FLORIDA OFFICE OF INSURANCE REGULATION

Life and Health Product Review Unit

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.

Individual Major Medical Contract Worksheet

Florida provisions (Blue); PPACA provisions (Red)

Legend: CFR=Code of Federal Regulations, Title 45, except where otherwise indicated; CMS=Centers for Medicare & Medicaid Services; EHB=Essential Health Benefits; FEDVIP=Federal Employee Dental and Vision Insurance Program; GP=Grandfathered Plan; NGP=Non-grandfathered Plan; PHSA=Public Health Service Act QHP=Qualified Health Plan; SADP= Stand-alone Dental Plan

Statute/Rule	Filing Compliance	Yes	No	N/A	Page #
69O-149.021(6)(b)	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-149.021(1)(b)	Required information to be submitted within the filing.				
69O-149.023(4)	Cover letters must describe the distribution system (e.g. internet filing, direct marketing, agents, financial institutions,) and intended target population.				
627.602(1)(f) 69O-149.021(6)(c)	Each form, including outlines of coverage, applications, riders, and endorsements, shall be identified by a form identification number in the lower left-hand corner of the first page of the form. Provide the form number(s), date(s) of approval, Florida file number(s), (e.g. FLH 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.				
	Policy Cover Page				
69O-154.001	Policy statement instructing the policyholder to read the application attached to the policy and inform the company within 10 days of any incomplete or incorrect information, or if any past medical history has been omitted.				
69O-154.003	"Free look" provision. Policy must notify the policyholder of the right to review the policy or contract and return it within 10 days of delivery for a full refund of premium paid if, after examination of the policy or contract, the purchaser is not satisfied with it for any reason				
69O-154-105(1)	Renewability provision. Each individual or family policy of accident and health insurance shall include a renewal, continuation or nonrenewal provision consistent with the type of contract to be issued (e.g., noncancellable and guaranteed renewable, guaranteed renewable, renewable at the option of the insurer, single term nonrenewable, etc.). Such provision must be appropriately captioned and begin or be referenced on the first page of the policy and must clearly state the duration (where limited) of renewability and term of coverage for which the policy is issued and for which it may be renewed.				
627.602(2)	Deductible statement. must appear in 18-point font on the policy or outline				

	of coverage.				
627.416	Execution of policies. Every form shall contain the signature of a company official.				
	Required Policy Contents				
627.413(1)(a)	The names of the parties to the contract.				
627.413(1)(b)	The subject (type) of insurance. Policy must have a title.				
627.413(1)(c)	The risk insured against. (Benefits)				
627.413(1)(e)	The premium (may be located on the application or schedule of benefits, if application/schedule is made a part of the policy).				
627.413(1)(f)	The conditions pertaining to the insurance. Qualification of the benefits.				
627.413(1)(g)	The form numbers and edition dates of all endorsements attached to the policy, only at time of original issue.				
627.4131	Telephone number required for policyholders and certificate holders to present inquiries or obtain information about coverage and to provide assistance in resolving complaints.				
69O-154.105(2)	Conditions of eligibility.				
627.602(1)(a)	Consideration. The monetary and other consideration to be expressed therein.				
627.4234	Cost containment. The contract must include one or more of the following cost containment provisions: hospital, surgical or medical expense incurred: co-insurance, deductible, utilization review, audit of provider's bills, scheduled				
69O-154.104	Definitions shall be contained in the contract.				
627.602(1)(c)	Must identify who is covered. This may be located in the outline of coverage or schedule of benefits if they are made a part of the policy.				
627.602(1)(d)	The style, arrangement, and overall appearance of the policy may not give any undue prominence to any portion of the text. Every printed portion of the text of the policy and of any endorsements or attached papers shall be plainly printed in lightfaced type of a style in general use, the size of which is uniform and is not less than 10 points with a lowercase, unspaced alphabet length of not less than 120 points.				
627.602(1)(e) 69O-154.105(8)	Requires listing of exceptions and reductions. (Exclusions.)				
	Mandatory Contractual Provisions				
627.606	The entire contract: list all forms that apply.				
627.609	Reinstatement.				
627.6044 627.662(13)	Claims payments methodology.				
627.610	Notice of claims: minimum of 20 days or as soon as reasonably possible.				
627.611	Claim forms: company must provide within 15 days.				
627.612 627.657(3)	Proof of loss: minimum of 90 days or as soon as reasonably possible within 1 year.				
627.613	Time of payment of claims: Company must pay or deny within 45 days.				
627.6131 627.662(6)	Claims payments.				
627.614	Payment of claims: maximum of $3,000 to person who cannot execute a valid release.				
627.6141	Denial of claims				

