S T A T E O F N E W Y O R K

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2011-2012 Regular Sessions

I N A S S E M B L Y

June 17, 2011

Introduced by M. of A. STEVENSON, MORELLE -- (at request of the New York State Insurance Department) -- read once and referred to the Committee on Insurance

AN ACT to amend the insurance law and the public health law, in relation to implementation of the federal affordable care act in health insurance policies and contracts

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Subsection (b) of section 3105 of the insurance law is amended to read as follows:

(b)(1) No misrepresentation shall avoid any contract of insurance or defeat recovery thereunder unless such misrepresentation was material. No misrepresentation shall be deemed material unless knowledge by the insurer of the facts misrepresented would have led to a refusal by the insurer to make such contract.

(2) WITH RESPECT TO A POLICY OF HOSPITAL, MEDICAL, SURGICAL, OR PRESCRIPTION DRUG EXPENSE INSURANCE SUBJECT TO ARTICLES THIRTY-TWO OR FORTY-THREE OF THIS CHAPTER, NO MISREPRESENTATION SHALL AVOID ANY CONTRACT OF INSURANCE OR DEFEAT RECOVERY THEREUNDER UNLESS THE MISREPRESENTATION WAS ALSO INTENTIONAL.

S 2. Subsection (a) of section 3216 of the insurance law, paragraph 4 as amended by section 65-d of part A of chapter 58 of the laws of 2007, and subparagraph (C) of paragraph 4 as added by chapter 240 of the laws of 2009, is amended to read as follows:

(a) In this section the term:

(1) "Policy of accident and health insurance" includes any individual policy or contract covering the kind or kinds of insurance described in paragraph three of subsection (a) of section one thousand one hundred thirteen of this chapter.

(2) "Indemnity" means benefits promised.

EXPLANATION--Matter in ITALICS (underscored) is new; matter in brackets [ ] is old law to be omitted.

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(3) "Family" may include [husband, wife] THE POLICYHOLDER'S SPOUSE, or dependent children, or any other person dependent upon the policyholder.

(4) "Dependent children" (A) shall include any children under a specified age which shall not exceed age nineteen except:

(i) Any unmarried dependent child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, or mental retardation as defined in the mental hygiene law, or physical handicap and who became so incapable prior to the age at which dependent coverage would otherwise terminate, shall be included in coverage subject to any pre-existing conditions limitation applicable to other dependents[.]; OR

(ii) Any unmarried student at an accredited institution of learning may be considered a dependent child until attaining age twenty-three[.] FOR A POLICY OTHER THAN HOSPITAL, MEDICAL, SURGICAL, OR PRESCRIPTION DRUG EXPENSE INSURANCE; OR

(III) ANY MARRIED OR UNMARRIED CHILD SHALL BE CONSIDERED A DEPENDENT CHILD UNTIL ATTAINING AGE TWENTY-SIX WITHOUT REGARD TO FINANCIAL DEPENDENCE, RESIDENCY WITH THE POLICYHOLDER, STUDENT STATUS, OR EMPLOYMENT, FOR A POLICY OF HOSPITAL, MEDICAL, SURGICAL, OR PRESCRIPTION DRUG EXPENSE INSURANCE.

(B) may include, at the option of the insurer, any unmarried child until attaining age twenty-five FOR A POLICY OTHER THAN HOSPITAL, MEDICAL, SURGICAL, OR PRESCRIPTION DRUG EXPENSE INSURANCE.

(C) In addition to the requirements of subparagraphs (A) and (B) of this paragraph, every insurer issuing a policy OF HOSPITAL, MEDICAL, OR SURGICAL EXPENSE INSURANCE pursuant to this section that provides coverage for dependent children must make available and, if requested by the policyholder, extend coverage under the policy to an unmarried child through age twenty-nine, without regard to financial dependence who is not insured by or eligible for coverage under an employer [sponsored] health benefit plan [covering them] as an employee or member, whether insured or self-insured, and who lives, works or resides in New York state or the service area of the insurer. Such coverage shall be made available at the inception of all new policies [and at the first anniversary date of a policy following the effective date of this subparagraph]. Written notice of the availability of such coverage shall be delivered to the policyholder thirty days prior to the inception of such [group] policy [and thirty days prior to the first anniversary date following the effective date of this subparagraph].

S 3. Paragraph 9 of subsection (i) of section 3216 of the insurance law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(9)(A) Every policy [which] THAT provides coverage for inpatient hospital care shall also include coverage for services to treat an emergency condition in hospital facilities[. An]:

(I) WITHOUT THE NEED FOR ANY PRIOR AUTHORIZATION DETERMINATION;

(II) REGARDLESS OF WHETHER THE HEALTH CARE PROVIDER FURNISHING SUCH SERVICES IS A PARTICIPATING PROVIDER WITH RESPECT TO SUCH SERVICES;

(III) IF THE EMERGENCY SERVICES ARE PROVIDED BY A NON-PARTICIPATING PROVIDER, 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 PARTICIPATING PROVIDERS; AND

(IV) IF THE EMERGENCY SERVICES ARE PROVIDED BY A NON-PARTICIPATING PROVIDER, THE COST-SHARING REQUIREMENT (EXPRESSED AS A COPAYMENT OR

COINSURANCE) SHALL BE THE SAME REQUIREMENT THAT WOULD APPLY IF SUCH SERVICES WERE PROVIDED BY A PARTICIPATING PROVIDER.

