The Florida Office of Insurance Regulation (Office) has developed the following worksheet to assist companies making PPACA (Patient Protection and Affordable Care Act)-compliant form filings. The Office encourages companies to download, complete, scan and upload this form as a part of the form filing submitted to the O682ffice via I-File. This will expedite the review process and increase speed to market. This worksheet will be updated on a continuing basis as additional federal guidance is issued. You are encouraged to use the most recently updated version. The worksheet may not contain all of the PPACA requirements The Office offers this worksheet as guidance only, and should not be considered a directive by the Office.

HMO Individual Contract Worksheet
Florida Provisions (Blue); ACA Provisions (Red)
Legend: CMS=Centers for Medicare & Medicaid Services; EHB=Essential Health Benefits; FEDVIP=Federal Employee Dental and Vision Insurance Program; FR=Federal Register; GP=Grandfathered Plan; NGP=Non-grandfathered Plan; PHSA=Public Health Service Act; QHP=Qualified Health Plan;

Statute/Rule	Description	Yes	No	N/A	Page #
69O-191.051	Review filings for correct product codes, properly completed UDL, inclusion of all required documents for a complete review and other requirements. Incorrect product codes and incomplete filings will be returned as incomplete with a letter of explanation.				
69O-191.051	Required information to be submitted within the filing.				
69O-191.051	Provide form number(s), date(s) of approval, Florida file number(s), (e.g. HMO 12-23456), and type of coverage of all policies or other related forms to be used or issued in connection with the form(s) submitted.				
69O-191.051(2)	All contracts and related forms shall contain a unique form number in the lower left corner.				
641.3104	Individual (or non-group) contracts to be executed by facsimile signature of an officer, attorney in fact, employee or representative duly authorized by the HMO.				
	Required Policy Contents				
69O-191.033(1)(j) 69O-191.039(17)	Access to services. The contract shall state where and in what manner the comprehensive healthcare services may be obtained. The names, addresses and phone numbers of physicians, clinics, hospitals, etc. must be provided to subscribers.				
PPACA 1001 PHSA 2711 CFR 147.126 CFR 147.140	Annual and lifetime limits. Plans may not establish lifetime or annual limits on the dollar value of essential health benefits (EHB). Plans may still impose annual and lifetime limits on specific covered benefits that are not EHB. (Lifetime limits apply to all plans, including GP. Annual limits apply to all plans except individual GP). Issuers are not prohibited from excluding all benefits for a condition. However, if any benefits are provided for a condition, then the provisions related to annual and lifetime limits apply. Other requirements of Federal or State law may require coverage of certain benefits. Individual health insurance coverage that on March 23, 2010, did not impose an overall annual or lifetime limit on the dollar value of all benefits ceases to be a GP if the plan or health insurance coverage imposes an overall annual limit on the dollar value of benefits.				

682 69O-191.033(1)(t)	Arbitration. If included, arbitration must be on a voluntary basis. Two or more parties 'may' agree in writing; cannot have binding arbitration in				
CFR 147.140(a)(2)	Benefit and plan description/statements required to be in a GP. P lan materials provided to an insured or subscriber must describe the benefits provided under the plan, identify the plan as a "grandfathered health plan" within the meaning of PPACA Section 1251 and include contact information for questions or complaints. The following model language may be used: *"This health plan believes this coverage is a PPACA grandfathered health plan. As permitted by the ACA, a grandfathered health plan means that your plan may not include certain consumer protections of the ACA that apply to other plans, for example, the requirements for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the ACA, for example, the elimination of lifetime limits on benefits.* *Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact info]. [For individual policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov]"*				
641.31(3)(b)	Change in rates: A change in rates requires at least 30-days advance written notice to the subscriber.				
641.312	Claims procedures. Comply with Office rules administering the NAIC Uniform Health Carrier External Review Model Act, (April 2010), unless HMO contract is subject to the Subscriber Assistance Program under s. 408.7056, F.S., or provides the types of benefits or coverages provided under s. 627.6561(5)(b)-(e), F.S., issued in any market. See internal grievance and external review under "Grievance procedures," below.				
627.4235 641.31(7) 69O-191.033(1)(q) 69O-191.039(10)	Coordination of benefits. A HMO is entitled to coordinate benefits on the same basis as an insurer under s. 627.4235. Under s. 627.4235, the contract must contain a coordination of benefits provision.				

641.19(5) 641.31(4), (12), (36) 69O-191.033(1)(g) 69O-191.035 69O-191.039(16)	"Copayment" means a specific dollar amount, except as otherwise provided for by statute, that the subscriber must pay upon receipt of covered health care services. Copayments may not be established in an amount that will prevent a person from receiving a covered service or benefit as specified in the subscriber contract approved by the office. Group and non-group subscriber contracts shall include all elements contained in this section: co-payment features, if any. The contract shall clearly define the co-payment required to be paid by the subscriber/member. The contract shall clearly define any cost sharing features, the financial responsibility of the subscriber/member, and how the subscriber/member obligation is determined. In the case of a high deductible contract, as defined in Section 641.20185, F.S., the deductible established under the contract must be satisfied before the application of any co-payments.				
PPACA 1302(c) PHSA 2707 CFR 156.130(a)(2) 80 FR 10824-25	Cost-sharing annual limits. For the 2016 Plan Year, all NGP group health plans must adopt an annual cost sharing limit for covered, in-network essential health benefits as follows: • **for self-only coverage, $6,850.** • **for other than self-only coverage, $13,700.** Beginning in PY 2016, self-only limits are embedded into family plans—the limit for self-only coverage applies to all individuals regardless of whether the individual is covered by a self-only plan or is covered by a plan that is other than self-only. In both of these cases, an individual's cost sharing for EHB may never exceed the self-only annual limitation on cost sharing.				

PPACA 1402(a)-(c) CFR 155.305(g)(2) CFR 155.410	Cost sharing reduced for Essential Health Benefits provided by a QHP. (Reduced cost-sharing does not apply to group plans.) For self-only coverage for an eligible insured with • household income between 100-200% FPL, $2,250 • household income between 200-250% FPL, $5,450 For other than self-only coverage for an eligible insured with • household income between 100-200% FPL, $4,500 • household Income between 200-250% FPL, $10,900.				
CFR 156.420(a)	Reduced cost sharing must result in an AV rating of: • 94%, if household income is between 100-150% FPL • 87%, if household income is between 150-200% FPL • 73%, if household income is between 100-150% FPL • 70%, if household income > 250% FPL				
CFR 156.420(a)	Silver plan variations. For each of its silver health plans that an issuer offers or intends to offer in the individual market on an Exchange, the issuer must submit annually to the Exchange for certification prior to each benefit year the standard silver plan and three variations of such plan, each with an annual limitation on cost sharing no greater than the reduced maximum annual limitation specified in the annual HHS notice of benefit and payment parameters for such individuals, and other cost-sharing reductions such that the AV of the silver plan variations are 94, 87, and 73 percent. A standard silver plan and each plan variation must cover the same benefits and providers. Each variation is subject to all requirements for the standard silver plan [except for the AV requirement as in §156.140(b)(2)]. Issuers must include the amount of premium reductions in each billing statement.				