627.615	Physical examinations and autopsy at company's expense.				
627.616 ; 95.11(2)(b)	Legal action: no legal action within 60 days after written proof of loss given; 5-year statute of limitations.				
627.617	Change of beneficiary: unless irrevocable.				
627.634	Age limit: if a contract will terminate when a covered person attains a certain age; if the premium is paid and accepted after such date, the coverage will continue until the end of the period for which the premium was paid.				
627.635 627.662(3)	Excess insurance: if a policy contains a provision that no benefits will be paid until all benefits are paid by all other contracts; this is excess insurance, and the contract shall have EXCESS INSURANCE stamped or printed on the face page.				
69O-154.105(4)	Non-duplication of coverage.				
	Policy Standards				
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 using lifetime limits for specific covered benefits that are not EHB. 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	Arbitration. If included, arbitration must be on a voluntary basis. Two or more parties 'may' agree in writing; cannot have binding arbitration in contracts.				
CFR 147.140(a)(2)	Benefit and plan description/statements required to be in a GP. Plan 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]*				

627.6471	Contracts for alternative rates of payment: An insurer may enter into contracts for alternate rates of payment with licensed health care providers and may limit payment under such policies and may offer the benefits alternative to insureds.				
627.646 69O-154.105(11)	Conversion on termination of eligibility. The contract must allow for persons who cease to be covered due to termination of eligibility (and prior to becoming eligible for Medicare or Medicaid) to have issued, without evidence of insurability, a policy (individual or family) provide application is made and premium is paid within 31 days. The coverage must be equal to or, at the option of the insured, less than the amount of the insurance which ceases due to termination. Maternity and dental benefits shall be offered if they were provided in the terminating coverage.				
627.4235(2)	Coordination of benefits. The policy may contain a provision in which the insurer reduces or refuses to pay benefits otherwise payable solely on account of the existence of similar benefits provided under insurance policies issued by the same or another insurer, health care services plan, or self-insurance plan which provides protection or insurance against hospital, medical, or surgical expenses only if, as a condition of coordinating benefits with another insurer, the insurers together pay 100 percent of the total reasonable expenses actually incurred of the type of expense within the benefits described in the policies and presented to the insurer for payment.				
PPACA 1302(c) PHSA 2707 CFR 156.130(a)(2) 26 USC 223(c)(12)(A)(ii) 80 FR 10824-25	Co-payment features (if any) 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.** • **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. (Reduced cost-sharing does not apply to group plans.)				

PPACA 1402(a)-(c) CFR 155.305(g)(2) 155.410 CFR 156.420(a)	Cost sharing reduced for EHB provided by QHP. 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. 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 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 the standard silver 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 silver plan variation must cover the same benefits and providers. Each silver plan variation is subject to all requirements applicable to the standard silver plan (except for the requirement that the plan have an AV as set forth 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 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."				
627.6487 627.6561	Creditable Coverage (GP). Coverage as outlined must be applied to reduce any pre-existing condition.				
627.607	(GP) Defenses. Time limit on certain defenses: 2-year maximum.				
PPACA 1302(b)(4) CFR 156.125(a) 80 FR 10822	Discrimination/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)	Discrimination/health status. (NGP) Discrimination based on health status is prohibited. (NGP) 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 Secretary.				
627.419 PPACA 1201 PHSA 2706 CCIIO ACA Implementation FAQs – Set 15	Discrimination/providers (NGP) Provider parity 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.				
CFR 147.104 CFR 155.410(a) & (e) 26 CFR 54.9801-6(a)(3)(i)-(iii) 80 FR 10750	Enrollment periods/annual open enrollment. **Annual Open Enrollment** The health insurance issuer must provide an open enrollment period. Applies to non-grandfathered policies, both on and off-Exchange. Length: November 1, 2015 through January 31, 2016, for benefit years beginning on or after January 1, 2016.				

CFR 147.104(b)(2) CFR 155.420(d) 80 FR 10750	Enrollment periods/limited open enrollment. **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. **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 circumstance.				