(B) ANY REQUIREMENTS OF SECTION 2719A(B) OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG19A(B) AND REGULATIONS THEREUNDER THAT EXCEED THE REQUIREMENTS OF THIS PARAGRAPH WITH RESPECT TO COVERAGE OF EMERGENCY SERVICES SHALL BE APPLICABLE TO EVERY POLICY SUBJECT TO THIS PARAGRAPH.

(C) FOR PURPOSES OF THIS PARAGRAPH, AN "emergency condition" means a medical or behavioral condition[, the onset of which is sudden,] that manifests itself by ACUTE symptoms of sufficient severity, including severe pain, SUCH that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in [(A)] (I) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy[, or (B)]; (II) serious impairment to such person's bodily functions; [(C)] (III) serious dysfunction of any bodily organ or part of such person; [or (D)] (IV) serious disfigurement of such person; OR (V) A CONDITION DESCRIBED IN CLAUSE (I), (II) OR (III) OF SECTION 1867(E)(1)(A) OF THE SOCIAL SECURITY ACT.

(D) FOR PURPOSES OF THIS PARAGRAPH, "EMERGENCY SERVICES" MEANS, WITH RESPECT TO AN EMERGENCY CONDITION: (I) A MEDICAL SCREENING EXAMINATION AS REQUIRED UNDER SECTION 1867 OF THE SOCIAL SECURITY ACT, 42 U.S.C. S 1395DD, WHICH IS WITHIN THE CAPABILITY OF THE EMERGENCY DEPARTMENT OF A HOSPITAL, INCLUDING ANCILLARY SERVICES ROUTINELY AVAILABLE TO THE EMERGENCY DEPARTMENT TO EVALUATE SUCH EMERGENCY MEDICAL CONDITION; AND (II) WITHIN THE CAPABILITIES OF THE STAFF AND FACILITIES AVAILABLE AT THE HOSPITAL, SUCH FURTHER MEDICAL EXAMINATION AND TREATMENT AS ARE REQUIRED UNDER SECTION 1867 OF THE SOCIAL SECURITY ACT, 42 U.S.C. S 1395DD, TO STABILIZE THE PATIENT.

(E) FOR PURPOSES OF THIS PARAGRAPH, "TO STABILIZE" MEANS, WITH RESPECT TO AN EMERGENCY CONDITION, TO PROVIDE SUCH MEDICAL TREATMENT OF THE CONDITION AS MAY BE NECESSARY TO ASSURE, WITHIN REASONABLE MEDICAL PROBABILITY, THAT NO MATERIAL DETERIORATION OF THE CONDITION IS LIKELY TO RESULT FROM OR OCCUR DURING THE TRANSFER OF THE INSURED FROM A FACILITY OR TO DELIVER A NEWBORN CHILD (INCLUDING THE PLACENTA).

S 4. Paragraph 11 of subsection (i) of section 3216 of the insurance law, as added by chapter 417 of the laws of 1989, is amended to read as follows:

(11) (A) Every policy [which] THAT provides coverage for hospital, surgical or medical care shall provide the following coverage for mammography screening for occult breast cancer:

(i) upon the recommendation of a physician, a mammogram at any age for covered persons having a prior history of breast cancer or [whose mother or sister has] WHO HAVE A FIRST DEGREE RELATIVE WITH a prior history of breast cancer;

(ii) a single baseline mammogram for covered persons aged thirty-five through thirty-nine, inclusive; AND

(iii) [a mammogram every two years, or more frequently upon the recommendation of a physician, for covered persons aged forty through forty-nine, inclusive; and

(iv)] an annual mammogram for covered persons aged [fifty] FORTY and older.

(B) Such coverage REQUIRED PURSUANT TO SUBPARAGRAPH (A) OR (C) OF THIS PARAGRAPH may be subject to annual deductibles and coinsurance as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given policy.

(C) For purposes OF SUBPARAGRAPHS (A) AND (B) of this paragraph, mammography screening means an X-ray examination of the breast using dedicated equipment, including X-ray tube, filter, compression device, screens, films and cassettes, with an average glandular radiation dose less than 0.5 rem per view per breast.