CFR 156.130(c) 80 FR 10824 CFR 156.130(g) CFR 147.138(b)(3)	Cost-sharing/out-of-network benefits. 1. For plans using a network of providers, cost sharing paid by, or on behalf of, an enrollee for benefits provided outside of the network are not required to count toward the annual limitation on cost sharing. 2. Any cost-sharing requirement expressed as a copayment amount or coinsurance rate imposed with respect to a participant, beneficiary, or enrollee for out-of-network emergency services cannot exceed the cost-sharing requirement imposed with respect to a participant, beneficiary, or enrollee if the services were provided in-network. However, a participant, beneficiary, or enrollee may be required to pay, in addition to the in-network cost-sharing, the excess of the amount the out-of-network provider charges over the greater of the amount 1) negotiated with in-network providers for the emergency service furnished; 2) the amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services, or 3) that would be paid under Medicare for the emergency service. In all three cases, excluding any in-network copayment or coinsurance imposed with respect to the participant, beneficiary, or enrollee. 3. Any cost-sharing requirement other than a copayment or coinsurance requirement (such as a deductible or out-of-pocket maximum) may be imposed with respect to emergency services provided out of network if the cost-sharing requirement generally applies to out-of-network benefits. A deductible may be imposed with respect to out-of-network emergency services only as part of a deductible that generally applies to out-of-network benefits. If an out-of-pocket maximum generally applies to out-of-network benefits, that out-of-pocket maximum must apply to out-of-network emergency services.				
PPACA 1001 PHSA 2713 CFR 147.130(a)(2)	Cost sharing for office visits (N/A to GP). Insurers may have cost-sharing for office visits. Examples of allowed cost-sharing includes billing preventive services separately from an office visit and an office visit where the preventative service is not the primary purpose and is not billed separately. Cost sharing for office visits is not allowed where the preventative service is the primary purpose of the visit and is not billed separately from the office visit. Plans that have a network of providers may impose cost sharing for preventive items and services delivered by out-of-network providers. A plan may impose cost-sharing for a treatment not described in the regulations, even if that treatment results from an item or service that is described in the regulations.				
PPACA 1402	Cost sharing includes deductibles, coinsurance, co-payments, or similar charges; and any other expenditure required of an insured individual which is a qualified medical expense for EHB covered under the plan. Defines “qualified medical expense.”				
641.31071(5)(a)	Creditable Coverage (GP). Coverage as outlined must be applied to reduce any pre-existing condition.				
641.31(23)	Defenses. “Time Limit on Certain Defenses” provision.				
69O-191.033(1)(a) 69O-191.039(1)	Definitions. Group and non-group subscriber contracts shall include definitions. When certificates or member handbooks are given to the subscriber in lieu of a subscriber contract, the certificate or member handbook must contain definitions.				

	Effective date of coverage. The time the insurance takes effect and the period it continues. Effective date/time and the termination date/time. An effective date and term of contract. <u>Annual enrollment periods</u> Individual market coverage must become effective consistent with the dates in CFR 155.410. Coverage effective dates applicable both inside and outside the Exchange: For the benefit year beginning on January 1, 2016, the Exchange must ensure that coverage is effective— • 1/1/16, for QHP selections received by the Exchange on or before 12/15/15. • 2/1/16, for QHP selections received by the Exchange from 12/16/15 through 1/15/16. • 3/1/16, for QHP selections received by the Exchange from 1/16/15 through 1/31/16. <u>Special enrollment periods</u> Coverage must be effective consistent with dates in CFR 155.420. An Exchange may set earlier effective dates for certain special enrollment periods. Coverage effective dates applicable both inside and outside the Exchange: Regular effective dates— • Enroll 1st-15th day of month, effective Day 1 of following month • Enroll 16th-last day of month, effective Day 1 of 2nd following month Special effective dates— • Date of event or may permit the enrollee to elect Day 1 of the following month: For birth, adoption or placement for adoption, or placement in foster care. • Day 1 of following month: For marriage or loss of minimum essential coverage. • The date of the triggering event or the regular effective dates: o enrollment or nonenrollment is unintentional; o enrollment or nonenrollment is the result of error or misrepresentation or inaction of the Exchange or HHS QHP in which person was enrolled violated a material provision of the contract relative to the enrollee; or o where enrollee meets other exceptional circumstances or qualified individual is not enrolled in QHP coverage as a result of misconduct on the part of a non-Exchange entity providing enrollment assistance or activity.				
69O-191.024(22) 69O-191.033(1)(e) 69O.191.039(2), (8)	Enrollment eligibility.				
	Enrollment periods/annual open enrollment. (NGP) The health insurance issuer must provide an open enrollment period. Applies to non-grandfathered policies, both on and off-Exchange. <u>Length</u>: for benefit years beginning on or after January 1, 2016, November 1, 2015 through January 31, 2016.				

CFR 147.104 CFR 155.410(a), (e) 26 CFR 54.9801-6(a)(3)(i)-(iii) 80 FR 10750	Enrollment periods/limited open enrollment. Health insurance issuer must provide a limited open enrollment process for the following events: 1. A qualified individual or dependent loses minimum essential coverage, loses pregnancy-related coverage under Medicaid, or loses medically needy coverage (Medicaid); [Note: See the circumstances described in 26 CFR 54-9801-6(a)(3)(i)- (iii).] 2. A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption or in foster care; 3. A qualified individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction; 4. An enrollee adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee; 5. A qualified individual or enrollee gains access to new QHPs as a result of a permanent move; 6. The Exchange determines that a qualified individual, enrollee, or dependent, did not enroll in QHP coverage or is eligible but not receiving premium tax credits or reduced cost sharing as a result of misconduct on the part of a non-Exchange entity providing enrolment assistance or activities.				
147.104(b)(4)	**Length:** 60 days from the date of the qualifying event. May be some other length not exceeding 60 days for certain qualifying events applicable to special enrollment periods, as appropriate based on circumstances.				
	Enrollment periods/special enrollment. **Off-Exchange**				
CFR 47.104(b)(3)	Qualifying events: Health insurance issuers must provide special enrollment periods based on qualifying events as defined under s. 603 of ERISA. These are in addition to any other special enrollment periods required under federal or state law and include: 1. The death of the employee; 2. The termination (other than through employee's gross misconduct) or reduction of hours of covered employee; 3. The divorce or legal separation of the covered employee from spouse; 4. The covered employee becoming entitled to Medicaid benefits (Title XVIII, SSA); 5. The dependent child ceasing to be a dependent child under generally applicable requirements of the plan; 6. A proceeding in a case under title 11 with respect to the employer.				
CFR 147.104(b)(4)	Length: The enrollment period must run for 60 days from the date of the qualifying event.				