	Enrollment periods/special enrollment periods. **Off-Exchange**				
CFR 147.104(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 periods. (continued).				
CFR 155.420(c) (d)(1)-(10), & (e) 80 FR 10798	**On Exchange** 1. 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: A qualified individual or dependent loses minimum essential coverage; is enrolled in any non-CY group health plan or individual health insurance coverage (off Exchange, including GP and transitional plans), even if the qualified individual or dependent has the option to renew overage; loses pregnancy-related coverage under Medicaid; or loses medically needy coverage (Medicaid). [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 a dependent/ becomes a dependent by marriage, birth, 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 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. 5. 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. 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 his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan. A qualified individual in a non-Medicaid expansion State who was previously ineligible for advance payments of the premium tax credit solely because of a household income below 100 percent of the FPL, who was ineligible for Medicaid during that same timeframe, and who has experienced a change in household income that makes the qualified individual newly eligible for advance payments of the premium tax credit. 7. A qualified individual or enrollee gains access to new QHPs due toa permanent move. 8. An Indian, (Indian Health Care Improvement Act), 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 guidelines issued by HHS, 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)	Enrollment periods/special enrollment periods. (continued). 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 circumstance.				
627.413(1)(d) 627.602(1)(b) CFR 147.104(b)(iii) CFR 155.410(f)(2)	Effective date of coverage Effective dates of Coverage for GP and off-Exchange NGP: Every policy shall specify the time when the insurance takes effect and the period during which the insurance is to continue. Effective date of coverage following open or special enrollment left to the insurer and the insured. Annual enrollment periods. 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.				
CFR 147.104(b)(5) CFR 155.420(b)(1)-(2) CFR 155.420(B)(3)	Effective date of coverage (continued). Special enrollment periods. Coverage must become effective consistent with the dates in CFR 155.420. 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; o where enrollee meets other exceptional circumstances.or qualified individual was not enrolled in QHP coverage as a result of misconduct on the part of a non-Exchange entity providing enrollment assistance/activity. An Exchange may set earlier effective dates for certain special enrollment periods.				

69O-154.105(9)	Elimination period (GP). That period of time after a disability begins for which benefits will not be paid.				
CFR 147.106 CFR 155.335(j)(1) & (2)	Enrollment/reenrollment of coverage in Exchange products Enrollment: 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 for enrollment in a QHP through the Exchange upon annual redetermination and the product under which the QHP in which he or she is 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 priority 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. • is 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 of priority: 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.				
627.411 69O-154.105(7)(c)	Exceptions, exclusions and reductions must be clearly expressed as a part of the benefit provision to which such applies, or if applicable to more than one benefit provision, shall be set forth as a separate provision and appropriately captioned. They must be clearly stated and unambiguous..				
627.608 CFR 156.270(d)	Grace period. The policy shall contain a minimum grace period of no less than 7 days for a weekly premium policy, 10 days for a monthly premium policy, or 31 days for all other policies. IF SOLD ON 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 second and third 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 ax credit for the 2nd and 3rd months if the enrollee exhausts the grace period.				
627.602(1)(h) PPACA 1001 PHSA 2719 CFR 147.136 29 CFR 2560.503-1	(GP and NGP) Internal grievances procedures. Procedures must comply with provisions of the Employee Retirement Income Security Act of 1974, as implemented by 29 C.F.R. s. 2560.503-1. (Obtain certification from company officer using standard language.) Grievance procedures. 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 set forth in PPACA implementing regulations. Applicable to issuers of individual and group NGP.				

PPACA 1201 PHSA 2702 CFR 148.120;	(GP) Guaranteed issue applies to small group only. It does not apply in the individual market. (NGP) Guaranteed issue. (N/A to GP, student health or short-term duration coverage) A health insurance issuer that offers health insurance coverage in the individual				
627.6425 69O-154.105(1)(c) PHSA 2703 CFR 148.122	(GP) Guaranteed renewability of coverage. Coverage must be renewed except for reasons outlined in rule. N/A to short-term duration coverage. (NGP) Guaranteed renewability of coverage. 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.				
627.411 69O-154.105(7)	Limitations. The limitations on the risk undertaken, whether applicable to amounts, duration of benefits, age, or other matters, must be specified with clarity and certainty in the appropriate provision of the contract.				
627.620	Misstatement of age.				
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. 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 PHSA. (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. 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.				
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. 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 thresahold for maintenance of the same provider network or service area to still be considered the same plan.				