(D) IN ADDITION TO SUBPARAGRAPH (A), (B) OR (C) OF THIS PARAGRAPH, EVERY POLICY THAT PROVIDES COVERAGE FOR HOSPITAL, SURGICAL OR MEDICAL CARE, EXCEPT FOR A GRANDFATHERED HEALTH PLAN UNDER SUBPARAGRAPH (E) OF THIS PARAGRAPH, SHALL PROVIDE COVERAGE FOR THE FOLLOWING MAMMOGRAPHY SCREENING SERVICES, AND SUCH COVERAGE SHALL NOT BE SUBJECT TO ANNUAL DEDUCTIBLES OR COINSURANCE:

(I) EVIDENCE-BASED ITEMS OR SERVICES FOR MAMMOGRAPHY THAT HAVE IN EFFECT A RATING OF 'A' OR 'B' IN THE CURRENT RECOMMENDATIONS OF THE UNITED STATES PREVENTIVE SERVICES TASK FORCE; AND

(II) WITH RESPECT TO WOMEN, SUCH ADDITIONAL PREVENTIVE CARE AND SCREENINGS FOR MAMMOGRAPHY NOT DESCRIBED IN ITEM (I) OF THIS SUBPARAGRAPH AND AS PROVIDED FOR IN COMPREHENSIVE GUIDELINES SUPPORTED BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION.

(E) FOR PURPOSES OF THIS PARAGRAPH, "GRANDFATHERED HEALTH PLAN" MEANS COVERAGE PROVIDED BY AN INSURER IN WHICH AN INDIVIDUAL WAS ENROLLED ON MARCH TWENTY-THIRD, TWO THOUSAND TEN FOR AS LONG AS THE COVERAGE MAINTAINS GRANDFATHERED STATUS IN ACCORDANCE WITH SECTION 1251(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18011(E).

S 5. Paragraph 15 of subsection (i) of section 3216 of the insurance law, as amended by chapter 43 of the laws of 1993, is amended to read as follows:

(15) (A) Every policy [which] THAT provides hospital, surgical or medical care coverage or provides reimbursement for laboratory tests or reimbursement for diagnostic X-ray services shall provide coverage for an annual cervical cytology screening for cervical cancer and its precursor states for women aged eighteen and older.

(B) For purposes OF SUBPARAGRAPHS (A) AND (C) of this paragraph, cervical cytology screening shall include an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.

(C) Such coverage REQUIRED PURSUANT TO SUBPARAGRAPH (A) OR (B) OF THIS PARAGRAPH may be subject to annual deductibles and coinsurance as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given policy.

(D) IN ADDITION TO SUBPARAGRAPH (A), (B) OR (C) OF THIS PARAGRAPH, EVERY POLICY THAT PROVIDES HOSPITAL, SURGICAL OR MEDICAL CARE COVERAGE, EXCEPT FOR A GRANDFATHERED HEALTH PLAN UNDER SUBPARAGRAPH (E) OF THIS PARAGRAPH, SHALL PROVIDE COVERAGE FOR THE FOLLOWING CERVICAL CYTOLOGY SCREENING SERVICES, AND SUCH COVERAGE SHALL NOT BE SUBJECT TO ANNUAL DEDUCTIBLES OR COINSURANCE:

(I) EVIDENCE-BASED ITEMS OR SERVICES FOR CERVICAL CYTOLOGY THAT HAVE IN EFFECT A RATING OF 'A' OR 'B' IN THE CURRENT RECOMMENDATIONS OF THE UNITED STATES PREVENTIVE SERVICES TASK FORCE; AND

(II) WITH RESPECT TO WOMEN, SUCH ADDITIONAL PREVENTIVE CARE AND SCREENINGS FOR CERVICAL CYTOLOGY NOT DESCRIBED IN ITEM (I) OF THIS SUBPARAGRAPH AND AS PROVIDED FOR IN COMPREHENSIVE GUIDELINES SUPPORTED BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION.

(E) FOR PURPOSES OF THIS PARAGRAPH, "GRANDFATHERED HEALTH PLAN" MEANS COVERAGE PROVIDED BY AN INSURER IN WHICH AN INDIVIDUAL WAS ENROLLED ON MARCH TWENTY-THIRD, TWO THOUSAND TEN FOR AS LONG AS THE COVERAGE MAIN-

TAINS GRANDFATHERED STATUS IN ACCORDANCE WITH SECTION 1251(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18011(E).

S 6. Paragraph 17 of subsection (i) of section 3216 of the insurance law, as added by chapter 728 of the laws of 1993, is amended to read as follows:

(17) (A) Every policy [which] THAT provides medical, major-medical or similar comprehensive-type coverage shall provide coverage for the provision of preventive and primary care services.

(B) For the purposes OF SUBPARAGRAPHS (A), (C) AND (D) of this paragraph, preventive and primary care services means the following services rendered to a [dependent] COVERED child of an insured from the date of birth through the attainment of nineteen years;

(i) an initial hospital check-up and well-child visits scheduled in accordance with the prevailing clinical standards of a national association of pediatric physicians designated by the commissioner of health (except for any standard that would limit the specialty or forum of licensure of the practitioner providing the service other than the limits under state law). Coverage for such services rendered shall be provided only to the extent that such services are provided by or under the supervision of a physician, or other professional licensed under article one hundred thirty-nine of the education law whose scope of practice pursuant to such law includes the authority to provide the specified services. Coverage shall be provided for such services rendered in a hospital, as defined in section twenty-eight hundred one of the public health law, or in an office of a physician or other professional licensed under article one hundred thirty-nine of the education law whose scope of practice pursuant to such law includes the authority to provide the specified services;

(ii) at each visit, services in accordance with the prevailing clinical standards of such designated association, including a medical history, a complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests which tests are ordered at the time of the visit and performed in the practitioner's office, as authorized by law, or in a clinical laboratory; and

(iii) necessary immunizations, as determined by the superintendent in consultation with the commissioner of health, consisting of at least adequate dosages of vaccine against diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, haemophilus influenzae type b and hepatitis b, which meet the standards approved by the United States public health service for such biological products.

