 79 FR 30350, May 27, 2014; 80 FR 10871, Feb. 27, 2015]

§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)(ii)(I) of the Internal Revenue Code of 1986 as amended, for self-only coverage that 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)(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 is not required to 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