CFR 147.104(f)	Policy period (NGP). 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.				
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.				
627.4145 CFR 155.205	Readable language in insurance policies. Minimum score of 45 on Flesch reading ease test. 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.				
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 the 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.				
627.6045 69O-154.105(5) PPACA 1201 & 1255 PHSA 2704 CFR 144.103 CFR 147.108	Pre-existing condition (GP). Issuer may not exclude for more than 24 months and applicable to only conditions that are manifested during the 24-month period before coverage. Contracts may exclude coverage for named specific conditions without time limit. Pre-existing conditions. A plan may not impose any pre-existing condition exclusions. Pre-existing condition exclusion means a limitation or exclusion of benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan or group or individual health insurance coverage (or other coverage provided to Federally eligible individuals pursuant to 45 CFR part 148), whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A pre-existing exclusion includes any limitation or exclusion of benefits (including denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage (or date of denial).				
627.64172	Pre-existing condition/routine follow-up care (GP). Follow-up care for a person who has been determined previously free of cancer does not constitute medical advice, diagnosis, care.				

CFR 155.430(b)(1), (d)(1)-(2) 80 FR 10800	Termination of coverage by the insured (including member) for non-grandfathered plans. Exchange-only products The Exchange must permit an enrollee to terminate 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 (not just cancel) 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.				
627.6043 69O-154.105(3)	Termination of coverage by the insurer Insurers must give the policyholder at least 45 days' advance notice of cancellation, expiration, nonrenewal, or a change in rates. Such notice shall be mailed to the policyholder's last address as shown by the records of the insurer. However, if cancellation is for nonpayment of premium, at least 10 days' written notice accompanied by the reason shall be given. Written notice of cancellation for nonpayment of premium shall not be required for health insurance policies under which premiums are payable monthly or more frequently and regularly collected by a licensed agent. If the insurer fails to provide the required notice, the coverage shall remain in effect at the existing rates until 45 days after the notice is given or until the effective date of replacement coverage obtained by the insured, whichever occurs first. A family policy providing hospital, surgical, medical expense, hospital confinement indemnity or accident only insurance shall include termination provisions which shall specify as to the insured, spouse and child, the age or event, if any, upon which coverage under the policy will terminate (e.g., age 65, eligibility for Medicare, legal separation, termination of marriage by divorce or annulment or similar actions.				

	Termination of coverage by the insurer (continued). <u>Market-wide</u> (not applicable to GP)				
CFR 147.106(a)-(b)	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.				
CFR 155.430(b)(2) CFR 156.270(a) 80 FR 10-801	<u>Exchange-only products</u> 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 woith 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 effective date being the date of death. • The enrollee's coverage has been rescinded per 147.128 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).				
CFR 155.430(b)(2)(vi) CFR 156.270(c)	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(d)(3)-(7) CFR 155.430(c)	Termination effective date. The termination effective date varies depending upon whether or not it is initiated by the insured or the Exchange/QHP issuer and the basis for termination. QHP issuers must maintain records of termination of coverage and send termination information to HHS, promptly and without undue delay.				
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.				
627.411	Terrorism exclusion. Terrorism cannot be excluded; companies must pay benefits to policyholders injured or killed by terrorist acts.				
627.602(1)(b) 69O-154.105(6) CFR 147.116(b) CFR 146.111(a)(3)(iii) CFR 146.115	Waiting period (or probationary period) is the period of time after a policy is issued before coverage is effective. 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." It must not exceed 30 days, subject to exceptions. If an individual seeks coverage in the individual market, a waiting period begins on the date the individual submits a substantially complete application for coverage and ends on the date coverage begins or if the application does not result in coverage, the date on which the application is denied by the issuer or the date on which the offer of coverage lapses. [Also applies to GP, per PPACA . 1251(a)(4)(A)(i)]. No express limit on length of waiting periods in the individual market. 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."				
	Mandated Coverages: Essential Health Benefits				
PPACA 1302 PHSA 2707 CFR 147.150(a) CFR 156.110(a)(1)-(10)	Essential health benefits (EHBs) (NGP). 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 PPACA 1302(b)(1)(A)	Ambulatory services. Coverage for ambulatory center services. Ambulatory services (NGP). Further guidance needed.				
PPACA 1001 & 1302(b)(1)(B) PHSA 2719A(b) CFR 147.138(b) PPACA 1001 PHSA 2719A(b) 42 USC 1395dd	Emergency services. N/A to GP. Emergency services. 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. The terms “emergency medical services” and “stabilize” have the meaning as defined in PHSA 2719A and 42 USC 1395dd. The term “emergency medical condition” has the meaning as provided in PHSA 2719A and 42 USC 1395dd.				
PPACA 1302(b)(1)(C)	Hospitalization. Hospitalization. Further federal guidance needed.				