(C) Such coverage REQUIRED PURSUANT TO SUBPARAGRAPH (A) OR (B) OF THIS PARAGRAPH shall not be subject to annual deductibles [and/or] OR coinsurance.

(D) Such coverage REQUIRED PURSUANT TO SUBPARAGRAPH (A) OR (B) OF THIS PARAGRAPH shall not restrict or eliminate existing coverage provided by the policy.

(E) IN ADDITION TO SUBPARAGRAPH (A), (B), (C) OR (D) OF THIS PARAGRAPH, EVERY POLICY THAT PROVIDES HOSPITAL, SURGICAL OR MEDICAL CARE COVERAGE, EXCEPT FOR A GRANDFATHERED HEALTH PLAN UNDER SUBPARAGRAPH (F) OF THIS PARAGRAPH, SHALL PROVIDE COVERAGE FOR THE FOLLOWING PREVENTIVE CARE AND SCREENINGS FOR INSUREDS, AND SUCH COVERAGE SHALL NOT BE SUBJECT TO ANNUAL DEDUCTIBLES OR COINSURANCE:

(I) EVIDENCE-BASED ITEMS OR SERVICES FOR PREVENTIVE CARE AND SCREENINGS THAT HAVE IN EFFECT A RATING OF 'A' OR 'B' IN THE CURRENT RECOMMENDATIONS OF THE UNITED STATES PREVENTIVE SERVICES TASK FORCE;

(II) IMMUNIZATIONS THAT HAVE IN EFFECT A RECOMMENDATION FROM THE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION WITH RESPECT TO THE INDIVIDUAL INVOLVED;

(III) WITH RESPECT TO CHILDREN, INCLUDING INFANTS AND ADOLESCENTS, EVIDENCE-INFORMED PREVENTIVE CARE AND SCREENINGS PROVIDED FOR IN COMPREHENSIVE GUIDELINES SUPPORTED BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION; AND

(IV) WITH RESPECT TO WOMEN, SUCH ADDITIONAL PREVENTIVE CARE AND SCREENINGS NOT DESCRIBED IN ITEM (I) OF THIS SUBPARAGRAPH AND AS PROVIDED FOR IN COMPREHENSIVE GUIDELINES SUPPORTED BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION.

(F) FOR PURPOSES OF THIS PARAGRAPH, "GRANDFATHERED HEALTH PLAN" MEANS COVERAGE PROVIDED BY AN INSURER IN WHICH AN INDIVIDUAL WAS ENROLLED ON MARCH TWENTY-THIRD, TWO THOUSAND TEN FOR AS LONG AS THE COVERAGE MAINTAINS GRANDFATHERED STATUS IN ACCORDANCE WITH SECTION 1251(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18011(E).

S 7. Subparagraph (E) of paragraph 24 of subsection (i) of section 3216 of the insurance law, as added by chapter 506 of the laws of 2001, is amended to read as follows:

(E) As used in this paragraph:

(i) "Prehospital emergency medical services" means the prompt evaluation and treatment of an emergency medical condition, and/or non-air-borne transportation of the patient to a hospital, provided however, where the patient utilizes non-air-borne emergency transportation pursuant to this paragraph, reimbursement [will] SHALL be based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in [(1)] (I) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; [(2)] (II) serious impairment to such person's bodily functions; [(3)] (III) serious dysfunction of any bodily organ or part of such person; [or (4)] (IV) serious disfigurement of such person; OR (V) A CONDITION DESCRIBED IN CLAUSE (I), (II), OR (III) OF SECTION 1867(E)(1)(A) OF THE SOCIAL SECURITY ACT.

(ii) "Emergency condition" means a medical or behavioral condition[, the onset of which is sudden,] that manifests itself by ACUTE symptoms of sufficient severity, including severe pain, SUCH that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in [(1)] (I) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; [(2)] (II) serious impairment to such person's bodily functions; [(3)] (III) serious dysfunction of any bodily organ or part of such person; [or (4)] (IV) serious disfigurement of such person; OR (V) A CONDITION DESCRIBED IN CLAUSE (I), (II), OR (III) OF SECTION 1867(E)(1)(A) OF THE SOCIAL SECURITY ACT.