	Enrollment periods/special enrollment (continued). **On Exchange**				
CFR 155.420(c), (d)(1)-(10), (e)	Qualifying events: An Exchange must provide special enrollment periods, during which qualified individuals may enroll in QHPs (or SADPs) and enrollees may change QHPs, (or SADPs) upon the occurrence of one of the following qualifying events: 1. A qualified individual or dependent loses minimum essential coverage; is enrolled in any non-calendar year group health plan or individual health insurance coverage (outside of an Exchange, including grandfathered and transitional plans), even if the qualified individual or his or her dependent has the option to renew such coverage; loses pregnancy-related coverage under Medicaid; or loses medically needy coverage (Medicaid). [Note: See the circumstances described in 26 CFR 54-9801-6(a)(3)(i)- (iii).; "loss of coverage" does not include voluntary termination or other loss due to nonpayment of premiums, including COBRA premiums and situations allowing for rescission.] 2. A qualified individual gains or becomes a dependent through birth, marriage, adoption or placement for adoption or in foster care; 3. An individual, who was not previously a citizen, national, or lawfully present individual gains such status; 4. A qualified individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and results from the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or instrumentalities as determined by the Exchange. The Exchange may take such action necessary to correct or eliminate the effects of the error, misrepresentation, or inaction. 5. An enrollee adequately demonstrates to the Exchange that the QHP in which enrolled substantially violated a material provision of its contract in relation to the enrollee. 6. An individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP. The Exchange must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for the employer's upcoming plan year to access this special enrollment period prior to the end of coverage through the eligible employer-sponsored plan. A qualified individual in a non-Medicaid expansion State previously ineligible for advance payments of the tax credit solely because of a household income below 100% of the FPL, who was ineligible for Medicaid during that same timeframe, and who has experienced a change in household income making the qualified individual newly eligible for advance payments of the credit. 7. A qualified individual or enrollee gains access to new QHPs as a result of a permanent move. 8. An Indian may enroll in a QHP or change from one QHP to another one time per month. 9. A qualified individual or enrollee demonstrates to the Exchange, in accordance with HHS guidelines that the individual meets other exceptional circumstances as the Exchange may provide. 10. The Exchange determines that a qualified individual, enrollee, or dependent, did not enroll in QHP coverage or is eligible but not receiving premium tax credits or reduced cost sharing as a result of misconduct on the part of a non-Exchange entity providing enrolment assistance or activities.				
CFR 155.420(c)(3)	Length: 60 days from the date of the qualifying event. May be some				

	other length not exceeding 60 days for qualifying events 4, 5, 9 and 10, as appropriate based on circumstances..				
CFR 147.106 CFR 155.335(j)(1)-(2)	Enrollment renewal: The Exchange may automatically enroll qualified individuals, at such time and in such manner as HHS may specify, and subject to the Exchange demonstrating to HHS that it has good cause to perform such automatic enrollments. Reenrollment/renewal: Unless the enrollee terminates coverage, if an enrollee remains eligible to enroll in a QHP through the Exchange upon annual redetermination and the product under which the QHP in which enrolled is: • available for renewal through the Exchange, coverage will be renewed in the same plan. If the plan is unavailable, coverage will be renewed in the following order: at the same metal level, one metal level higher or lower, or any other plan offered under the product in which the enrollee's current QHP is offered in which the enrollee is eligible to enroll; or				

CFR 144.103	• not available for renewal through the Exchange, the enrollee may be enrolled in a plan under a different product offered by the same QHP issuer, to the extent permitted by State law, at the same metal level as the enrollee's current QHP in the product offered by the same issuer that is the most similar to the enrollee's current product. If the issuer does not offer another plan through the Exchange at the same metal level, the enrollee will be re-enrolled in a plan through the Exchange in the following order:: one metal level higher or lower than the enrollee's current QHP in the product offered by the same issuer through the Exchange that is the most similar to the current product; or any other plan offered through the Exchange by the same issuer in which the enrollee is eligible to enroll. The plan will be considered the same plan if it has the same cost-sharing structure as before the modification, or any variation is solely related to changes in cost of utilization, or is to maintain the same metal tier; continues to cover a majority of the same service area and provider network. A state may permit greater changes to the cost-sharing structure, or designate a lower threshold for maintenance of the same provider network or service area to still be considered the same plan.				
641.31(15) 69O-191.033(1)(f) 69O-191.039(7) CFR 156.270(d)	Grace period. Contain a minimum grace period of 10 days for late payments, during which the contract remains in force. EXCHANGE ONLY (NGP). Individuals who receive an advanced premium tax credit and lose coverage due to non-payment of premium must be provided a 3-month grace period. The QHP must cover all allowable claims for the first month and may pend subsequent claims in the 2nd and 3rd months. During the grace period, a QHP issuer will continue to collect subsidy payments on the delinquent enrollee's behalf and return payments of the premium tax credit for the 2nd and 3rd months if the enrollee exhausts the grace period.				
641.185(1)(i) 641.31(5) 641.511 69O-191.033(1)(o) 69O-191.039(15) PPACA 1001 PHSA 2719 CFR 147.136 29 CFR 2560.503-1	(GP) Grievances. Every contract must contain an informal and formal grievance procedure and urgent grievance procedure. The contract shall include a clear and understandable description of the HMO method for resolving subscriber grievances. The issuer is required to include a description of procedures and applicable time frames for claims, obtaining prior approval, preauthorization, and utilization review. Detailed procedures are set forth in PPACA implementing regulations. (Individual and group NGP).				
PPACA 1201 PHSA 2702 CFR 147.104 CFR 148.120	Guaranteed issue (NGP). (N/A to GP, student health and bona fide association coverage) A health insurance issuer that offers health insurance coverage in the individual market must offer to any individual or employer in the State all products that are approved for sale in the applicable market, and must accept any individual or employer that applies for any of those products.				
PHSA 2703 CFR 148.122	Guaranteed renewability of coverage (NGP). A health insurance issuer offering health insurance coverage in the individual market is required to renew or continue in force the coverage at the option of the plan sponsor or the individual, as applicable. Insurers must renew or continue coverage at the option of the individual except for non-payment of premium, fraud, plan termination, movement outside of service area or association membership ceases.				