	Maternity and newborn care.				
627.6406(1) 69O-125.001(3)(f)	Any health policy that provides for maternity care shall also cover for the services of certified midwives, licensed midwives and the services of birthing centers. The complications of pregnancy must be treated the same as any other illness.				
627.6406(2)	A policy that provides coverage for maternity benefits or newborn coverage may not limit coverage for length of stay in a hospital or for follow-up care outside of a hospital to any time period less than that determined to be medically necessary by the treating obstetrical care provider or the pediatric care provider in accordance with prevailing medical standards. The policy must provide coverage for post-delivery care for the mother and infant, including medically necessary clinical tests and immunizations.				
627.641	Newborn children coverage must be provided from the moment of birth.				
PPACA 1302(b)(1)(D) PHSA 2725 CFR 148.170 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. Prior authorization for the 48/96 hour hospital stay is not required. This does not apply if the provider, in consultation with the mother, discharges the mother or the newborn earlier. 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 notify 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.				

627.42395 CFR 147.130 CFR 148.170(d)	Enteral feeding formulas. Insurer must make available for additional premium, coverage for medically necessary prescription and nonprescription enteral formulas for home use. Coverage for inherited diseases of amino and organic acids must include modified food products in an amount not to $2,500 per year for any insured individual through age 24. Phenylketonuria (PKU). Screening for this genetic disorder in newborns as part of preventive services with no cost-sharing if performed by in-network provider. This section applies to all health insurance coverage issued in the individual market, and is not limited in its application to coverage that is provided to eligible individuals as defined in section 2741(b) of the PHSA..				
PPACA 1302(b)(1)(E) PPACA 1311(j) PHSA 2726 CFR 146.136 CFR 147.160 CFR 156.115(a)(3) Groups > 100	Mental and nervous disorders and substance abuse. Provide mental health and substance abuse 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 mental health and substance abuse treatment services in addition to medical or surgical services may not impose financial requirements and treatment limitations upon mental health and substance abuse 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 mental health and substance abuse disorders, the plan may not impose less favorable benefits limitations on those benefits than on medical/surgical coverage. Mental health and substance abuse 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 mental health and substance abuse treatment. PPACA includes both a small employer exemption 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. <u>Exceptions Processes</u> (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, the health plan must have a process for having the original exception request reviewed by an independent organization. The health plan must make its determination on the external exception 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 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 after receipt of the request. <u>List of Covered Drugs</u> PY 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, including any tiering structure and any restrictions on how 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. <u>Accessing benefits</u>. For PY beginning on or after 1/1/17, a health 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.				
PPACA 1302(b)(1)(F) CFR 156.122(a)					
CFR 156.122(c)					
80 FR 10818					
CFR 156.122(d) 80 FR 10819					
CFR 156.122(e) 80 FR 10821					

PPACA 1302(b)(1)(G) CFR 156.115(a)(5) CFR 156.110(f)	Rehabilitative and habilitative services and devices. Rehabilitative services and devices are not defined in law but 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 include 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.				
PPACA 1302(b)(1)(H) CFR 156.110(a)(8)	Laboratory services. Laboratory services. Further guidance needed				

	Preventative and well care services. Preventive and wellness services and chronic disease management.				
PPACA 1001 & 1302(b)(1)(I) PHSA 2713 CFR 156.110(a)(4), (9) CFR 147.130 CFR 156.115(a)(4) CCIO ACA Implementation FAQs – Sec. 18	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; and • Current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention.				
PPACA 1001 PHSA 2715	Network plans may have cost sharing for preventative benefits when out-of-network providers are used. Issuers must provide 60 days advance notice to enrollees before the effective date of any material modification in preventive benefits				
PHSA 2713 CCIIO and CMS Guidance regarding Contraceptive Services, February 10, 2012	Contraceptives. For all non-exempted, non-grandfathered plans and policies, coverage of the recommended women's preventive services, including the recommended contraceptive services, is required without cost sharing, for policy ears (or, in the group market, plan years) beginning on or after August 1, 2012. (Note: Contraception is not specifically referenced in the PPACA.)				
Joint FAQ 5/11/15 (HHS, Labor, Treasury)	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.				
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.				
627.6408 59B-7.001	Diabetes treatment services (GP). Covers all medically approved equipment, supplies, outpatient self-management training and educational services used to treat diabetes if physician specializing in the treatment of diabetes certifies such services are necessary.				
CFR 147.130	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.				