S 8. Section 3217-c of the insurance law, as added by chapter 554 of the laws of 2002, is amended to read as follows:

S 3217-c. Primary and preventive obstetric and gynecologic care. (a) No insurer subject to this article shall by contract, written policy or procedure limit a female insured's direct access to primary and preventive obstetric and gynecologic services, INCLUDING ANNUAL EXAMINATIONS, CARE RESULTING FROM SUCH ANNUAL EXAMINATIONS, AND TREATMENT OF ACUTE GYNECOLOGIC CONDITIONS, from a qualified provider of such services of

her choice from within the plan [to less than two examinations annually for such services] or [to] FOR any care related to a pregnancy[. In addition, no insurer subject to this article shall by contract, written policy or procedure limit direct access to primary and preventive obstetric and gynecologic services required as a result of such annual examinations or as a result of an acute gynecologic condition], provided that: (1) such qualified provider discusses such services and treatment plan with the insured's primary care practitioner in accordance with the requirements of the insurer; AND (2) SUCH QUALIFIED PROVIDER AGREES TO ADHERE TO THE INSURER'S POLICIES AND PROCEDURES, INCLUDING ANY APPLICABLE PROCEDURES REGARDING REFERRALS AND OBTAINING PRIOR AUTHORIZATION FOR SERVICES OTHER THAN OBSTETRIC AND GYNECOLOGIC SERVICES RENDERED BY SUCH QUALIFIED PROVIDER, AND AGREES TO PROVIDE SERVICES PURSUANT TO A TREATMENT PLAN (IF ANY) APPROVED BY THE INSURER.

(b) AN INSURER SHALL TREAT THE PROVISION OF OBSTETRIC AND GYNECOLOGIC CARE, AND THE ORDERING OF RELATED OBSTETRIC AND GYNECOLOGIC ITEMS AND SERVICES, PURSUANT TO THE DIRECT ACCESS DESCRIBED IN SUBSECTION (A) OF THIS SECTION BY A PARTICIPATING QUALIFIED PROVIDER OF SUCH SERVICES, AS THE AUTHORIZATION OF THE PRIMARY CARE PROVIDER.

(C) It shall be the duty of the administrative officer or other person in charge of each insurer subject to THE PROVISIONS OF this article to advise each female insured, in writing, of the provisions of this section.

S 9. The insurance law is amended by adding a new section 3217-e to read as follows:

S 3217-E. CHOICE OF HEALTH CARE PROVIDER. AN INSURER THAT IS SUBJECT TO THIS ARTICLE AND REQUIRES OR PROVIDES FOR DESIGNATION BY AN INSURED OF A PARTICIPATING PRIMARY CARE PROVIDER SHALL PERMIT THE INSURED TO DESIGNATE ANY PARTICIPATING PRIMARY CARE PROVIDER WHO IS AVAILABLE TO ACCEPT SUCH INDIVIDUAL, AND IN THE CASE OF A CHILD, SHALL PERMIT THE INSURED TO DESIGNATE A PHYSICIAN (ALLOPATHIC OR OSTEOPATHIC) WHO SPECIALIZES IN PEDIATRICS AS THE CHILD'S PRIMARY CARE PROVIDER IF SUCH PROVIDER PARTICIPATES IN THE NETWORK OF THE INSURER.

S 10. The insurance law is amended by adding a new section 3217-f to read as follows:

S 3217-F. PROHIBITION ON LIFETIME AND ANNUAL LIMITS. (A) AN INSURER SHALL NOT ESTABLISH A LIFETIME LIMIT ON THE DOLLAR AMOUNT OF ESSENTIAL HEALTH BENEFITS IN AN INDIVIDUAL, GROUP OR BLANKET POLICY OF HOSPITAL, MEDICAL, SURGICAL OR PRESCRIPTION DRUG EXPENSE INSURANCE.

(B) AN INSURER SHALL NOT ESTABLISH AN ANNUAL LIMIT ON THE DOLLAR AMOUNT OF ESSENTIAL HEALTH BENEFITS IN AN INDIVIDUAL, GROUP OR BLANKET POLICY OF HOSPITAL, MEDICAL, SURGICAL OR PRESCRIPTION DRUG EXPENSE INSURANCE FOR POLICY YEARS BEGINNING ON AND AFTER JANUARY ONE, TWO THOUSAND FOURTEEN.

(C) FOR POLICY YEARS BEGINNING PRIOR TO JANUARY ONE, TWO THOUSAND FOURTEEN, AN INSURER MAY ESTABLISH RESTRICTED ANNUAL LIMITS ON THE DOLLAR AMOUNT OF ESSENTIAL HEALTH BENEFITS IN AN INDIVIDUAL, GROUP, OR BLANKET POLICY OF HOSPITAL, MEDICAL, SURGICAL OR PRESCRIPTION DRUG EXPENSE INSURANCE CONSISTENT WITH SECTION 2711 OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-11 OR ANY REGULATIONS THEREUNDER.

(D) THE REQUIREMENTS OF SUBSECTIONS (B) AND (C) OF THIS SECTION SHALL NOT BE APPLICABLE TO AN INDIVIDUAL POLICY THAT IS A GRANDFATHERED HEALTH PLAN. FOR PURPOSES OF THIS SECTION, "GRANDFATHERED HEALTH PLAN" MEANS COVERAGE PROVIDED BY AN INSURER IN WHICH AN INDIVIDUAL WAS ENROLLED ON MARCH TWENTY-THIRD, TWO THOUSAND TEN FOR AS LONG AS THE COVERAGE MAIN-

TAINS GRANDFATHERED STATUS IN ACCORDANCE WITH SECTION 1251(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18011(E).