69O-191.033(1)(l), (4)	Limitations, exclusions and exceptions. All contractual limitations, exclusions and exceptions shall be grouped together with captions in bold-faced type and shall be printed with at least the same prominence as provisions that describe benefits.				
PHSA 2702(c) CFR 156.230 80 FR 10830	Network adequacy. Provider network consists of only providers contracted as in-network. The general availability of out-of-network providers may not be counted for purposes of meeting network adequacy requirements. (Applicable to QHP in FFE.) Reasonable access standard adopted in the *2015 Letter to Insurers in the Federally-facilitated Marketplaces (March 14, 2014)*. All services must be accessible without unreasonable delay consistent with the network adequacy provisions of section 2702(c) of the Public Health Service Act. (Applicable to QHP in FFE.) A provider directory is easily accessible when the general public is able to view all current providers on the issuer's public Web site through a clearly identifiable link or tab and without creating or accessing an account or entering a policy number; and the general public is able to easily discern which providers participate in which plans and which provider networks, where there are multiple networks. (Applicable to QHP in FFE.) For Plan Years beginning on or after January 1, 2016, a QHP issuer must publish an up-to-date, accurate, and complete provider directory, including information on which providers are accepting new patients, the provider's location, contact information, specialty, medical group, and any institutional affiliations, in a manner that is easily accessible.				
PPACA 1302(b)(4) CFR 156.125(a) 80 FR 10822	Nondiscrimination/benefit design. (NGP) 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. Three examples of potentially discriminatory practices: 1. attempting to circumvent coverage of medically necessary benefits by labeling them a pediatric service. 2. refusing to cover a single-tablet drug regimen or extended-release product customarily prescribed and just as effective as a multi-tablet regimen, absent an appropriate reason for such refusal. 3. placing most or all drugs that treat a specific condition on the highest cost tiers.				
PHSA 2705 CFR 146.121 CFR 147.110(a)	Nondiscrimination/health status. (NGP) Discrimination based on health status is prohibited. A plan may not establish rules for eligibility based on any of the following health-related factors: • Health status • Medical condition • Claims experience • Receipt of health care • Medical history • General information • Evidence of insurability (including conditions arising out of domestic violence or participation in activities such as motorcycling, snowmobiling, etc.) • Disability				

	Any other health-status related factor deemed appropriate by the HHS Secretary.				
	Nondiscrimination/providers. (NGP)				
627.419	Provider parity				
641.19(12)(d)	Physicians licensed under Chapters 458, 459, 460 and 461: allopathic, osteopaths, chiropractors and podiatrists. (Section 458 defines physician to mean a person who is licensed to practice medicine in this state.)				
641.31(28)	A health maintenance organization may not discriminate against or fail to contract with a hospital, based solely on the fact that the hospital's medical staff is comprised of physicians licensed under chapter 459.				
PPACA 1201 PHSA 2706 CCIIO ACA Implementation FAQs – Set 15	Discrimination against providers. (N/A to GP) Providers operating within the scope of their practice cannot be discriminated against. Issuers may not discriminate against any provider operating within their scope of practice. Note: This law does not require that a plan contract with any willing provider and does not prohibit tiered networks. QHPs must ensure a sufficient choice of providers in a manner consistent with network adequacy provisions.				
69O-191.033(1)(p)	Other factors. Any other factors necessary for complete understanding of what is covered and what is excluded by the contract.				
69O-191.033(1)(d)	Payment frequency. Payment on monthly, quarterly or other basis, with provision for change of mode if applicable.				
CFR 144.103	Plan and product defined. A "plan" is defined as "the pairing of health insurance coverage benefits under the product with a particular cost-sharing structure, provider network, and service area." The "product" comprises all plans offered with those characteristics and the combination of the service areas for all plans offered within a product constitutes the total service area of the product. [Applicable to parts 146 (group market), 147 (group and individual market), 148 (individual market), and 150 (enforcement).] The plan will be considered the same plan if it has the same cost-sharing structure as before the modification, or any variation is solely related to changes in cost of utilization, or is to maintaion the same metal tier; continues to cover a majority of the same service area and provider network. A state may permit greater changes to the cost-sharing structure, or designate a lower thresahold for maintenance of the same provider network or service area to still be considered the same plan.				
CFR 147.104(f)	(NGP) Policy period. An issuer that offers coverage in the individual market, or in a merged market in a State that has elected to merge the individual market and small group market risk pools, must ensure that such coverage is offered on a calendar year basis with a policy year ending on December 31 of each calendar year.				
PPACA 1201 & 1255 PHSA 2704 CFR 144.103 CFR 147.108	(NGP) Pre-existing conditions. A plan may not impose any pre-existing condition exclusions.				
CFR146.111(a)(3)(i)-(iii)	The enrollment date means the first day of coverage or, if there is a waiting period, the first day of the waiting period.				
CFR 155.400(e)	Premium payment dates. FFE EXCHANGE ONLY. To effectuate enrollment, the FFE requires payment of the first month (or binder payment) premium. For coverage being effectuated under regular				

	coverage effective dates, FFE premium payment deadlines must be no earlier than the coverage effective date, but no later than 30 calendar days from the coverage effective date. For coverage being effectuated under special effective dates, premium payment deadlines must be 30 calendar days from the date the issuer receives the enrollment transaction.				
69O-191.039(17)	Provider contact information. The names, addresses and phone numbers of physicians, clinics, hospitals, etc. must be provided to subscribers.				
641.31(3)(b)	Rate change notice. A change in rates requires at least 30 days advanced written notice to the subscriber. (For group members, there may be a contractual agreement to have the employer provide the notice.)				
641.31(6) 69O-191.033(1)(c)	Rate of payments. Space for rate to be charged. The rate of payments must be stated in the contract.				
641.305 CFR 155.205	Readability. All HMO contracts must at least be printed in English. Plain language requirement (Exchange standard). Issuers must provide applicants and enrollees information in plain language and in a manner that is accessible and timely. Required notices must meet certain specified standards.				
641.31(8) 69O-191.033(1)(s) 69O-191.039(12)	Reimbursement. Provisions relating to the right of reimbursement pursuant to Section 641.31(8), F.S., shall be allowed, if not in conflict with Florida Statutes or decisions eliminating or restricting such rights.				
CFR 147.106(f)	Renewal of coverage. An issuer in the individual market renewing a NGP, or uniformly modifying a NGP, must provide to each individual written notice of renewal before the date of the first day of the next annual open enrollment period in a form and manner specified by the HHS Secretary.				
PPACA 1001 PHSA 2712 CFR 147.128	Rescissions. Coverage may be rescinded only for fraud or intentional misrepresentation of material fact as prohibited by the terms of the coverage. 30-day notice must be made to policyholder prior to cancellation.. (Includes GP)				
641.51(5)	Second opinions. The subscriber has a right to a second medical opinion from participating / non-participating physicians and a 40% co-pay or				
641.185(1)(l) 690-191.033(1)(i)	Services to be furnished and where and in what manner the comprehensive health care services may be obtained.				
69O-191.033(1)(r) 69O-191.039(11)	Subrogation. Provisions relating to the right of subrogation shall be allowed, providing it is not in conflict with any Florida Statute or the decisions of courts of competent jurisdiction which eliminate or restrict such rights.				
69O-191.039(18)	Term of coverage. Shall be no less than a period of 12 months unless requested by the subscriber in writing. HMOs shall not offer or initiate this request during initial solicitation or prior to renewal.				