	Preventative and well care services (continued).				
627.6418	Mammograms: The contract must provide coverage at specified intervals. Requires application to present option to purchase coverage without underwriting.				
CFR 147.130	Provides screenings every 1 to 2 years for women over 40 w/no cost-sharing if by in-network provider as part of preventive services. (Note: This is not expressly provided for in 45 CFR 147.130.)				
627.6409	Osteoporosis.				
CFR 147.130	Screening for women over age 60 depending on risk factors as part of preventive services, no cost-sharing if performed by in-network provider.				
	Pediatric services, including oral and vision care.				
627.6416	Child health supervision services. If coverage provided for a family member, the contract must provide that benefits applicable for the children include coverage for children under supervision from the moment of birth through age 16.				
627.4295	(GP) Dental procedures for children: If the contract provides coverage for general anesthesia and hospitalization services, such services must be provided for dental care to persons less than 8 years of age.				
PPACA 1302(b)(1)(J) PHSA 2722(c)(1) & 2791(c)(2) CFR 156.110(a)(10) & (b)(2)-(3)	Dental and vision may be provided through a mix of comprehensive coverage plans or stand-alone coverage (CFR and 1311(d)(2)(B)(ii) of PPACA) 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.				
CFR 156.115(a)(6)	Pediatric services must be covered until the end of the month in which the enrollee turns 19.				
	Benefits Other Than Essential Health Benefits				
627.6403	Acupuncturists				
627.6415	Adopted and foster children. Coverage for adopted and foster children upon placement in the residence: A policy providing coverage for a member of a family must also provide for coverage for an adopted child placed in compliance with Chapter 63, prior to the child's 18th birthday.				
CFR 146.130	Autism. Screening for children at 18 and 24 months as part of p reventive services. No cost sharing if performed by in- network provider.				
PPACA 1311(j) PHSA 2726 CFR 146.136 CFR 56.115(a)(3)	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	Bone marrow transplant. An insurer 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.				
627.4239 627.42391	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.				
627.419(4)	Chiropractors				
627.64193	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				
627.603	Death benefits (optional). A health policy may include a provision for paying a death benefit from any cause not to exceed $1,000; no limit for accidental death.				

627.602(1)(c); 627.6562 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; 45 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."				
627.6471(5) 627.6472(16) 627.662	Dermatologists. Any policy which does not provide direct patient access to a dermatologist must conform to the requirements of s. 627.6472(16) which provides that contracts must provide direct access w/o referral and up to five (5) visits annually.				
627.6041	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				
627.429 627.411(1)(g)	HIV infection (GP). A contract may not exclude coverage for HIV infection or AIDS.				
627.6407	Massage therapist. If the contract provides coverage for massage, it must cover the services of a licensed massage therapist.				

627.6417 627.64171 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. 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 may 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.				
PPACA 1001 PHSA 2719A(d) CFR 147.138(a)(3)-(4)	OB/GYN (N/A to GP). The plan may not require authorization or referral for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics and gynecology. A notice must be provided with the summary plan descriptions or in the policy, certificate or contract.				
627.419(3)	Ophthalmologists				
627.419(2)	Optometrists				
627.419(2)	Osteopaths				
627.4232	Out-of-hospital benefits: treatment performed outside the hospital will be paid the same as if performed in a hospital provided it would have been covered on an inpatient basis.				
627.419(2) 627.6699(12)(b)	Physician. For a contract providing surgical benefits, the word "physician" must include payment to a dentist.				
627.419(3)	Podiatrists				
PPACA 1001 PHSA 2719A CFR 147.138(a)	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.				
627.6471 627.6472	Psycho-therapeutic providers – PPO and EPO contracts that cover psychotherapeutic services, must provide eligibility requirements of health care providers licensed under chapters 458, 459, 490 or 491, which include psychotherapy in their scope of practice, and certified advanced registered nurse practitioners in psychiatric mental health under 464.012.				
627.419(7)	TMJ (Temporomadibular joint). Diagnostic and surgical procedures involving bones or joints of the skeleton				
	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.				