(E) FOR PURPOSES OF THIS SECTION, "ESSENTIAL HEALTH BENEFITS" SHALL HAVE THE MEANING ASCRIBED BY SECTION 1302(B) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(B).

S 11. Subsection (e) of section 3221 of the insurance law is amended by adding a new paragraph 12 to read as follows:

(12) FOR PURPOSES OF THIS SUBSECTION, THE TERM "DEPENDENT" SHALL INCLUDE A CHILD AS DESCRIBED IN SUBSECTION (F) OF SECTION FOUR THOUSAND TWO HUNDRED THIRTY-FIVE OF THIS CHAPTER.

S 12. Subsection (h) of section 3221 of the insurance law is amended by adding a new paragraph 5 to read as follows:

(5) FOR THE PURPOSE OF DETERMINING THE BENEFITS PAYABLE FOR A COVERED PERSON, AN INSURER SHALL NOT IMPOSE A LIFETIME LIMIT ON THE DOLLAR AMOUNT OF BENEFITS THAT ARE DEFINED AS ESSENTIAL HEALTH BENEFITS PURSUANT TO SECTION 1302(B) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(B).

S 13. Paragraph 4 of subsection (k) of section 3221 of the insurance law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(4) (A) Every group policy delivered or issued for delivery in this state [which] THAT provides coverage for inpatient hospital care shall include coverage for services to treat an emergency condition provided in hospital facilities, except that this provision shall not apply to a policy which [cover] COVERS persons employed in more than one state or the benefit structure of which was the subject of collective bargaining affecting persons who are employed in more than one state UNLESS THE POLICY OTHERWISE PROVIDES COVERAGE FOR SERVICES TO TREAT AN EMERGENCY CONDITION PROVIDED IN HOSPITAL FACILITIES:

(I) WITHOUT THE NEED FOR ANY PRIOR AUTHORIZATION DETERMINATION;

(II) REGARDLESS OF WHETHER THE HEALTH CARE PROVIDER FURNISHING SUCH SERVICES IS A PARTICIPATING PROVIDER WITH RESPECT TO SUCH SERVICES;

(III) IF THE EMERGENCY SERVICES ARE PROVIDED BY A NON-PARTICIPATING PROVIDER, 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 PARTICIPATING PROVIDERS; AND

(IV) IF THE EMERGENCY SERVICES ARE PROVIDED BY A NON-PARTICIPATING PROVIDER, THE COST-SHARING REQUIREMENT (EXPRESSED AS A COPAYMENT OR COINSURANCE) SHALL BE THE SAME REQUIREMENT THAT WOULD APPLY IF SUCH SERVICES WERE PROVIDED BY A PARTICIPATING PROVIDER.

(B) ANY REQUIREMENTS OF SECTION 2719A(B) OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG19A(B) AND REGULATIONS THEREUNDER THAT EXCEED THE REQUIREMENTS OF THIS PARAGRAPH WITH RESPECT TO COVERAGE OF EMERGENCY SERVICES SHALL BE APPLICABLE TO EVERY POLICY SUBJECT TO THIS PARAGRAPH.

(C) In this paragraph, an "emergency condition" means a medical or behavioral condition[, the onset of which is sudden,] that manifests itself by ACUTE symptoms of sufficient severity, including severe pain, SUCH that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy[, or]; (ii) serious impairment to such person's bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; [or] (iv) serious disfigurement of such person; OR (V) A CONDI-

TION DESCRIBED IN CLAUSE (I), (II) OR (III) OF SECTION 1867(E)(1)(A) OF THE SOCIAL SECURITY ACT.

(D) IN THIS PARAGRAPH, "EMERGENCY SERVICES" MEANS, WITH RESPECT TO AN EMERGENCY CONDITION: (I) A MEDICAL SCREENING EXAMINATION AS REQUIRED UNDER SECTION 1867 OF THE SOCIAL SECURITY ACT, 42 U.S.C. S 1395DD, WHICH IS WITHIN THE CAPABILITY OF THE EMERGENCY DEPARTMENT OF A HOSPITAL, INCLUDING ANCILLARY SERVICES ROUTINELY AVAILABLE TO THE EMERGENCY DEPARTMENT TO EVALUATE SUCH EMERGENCY MEDICAL CONDITION: AND (II) WITHIN THE CAPABILITIES OF THE STAFF AND FACILITIES AVAILABLE AT THE HOSPITAL, SUCH FURTHER MEDICAL EXAMINATION AND TREATMENT AS ARE REQUIRED UNDER SECTION 1867 OF THE SOCIAL SECURITY ACT, 42 U.S.C. S 1395DD, TO STABILIZE THE PATIENT.