69O-191.042 CFR 155.430(b)(1), (d)(1)-(2) 80 FR 10800	Termination of coverage by the member. Termination of coverage by the insured (including member) (NGP). **Exchange-only** The Exchange must permit an enrollee to terminate his or her enrollment in a QHP, including termination as a result of obtaining other minimum essential coverage, with appropriate notice to the Exchange or the QHP. To the extent an enrollee may terminate under existing state laws, including "free look" cancellation laws, the enrollee may do so in accordance with such laws. The termination date is the date specified by the enrollee, if the enrollee provides reasonable notice. If the enrollee does not provide reasonable notice, the last day of coverage is 14 days after the date the enrollee requests termination. "Reasonable notice" is defined as notice occurring 14 days before the requested effective date of termination. If the enrollee requests an earlier termination date and the enrollee's QHP issuer agrees to termination in fewer than 14 days, then the date of termination is on or after the date requested by the enrollee.				
641.3108 69O-191.042 CFR 147.106(a)-(b)	Termination of coverage by an insurer. Except for nonpayment of premium or termination of eligibility, no HMO may cancel or otherwise terminate or fail to renew a HMO contract without giving the subscriber at least 45 days' notice in writing of the cancellation, termination, or nonrenewal. The written notice shall state the reason. All HMO contracts shall contain a clause requiring this notice be given. Upon written notice, an HMO may cancel or terminate the coverage if the subscriber: • Engages in disruptive, unruly, abusive, unlawful, fraudulent or uncooperative behaviour to the extent that continuing membership in the HMO seriously impairs the ability of the HMO to furnish services to either the subscriber or other subscribers prior to disenrolling a member, • Makes a fraudulent or material misrepresentation in applying for or presenting any claim for benefits under the HMO contract; • Misuses the HMO identification membership card; • Furnishes incorrect or incomplete information to the HMO for the purpose of fraudulently obtaining coverage; • Leaves the HMO geographical service area with the intent to relocate or establish a new residence outside of the service area; • Has a dependent who reaches the limiting age under the HMO contract, provided the termination shall only apply to coverage of the dependent. **Market-wide** (N/A GP) Exceptions to guaranteed renewability. An issuer may nonrenew or discontinue health insurance coverage: • for nonpayment of premium, fraud or intentional misrepresentation of a material fact, violation of participation or contribution rules, by the plan sponsor or individual; • if discontinuing a particular product or all coverage in a given market or all markets: • if no enrollees under the plan still live, reside, or work in the service area of the issuer (or in the area for which the issuer is authorized to do business).				

CFR 147.106(h)	Medicare eligibility or entitlement is not a basis for nonrenewal or termination of an individual's health insurance coverage in the individual market. **Exchange-only** Termination of enrollment in a QHP through the Exchange (distinct from termination of coverage with the issuer outside the Exchange) The Exchange may initiate termination of an enrollee's coverage in a QHP, and must permit a QHP issuer to terminate such coverage or enrollment, in the following circumstances with the following termination dates: • The enrollee is no longer eligible for coverage. In this case, the termination date is the last day of QHP coverage or eligibility; • Non-payment of premium, and the 3-month grace period required by 45 CFR 156.270 for advance payment of premium tax credits or any other applicable grace period has expired. In this case, the termination date is the last day of the first month of the 3-month grace period. • Non-payment of premium, and some other applicable grace period has been exhausted. In this case, the termination date is the date consistent with existing state laws regarding grace periods. • The enrollee changes plans during an open or special enrollment period. In this case, the last day of coverage in the prior QHP is the day before the effective date of coverage in the new QHP, including any retroactive enrollments/termination dates. • Death of the enrollee, with the date of death the effective date. • The enrollee's coverage has been rescinded because the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage. In this case, the issuer must provide a 30-day advance notice to each participant per 45 CFR 147.128(a). • The QHP terminates or is decertified by the Exchange. • Any of the reasons for termination of coverage under CFR 147.106 (i.e., exceptions to guaranteed renewability). A QHP issuer must establish a standard policy for the termination of enrollment of enrollees through the Exchange due to non-payment of premium as permitted by the Exchange.				
CFR 155.430(b)(2) CFR 156.270(a) 80 FR 10-801 CFR 155.430(b)(2)(vi) CFR 156.270(c)					
CFR 156.270(b) CFR 155.430(c)	Termination notice. If a QHP issuer terminates an enrollee's coverage in accordance with §155.430(b)(2)(i), (ii), or (iii), the QHP issuer must, promptly and without undue delay provide the enrollee with a notice of termination of coverage that includes the termination effective date and reason for termination. QHP issuers must maintain records of termination of coverage and send termination information to HHS, promptly and without undue delay.				
641.51(8)	Termination/other than for cause. If a contract between an HMO and a provider is terminated for any reason other than for cause, each party shall allow HMO subscribers for whom treatment was active, to continue coverage through completion of medically necessary treatment, until the subscriber picks another provider, or during the next open enrollment period offered by the HMO, not to exceed 6 months or through postpartum care if pregnant.				
627.411	Terrorism exclusion. Terrorism cannot be excluded; companies must pay benefits to policyholders injured or killed by terrorist acts.				

641.31071 69O-191.024(22) 69O-191.033(1)(e) 69O.191.039(2) & (8) CFR 147.116(b)	Waiting periods. Group and non-group subscriber contracts shall include eligibility requirements for enrollment, including waiting periods for receiving services and any other restrictions. "Waiting period" is defined as "that period of time which may be specified in the policy and which must follow the date a person is initially insured under the policy before the coverage or coverages of the policy shall become effective as to such person." Defines "waiting period" in a group context as "the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective. If an employee or dependent enrolls as a late enrollee or special enrollee, any period before such late or special enrollment is not a waiting period." No express limit on length of waiting periods in the individual market.				
	Mandated Coverages: Essential Health Benefits				
PPACA 1302 PHSA 2707 CFR 147.150(a) CFR 156.110(a)(1)-(10)	(NGP) Essential health benefits . Health insurance issuers offering health insurance coverage in the individual market, both inside and outside of an Exchange, must offer a core package of items and services, known as "essential health benefits," within at least the following 10 categories: 1. Ambulatory patient services 2. Emergency services 3. Hospitalization 4. Maternity and newborn care 5. Mental health and substance use disorder services, including behavioral health treatment 6. Prescription drugs 7. Rehabilitative and habilitative services and devices 8. Laboratory services 9. Preventive and wellness services and chronic disease management 10. Pediatric services, including oral and vision care				
  627.6056	Ambulatory services. Coverage for ambulatory center services.				

	Emergency services. 641.31(12) 641.513(3) 69O-191.024(6) PPACA 1001 & 1302(b)(1)(B) PHSA 2719A CFR 147.138(b)	(GP) The contract shall cover out-of-network emergency services without prior authorization by the HMO. The contract must cover emergency services and must not require prior authorization and limit coverage to only services and care at participating providers.. Plan or issuer must provide coverage for services without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from in-network providers, with cost-sharing that is no greater than that which would apply for a participating provider, and without regard to any other restriction other than an exclusion or coordination of benefits, an affiliation or waiting period, and cost-sharing. The insured will be required to pay any excess out-of-network provider charges beyond the greatest of: • The amount negotiated with in-network providers for the emergency services furnished, excluding any in-network copayments or coinsurance or, if more than one amount, then the median amount. • The amount for the emergency service calculated using the same method of the plan generally used to determine payments for out-of-network services (such as usual, customary and reasonable), excluding any in-network copayments or coinsurance. • The Medicare rate, excluding any in-network copayments or coinsurance.				
641.19(7) 69O-191.024(15) PPACA 1001 PHSA 2719A 42 USC 1395dd 641.19(6); 69O-191.024(6) 69O-191.024(13) 69O-191.033(1)(m) PPACA 1001 PHSA 2719A 42 USC 1395dd	Definitions of emergency medical services and care. The terms “emergency medical services” and “stabilize” have the meaning as defined in PHSA 2719A and 42 USC 1395dd. Definition of emergency medical condition - The contract shall also contain a definition of emergency services per 69O-191.024(6) including provisions covering in and out of area emergencies and minimum services. The term “emergency medical condition” has the meaning as provided in PHSA 2719A and 42 USC 1395dd.				
PPACA 1302(b)(1)(C)	Hospitalization. Further federal guidance needed.				