(E) IN THIS PARAGRAPH, "TO STABILIZE" MEANS, WITH RESPECT TO AN EMERGENCY CONDITION, TO PROVIDE SUCH MEDICAL TREATMENT OF THE CONDITION AS MAY BE NECESSARY TO ASSURE, WITHIN REASONABLE MEDICAL PROBABILITY, THAT NO MATERIAL DETERIORATION OF THE CONDITION IS LIKELY TO RESULT FROM OR OCCUR DURING THE TRANSFER OF THE INSURED FROM A FACILITY OR TO DELIVER A NEWBORN CHILD (INCLUDING THE PLACENTA).

S 14. Paragraph 13 of subsection (k) of section 3221 of the insurance law, as added by chapter 554 of the laws of 2002, is amended to read as follows:

(13) Every group or blanket policy delivered or issued for delivery in this state [which] THAT provides major medical or similar comprehensive-type coverage shall provide such coverage for bone mineral density measurements or tests, and if such contract otherwise includes coverage for prescription drugs, drugs and devices approved by the federal food and drug administration or generic equivalents as approved substitutes. In determining appropriate coverage provided by SUBPARAGRAPHS (A), (B) AND (C) OF this paragraph, the insurer or health maintenance organization shall adopt standards [which] THAT include the criteria of the federal [medicare] MEDICARE program and the criteria of the national institutes of health for the detection of osteoporosis, provided that such coverage shall be further determined as follows:

(A) for purposes OF SUBPARAGRAPHS (B) AND (C) of this paragraph, bone mineral density measurements or tests, drugs and devices shall include those covered under the federal Medicare program as well as those in accordance with the criteria of the national institutes of health, including, as consistent with such criteria, dual-energy x-ray absorptiometry.

(B) for purposes OF SUBPARAGRAPHS (A) AND (C) of this paragraph, bone mineral density measurements or tests, drugs and devices shall be covered for individuals meeting the criteria under the federal Medicare program or the criteria of the national institutes of health; provided that, to the extent consistent with such criteria, individuals qualifying for coverage shall at a minimum, include individuals:

(i) previously diagnosed as having osteoporosis or having a family history of osteoporosis; or

(ii) with symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis; or

(iii) on a prescribed drug regimen posing a significant risk of osteoporosis; or

(iv) with lifestyle factors to such a degree as posing a significant risk of osteoporosis; or

(v) with such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.

(C) Such coverage REQUIRED PURSUANT TO SUBPARAGRAPH (A) OR (B) OF THIS PARAGRAPH may be subject to annual deductibles and coinsurance as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given policy.

(D) IN ADDITION TO SUBPARAGRAPH (A), (B) OR (C) OF THIS PARAGRAPH, EVERY GROUP OR BLANKET POLICY THAT PROVIDES HOSPITAL, SURGICAL OR MEDICAL CARE COVERAGE, EXCEPT FOR A GRANDFATHERED HEALTH PLAN UNDER SUBPARAGRAPH (E) OF THIS PARAGRAPH, SHALL PROVIDE COVERAGE FOR THE FOLLOWING ITEMS OR SERVICES FOR BONE MINERAL DENSITY AND SUCH COVERAGE SHALL NOT BE SUBJECT TO ANNUAL DEDUCTIBLES OR COINSURANCE:

(I) EVIDENCE-BASED ITEMS OR SERVICES FOR BONE MINERAL DENSITY THAT HAVE IN EFFECT A RATING OF 'A' OR 'B' IN THE CURRENT RECOMMENDATIONS OF THE UNITED STATES PREVENTIVE SERVICES TASK FORCE; AND

(II) WITH RESPECT TO WOMEN, SUCH ADDITIONAL PREVENTIVE CARE AND SCREENINGS FOR BONE MINERAL DENSITY NOT DESCRIBED IN ITEM (I) OF THIS SUBPARAGRAPH AND AS PROVIDED FOR IN COMPREHENSIVE GUIDELINES SUPPORTED BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION.

(E) FOR PURPOSES OF THIS PARAGRAPH, "GRANDFATHERED HEALTH PLAN" MEANS COVERAGE PROVIDED BY AN INSURER IN WHICH AN INDIVIDUAL WAS ENROLLED ON MARCH TWENTY-THIRD, TWO THOUSAND TEN FOR AS LONG AS THE COVERAGE MAINTAINS GRANDFATHERED STATUS IN ACCORDANCE WITH SECTION 1251(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18011(E).

S 15. Paragraph 8 of subsection (l) of section 3221 of the insurance law, as amended by chapter 728 of the laws of 1993, is amended to read as follows:

(8) (A) Every insurer issuing a group policy for delivery in this state [which] THAT provides medical, major-medical or similar comprehensive-type coverage [must] SHALL provide coverage for the provision of preventive and primary care services.