	Maternity and newborn care.				
641.31(18)	Maternity care. Contracts that cover normal maternity care shall provide the option to cover services of nurse-midwives, midwives licensed per Chapter 467 and birth centers. Must not limit coverage for length of a maternity/newborn stay in a hospital or for out-of-hospital follow-up care to any time period less than that which is medically necessary.				
641.31(9) 69O-191.045	Newborn children coverage from the moment of birth.				
1302(b)(1)(D) PHSA 2725 CFR 146.130 CFR 156.115(a)(2)	Maternity and newborn care: Any health policy that provides for maternity care may NOT restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. (Newborn's and Mother's Health Protection Act (NMHPA) of 1996.). Hospital length of stay begins at the time of delivery if delivery occurs in a hospital and at time of admission if delivery occurs outside the hospital. In the case of multiple births, it begins at time of the last delivery. This section does not apply to any issuer that does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn child. No prior authorization required for the 48/96 hour hospital stay. EXCEPTION: This does not apply if the provider, in consultation with the mother, decides to discharge the mother or the newborn prior to the minimum length of stay. The issuer may not: • Deny a mother or her newborn child eligibility or continued eligibility to enroll in or renew coverage solely to avoid the requirements of this section; • Provide payments or rebates to a mother to encourage her to accept less than the minimum protections under this section; • Penalize (for example, take disciplinary action against or retaliate against), or otherwise reduce or limit the compensation of, an attending provider because the provider furnished care to a covered individual in accordance with this section; • Restrict benefits for any portion of a hospital length of stay in a manner that is less favorable than the benefits provided for any preceding portion of the stay; • Provide monetary or other incentives to an attending provider to induce the provider to furnish care to a covered individual in a manner inconsistent with this section; and • Require a mother to give birth in a hospital; or stay in the hospital for a fixed period of time following childbirth. Notice requirement. An issuer must notifies covered individuals of their rights using the "Statement of Rights Under the Newborns' and Mothers' Health Protection Act." These notice requirements do not apply with respect to coverage regulated under a state law if it provides for the same 48/96-hour hospital length of stay, requires maternity and pediatric care in accordance with guidelines for care following childbirth and requires that the hospital length of stay is left to the decision of the attending provider in consultation with the mother.				

	Mental and nervous disorders and substance abuse.				
PPACA 1302(b)(1)(E) PPACA 1311(j) PHSA 2726 CFR 146.136 CFR 147.160 CFR 156.115(a)(3)	Provide mental health and substance abuse (MHSA) disorder services, including behavioral health treatment, in compliance with PPACA, the Mental Health Parity and Addiction Equity Act and corresponding regulations. "Mental health benefits" (and "substance use disorder benefits") means benefits with respect to items or services for mental health conditions (substance use disorders), as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any condition (disorder) defined by the plan or coverage as being or as not being a mental health condition (substance use disorder) must be defined to be consistent with generally recognized independent standards of current medical practice. The PPACA, through the MHPAE, defines parity in terms of the aggregate lifetime and annual dollar limits placed on medical/surgical benefits and financial requirements and treatment limitations. The PPACA annual and lifetime dollar limits include mental health and substance abuse disorders (MH/SUD) as part of the EHB. • If the plan places no limits or limits on less than 1/3 rd of all medical /surgical benefits, then no such limits may be imposed on MH/SUD benefits. • If the plan places a limit on at least 2/3rds of all medical/surgical benefits, it must either: 1) apply the limits both to the medical/surgical benefits to which it would apply and to MH/SUD benefits in a manner that does not distinguish between MH/SUD; or 2) not include limits on MH/SUD benefits that are less than those placed on medical/surgical benefits. Plans covering MHSA treatment services in addition to medical or surgical services may not impose financial requirements and treatment limitations upon MHSA treatment services that are more restrictive than the predominant requirements and limitations that apply to substantially all medical and surgical services. Financial requirements include deductibles, copayments, coinsurance and out-of-pocket maximum, but excludes aggregate lifetime and annual dollar limit. If a NGP provides coverage for MHSA disorders, the plan may not impose less favorable benefits limitations on those benefits than on medical/surgical coverage. MHSA services may not be subject to separate cost-sharing requirements, and if a plan provides for out-of-network coverage of medical and surgical services, it must also provide out-of-network coverage for MHSA treatment. PPACA includes both a small employer and an increased cost exemption (actual cost increase of more than 2% in first year and 1 percent in each plan year thereafter) from the requirements of the mental health parity provisions in CFR 146.136.				

	Prescription drug benefits. To provide essential health benefits, a health plan must: 1. cover at least the greater of one drug in each U.S. Pharmacopeia category and class; or the same number of drugs in each category and class as the EHB–benchmark plan. ("Drug count standard") 2. submit its formulary drug list to the Exchange and the State. 3. beginning in 2017, use a pharmacy and therapeutic (P & T) committee system meeting certain specified standards. Health plans must establish and maintain formulary drug lists in compliance with committee standards.				
PPACA 1302(b)(1)(F) CFR 156.122(a)					
CFR 156.122(c) 80 FR 10818	Exceptions Processes (applies to non-formulary drugs; complements external review process in CFR 147.136 for denial of drugs on plan's formulary) ("Review must begin following receipt of information sufficient to begin review") 1. External Exception Request Review (formulary drugs). For Plan Years beginning on or after 1/1/16, if a health plan denies a request for a standard exception or expedited exception, it must have a process for having the original exception request reviewed by an independent organization. The plan must make its determination on the request within 72 hours if the original request was a standard exception request and 24 hours if it was an expedited exception request. If granted, the health plan must provide coverage for the duration of the prescription (standard exception) and the exigency (expedited exception). 2. Exceptions processes: a. Standard exception request. A health plan must notify the enrollee and prescribing physician of the determination within 72 hours after receiving the request. If granted, the plan must treat the non-formulary drug as an EHB, including by counting any cost sharing, and provide coverage of the drug for the duration of the prescription including refills. b. Expedited exception request. A health plan must have a process for requesting an expedited review based on exigent circumstances. 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." The coverage determination must be made within 24 hours.				
CFR 156.122(d) 80 FR 10819	List of Covered Drugs For Plan Years beginning on or after 1/1/16, a health plan must publish an up-to-date, accurate, and complete list of all covered drugs on the formulary drug list, including any tiering structure and any restrictions on the manner in which a drug can be obtained in a manner easily accessible to plan enrollees, and others. Restrictions include prior authorization, step therapy, quantity limits and access restrictions. Issuers are encouraged to provide detailed cost-sharing information.				
CFR 156.122(e) 80 FR 10821	Accessing benefits. For Plan Years beginning on or after 1/1/17, a plan: • must give enrollees the option of accessing prescription drug benefits at in-network retail pharmacies. • may charge enrollees a different cost sharing amount for obtaining a covered drug at a retail pharmacy, but all cost sharing, *including any difference between the cost-sharing for mail order and for retail*, must count towards the plans annual limit on cost sharing and must be taken into account when calculating the AV of the health plan.				

1302(b)(1)(G) CFR 156.110(f) CFR 156.115(a)(5) 80 FR 10811	Rehabilitative and habilitative services and devices. Rehabilitative services and devices are an EHB but not defined in law. They generally mean "relearning existing skills or functions;" Habilitative services and devices defined using the same definition of habilitative services from the Uniform Glossary of Health Coverage and Medical Terms, effective beginning with PY 2016. Covers health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may: • I nclude physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings; • May not impose limits on coverage of habilitative services and devices that are less favorable than any such limits imposed on coverage of rehabilitative services and devices; and • For plan years beginning on or after January 1, 2017, cover habilitative and rehabilitative services and devices with separate limits for each.				
1302(b)(1)(H) CFR 156.110(a)(8)	Laboratory services. Further guidance needed				
PPACA 1001 & 1302(b)(1)(I) PHSA 2713 CFR 147.130 CFR 156.110(a)(9) CFR 156.115(a)(4)	Preventive and wellness services and chronic disease management. Covers preventive services without cost-sharing requirements including deductibles, co-payments and co-insurance. Covered preventive services include: • Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the US Preventive Services Task Force (USPSTF). • Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC. • Evidence-informed preventive care and screenings in the Health Resources and Services Administration (HRSA) guidelines for infants, children, adolescents, and women.				
641.31095 CFR 147.130	Mammograms: The contract must provide coverage at specified intervals. Requires application to present option to purchase coverage without underwriting. Current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention. Issuers must provide 60 days advance notice to enrollees before the effective date of any material modification in preventive benefits [PHSA 2715 (75 FR 41760)] Provides breast cancer mammography screenings every 1 to 2 years for women over 40 with no cost-sharing if by in-network provider as part of preventive services.				
Joint FAQ 5/11/15 (HHS, Labor, Treasury)	Cancer screening. For women at increased risk for having a potentially harmful mutation in genes that suppress tumors – the BRCA-1 or BRCA-2 cancer susceptibility gene, a plan or issuer must cover the preventive screening, genetic counseling, and BRCA genetic testing with no cost-sharing, as long as the woman had not been diagnosed with BRCA-related cancer.				

PHSA 2713 CCIIO and CMS Guidance regarding Contraceptive Services, 2/10/12 Joint FAQ 5/11/15 (HHS, Labor, Treasury)	Contraceptives. For all non-exempted, NGP and policies, coverage of the recommended women's preventive services, including the recommended contraceptive services, is required without cost sharing, for policy years (or, in the group market, plan years) beginning on or after August 1, 2012. (Note: Contraception is not specifically referenced in the PPACA.) Plans and issuers must cover without cost sharing at least one form of contraception in each of the methods (currently 18) that the FDA has identified for women in its current Birth Control Guide. This coverage must also include the clinical services, including patient education and counseling, needed for provision of the contraceptive method.				
641.31(26) 69O-191.037 59B-17.001 CFR 147.130 641.31(27) CFR 147.130	Diabetes (GP). Shall cover equipment, supplies and outpatient self-management training and education to treat diabetes. Diabetes, Type 2 screening for adults as part of preventive services with no cost-sharing if performed by in-network provider. Diabetes coverage is included as an EHB with no cost-sharing. Osteoporosis. Screening for women over age 60 depending on risk factors as part of preventive services, no cost-sharing if performed by in-network provider.				
641.31 (30) 641.31(34) CFR 156.115(a)(6) PPACA 1302(b)(1)(J) & 1311(d)(2)(B)(ii) PHSA 2722(c)(1) & 2791(c)(2) CFR 156.110(a)(10), (b)(2)-(3)	Pediatric services, including oral and vision care. All health maintenance contracts which provide coverage, benefits, or services for a member of the family of the subscriber must, as to such family member's coverage, benefits, or services, also provide that the benefits applicable for children include coverage for child health supervision services from the moment of birth to age 16 years. (GP) Any contract that provides coverage for anesthesia and hospitalization must provide for dental care to a person under age 8 if the dental condition is likely to result in a medical condition that if left untreated and the child's dentist and physician determine dental treatment in a hospital or ambulatory surgical center is necessary due to the complex nature of the procedure or due to a significant or undue medical risk. Pediatric services must be covered until the end of the month in which the enrollee turns 19. Dental and vision may be provided through a mix of comprehensive coverage plans or stand-alone coverage separate from the major medical coverage. • FEDVIP – Vision plan covers routine eye exams with refraction, corrective lenses and contact lenses. • FEDVIP – Dental (or Oral) plan coverage cleanings and fillings as well as advanced dental services such as root canals, crowns and medically necessary orthodontia. • Benefits available under the state CHIP Plan if one exists.				
	Benefits Other Than Essential Health Benefits				
69O-191.033(1)(n) 69O-191.039(5)	Additional family members. Provision for adding new family members.				
641.31(17) 69O-191.039(6) 69O-191.045	Adopted Child or Adopted Newborn: Coverage from the moment of placement or the moment of birth of newborn.				

CFR 146.130 PPACA 1311(j) PHSA 2726 CFR 146.136 CFR 56.115(a)(3)	Autism. Screening for children at 18 and 24 months as part of preventive services. No cost sharing if performed by in-network provider. Included within mental health and substance abuse disorder services, including behavioral health treatment are an EHB (and, therefore, applicable to groups of 50 or less). If a plan provides coverage for mental health and substance abuse disorders, the plan may not impose less favorable benefits limitations on those benefits than on medical/surgical coverage.				
627.4236 PPACA 1201 PHSA 2709	Bone marrow transplant. An HMO may not exclude coverage for procedures recommended by the referring physician and the treating physician under a policy exclusion for experimental, clinical investigative, educational, or similar procedures. Coverage must include costs associated with the donor-patient (e.g., extraction costs) to the same extent as costs associated with the insured, except that the insurer may limit to the reasonable cost of searching for the donor. See below, clinical trial participation.				
627.64172 627.6419	Breast cancer. Routine follow-up care for a person who has been previously determined to be free of breast cancer does not constitute medical advice, diagnosis, care or treatment. An insurer may not deny the issuance or renewal of, or cancel a policy, nor include exception or exclusion of benefits in a policy solely because the insured has been diagnosed as having a fibrocystic condition.				
641.313 641.313	Cancer treatment drugs. An insurer may not exclude coverage of any drug prescribed for the treatment of cancer on the ground the drug is not approved by the U.S. Food and Drug Administration for a particular indication, if the drug is recognized for the treatment of that indication. Plans providing coverage for cancer treatment medications must also cover those that are orally administered and may not apply cost-sharing requirements that are less favorable than those for intravenous treatment medications.				
641.31(30)	Child health supervision services				
641.31(35)	Cleft lip and cleft palate for children.				
PPACA 1201 PHSA 2709	Clinical trial participation (N/A to GP). A plan may not deny coverage for a "qualified" individual participating in an "approved clinical trial" for cancer or a life-threatening disease or condition, may not deny or limit coverage of routine patient costs for items and services provided in connection with the trial, and may not discriminate against participants in a clinical trial. Plans may not deny coverage because a member is participating in an approved clinical trial conducted outside of the state in which the member lives. Plans are not required to cover treatments that fall outside of the designated class of approved clinical trials. A "qualified individual" is someone who is eligible to participate in an "approved clinical trial" and either the individual's doctor has concluded that participation is appropriate or the individual provides medical and scientific information establishing that their participation is appropriate. An "approved clinical trial" is defined as a Phase I, II, III or IV clinical trial for the prevention, detection or treatment of cancer or other life-threatening condition or disease (or other condition described in PPACA.				
Joint FAQ 5/11/15 (HHS, Labor, Treasury)	Colonoscopies. Issuers cannot impose cost-sharing for anesthesia services performed in connection with preventive colonoscopies				

627.6562 641.31(41) 641.31(29)(a), (b) PPACA 1251(a)(4)(A)(iv) PHSA 2714 CFR 147.120 Joint FAQ 5/11/15 (HHS, Labor, Treasury)	Dependent Coverage. If dependent coverage is included, the policy must insure a dependent child at least until the end of the calendar year in which the child reaches the age of 25. Such a policy must also offer the policyholder or certificateholder the option of insuring the child until the end of the calendar year in which the child reaches age 30. Attainment of Limiting Age: Coverage does not terminate if the child continues to be: incapable of self-sustaining employment by reason of mental retardation of physical handicap and is chiefly dependent on the member for support or maintenance. (GP, NGP) Requires all plans offering dependent coverage to allow dependent children to remain on their parent's plan until age 26. Eligible children are defined based on their relationship with the participant such as financial dependency, residency, student status, employment, eligibility for other coverage and marital status. Adult children up to age 26 may not be defined for purposes of eligibility other than in terms of the relationship between the child and insured. The policy term s for dependent coverage cannot vary based on the age of a child. Coverage of grandchildren not required. If a plan or issuer covers dependent children, they must provide recommended preventive services for those dependent children. This includes recommended services related to pregnancy, including preconception and prenatal care.				
PHSA 2728 CFR 147.145	Dependent Student. Coverage for dependent student on medically necessary leave of absence ("Michelle's Law"). Issuer cannot terminate coverage within certain specified timeframes, cannot change benefits, and must include with any notice regarding a requirement for certification of student status for coverage. Defines "medically necessary leave of absence."				
641.31(33)	Dermatologist. Must provide direct access to dermatologist for up to five (5) visits and testing annually.				
641.31(29)	Handicapped children. A child who is incapable of self-sustaining employment due to mental retardation or physical handicap and who is chiefly dependent on the policyholder for support and maintenance may continue to be covered as a dependent beyond the attaining age.				
641.3007(5)	Human Immunodeficiency Virus (HIV) infection (GP). Contract shall not exclude or limit coverage for HIV infection.				
641.31(37)	Massage therapist. If the contract provides coverage for massage, it must cover the services of a licensed massage therapist.				

641.31(32) 641.31(31)(a) PHSA 2727	Mastectomies (GP). A policy that provides coverage for mastectomies must also provide coverage for prosthetic devices and breast reconstructive surgery incident to the mastectomy. Length of stay and out-patient coverage. The contract may not limit inpatient hospital coverage for mastectomies to any period that is less than is determined by the treating physicians. Provides coverage for reconstructive surgery after mastectomy (Women's Health and Cancer Rights Act). If covers mastectomy, then must also cover reconstructive surgery in a manner determined in consultation with provider and patient. Coverage must include: • Reconstruction of the breast on which the mastectomy was performed (all stages). • Surgery and reconstruction of the other breast to produce a symmetrical appearance and includes coverage for lymphedema. • Prostheses; and • Treatment of physical complications at all stages of mastectomy. This benefit can be subject to annual deductibles and coinsurance provisions if consistent with those established for other medical/surgical benefits under the coverage. The issuer is prohibited for denying a patient eligibility to enroll or renew coverage solely to avoid these requirements; penalizing or offering incentives to an attending provider to induce the provider to furnish care inconsistent with these requirements. Notice about the availability of mastectomy-related benefits must be given at issue and annually.				
641.31(21)	Nurse anesthetist. Contract which provide anesthesia coverage, benefits and services, shall offer to the subscriber, if requested and available, the services of a certified registered nurse anesthetist.				
641.19(12)(e) 641.51(11)	OB/GYN (GP). Female subscriber may select MD/Osteopath/OB-GYN as primary care physician. Female subscriber must be allowed, without				
641.31(20) 641.19(12)(d)-(e)	Ophthalmologists.				
641.31(19) 69O-191.033(6)	Optometrists.				
641.31(28) 641.19(12)(d)-(e)	Osteopaths.				
641.31(24)	Osteopathic hospitals. HMO contracts that provide for inpatient and outpatient services must provide as an option services of an osteopathic hospital when services are available in the service area.				
641.19(12)(d)-(e)	Podiatrists				
641.19(12)(e) PPACA 1001 PHSA 2719A CFR 147.138(a)	Primary care physician. Each subscriber, upon request, may designate a physician under chapters 458, 459, 460 and 461 as their primary care physician. Primary care provider (N/A to GP). A plan that provides for designation of a primary care provider must allow the choice of any participating primary care provider, who is available to accept them, including pediatricians.				
641.31094	TMJ (Temporomadibular joint). Nondiscrimination of coverage for surgical procedures involving bones and joints of the jaw and facial region.				

	Other Provisions				
PPACA 1303(a)-(b)(1) & (2)(A)-(C)	State opt-out of abortion coverage. A state may elect to prohibit by law abortion coverage in QHP offered through an Exchange. "Nothing in PPACA" requires a QHP to provide coverage of services for abortions, but a QHP may include coverage, as follows: • If a plan chooses to cover abortion services currently permitted under the Hyde Amendment i.e., life endangerment, rape and incest) the plan does not have to follow any specific segregation requirements. Federal subsidies are allowed to go towards those abortion services. • If a plan chooses to cover abortion services beyond those currently permitted under the Hyde Amendment, the plan issuer may not use federal subsidies to pay for these abortion services and must comply with PPACA segregation requirements.(Note: PPACA requires a QHP to segregate funds in a separate allocation account to pay for coverage of certain elective abortion services that cannot be paid for with federal funds. A QHP must also submit a plan to the state insurance commissioner that details its process and methodology for complying with these requirements.				