(B) In SUBPARAGRAPHS (A), (C) AND (D) OF this paragraph, preventive and primary care services means the following services rendered to a [dependent] COVERED child of an insured from the date of birth through the attainment of nineteen years of age:

(i) an initial hospital check-up and well-child visits scheduled in accordance with the prevailing clinical standards of a national association of pediatric physicians designated by the commissioner of health (except for any standard that would limit the specialty or forum of licensure of the practitioner providing the service other than the limits under state law). Coverage for such services rendered shall be provided only to the extent that such services are provided by or under the supervision of a physician, or other professional licensed under article one hundred thirty-nine of the education law whose scope of practice pursuant to such law includes the authority to provide the specified services. Coverage shall be provided for such services rendered in a hospital, as defined in section twenty-eight hundred one of the public health law, or in an office of a physician or other professional licensed under article one hundred thirty-nine of the education law whose scope of practice pursuant to such law includes the authority to provide the specified services;

(ii) at each visit, services in accordance with the prevailing clinical standards of such designated association, including a medical history, a complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests which tests are ordered at the time of the visit and performed in the practitioner's office, as authorized by law, or in a clinical laboratory; and

(iii) necessary immunizations, as determined by the superintendent in consultation with the commissioner of health, consisting of at least adequate dosages of vaccine against diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, haemophilus influenzae type b and hepatitis b, which meet the standards approved by the United States public health service for such biological products.

(C) Such coverage REQUIRED PURSUANT TO SUBPARAGRAPH (A) OR (B) OF THIS PARAGRAPH shall not be subject to annual deductibles [and/or] OR coinsurance.

(D) Such coverage REQUIRED PURSUANT TO SUBPARAGRAPH (A) OR (B) OF THIS PARAGRAPH shall not restrict or eliminate existing coverage provided by the policy.

(E) IN ADDITION TO SUBPARAGRAPH (A), (B), (C) OR (D) OF THIS PARAGRAPH, EVERY GROUP POLICY THAT PROVIDES HOSPITAL, SURGICAL OR MEDICAL CARE COVERAGE, EXCEPT FOR A GRANDFATHERED HEALTH PLAN UNDER SUBPARAGRAPH (G) OF THIS PARAGRAPH, SHALL PROVIDE COVERAGE FOR THE FOLLOWING PREVENTIVE CARE AND SCREENINGS FOR INSUREDS, AND SUCH COVERAGE SHALL NOT BE SUBJECT TO ANNUAL DEDUCTIBLES OR COINSURANCE:

(I) EVIDENCE-BASED ITEMS OR SERVICES FOR PREVENTIVE CARE AND SCREENINGS THAT HAVE IN EFFECT A RATING OF 'A' OR 'B' IN THE CURRENT RECOMMENDATIONS OF THE UNITED STATES PREVENTIVE SERVICES TASK FORCE;

(II) IMMUNIZATIONS THAT HAVE IN EFFECT A RECOMMENDATION FROM THE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION WITH RESPECT TO THE INDIVIDUAL INVOLVED;

(III) WITH RESPECT TO CHILDREN, INCLUDING INFANTS AND ADOLESCENTS, EVIDENCE-INFORMED PREVENTIVE CARE AND SCREENINGS PROVIDED FOR IN COMPREHENSIVE GUIDELINES SUPPORTED BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION; AND

(IV) WITH RESPECT TO WOMEN, SUCH ADDITIONAL PREVENTIVE CARE AND SCREENINGS NOT DESCRIBED IN ITEM (I) OF THIS SUBPARAGRAPH AND AS PROVIDED FOR IN COMPREHENSIVE GUIDELINES SUPPORTED BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION.

(F) THE REQUIREMENTS OF THIS PARAGRAPH SHALL ALSO BE APPLICABLE TO A BLANKET POLICY OF HOSPITAL, MEDICAL OR SURGICAL EXPENSE INSURANCE COVERING STUDENTS PURSUANT TO SUBPARAGRAPH (C) OF PARAGRAPH THREE OF SUBSECTION (A) OF SECTION FOUR THOUSAND TWO HUNDRED THIRTY-SEVEN OF THIS CHAPTER.

(G) FOR PURPOSES OF THIS PARAGRAPH, "GRANDFATHERED HEALTH PLAN" MEANS COVERAGE PROVIDED BY AN INSURER IN WHICH AN INDIVIDUAL WAS ENROLLED ON MARCH TWENTY-THIRD, TWO THOUSAND TEN FOR AS LONG AS THE COVERAGE MAINTAINS GRANDFATHERED STATUS IN ACCORDANCE WITH SECTION 1251(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18011(E).

S 16. Paragraph 11 of subsection (l) of section 3221 of the insurance law, as amended by chapter 554 of the laws of 2002, is amended to read as follows:

(11) (A) Every insurer delivering a group or blanket policy or issuing a group or blanket policy for delivery in this state [which] THAT provides coverage for hospital, surgical or medical care shall provide the following coverage for mammography screening for occult breast cancer:

(i) upon the recommendation of a physician, a mammogram at any age for covered persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer;

(ii) a single baseline mammogram for covered persons aged thirty-five through thirty-nine, inclusive; and

(iii) an annual mammogram for covered persons aged forty and older.

(B) Such coverage REQUIRED PURSUANT TO SUBPARAGRAPH (A) OR (C) OF THIS PARAGRAPH may be subject to annual deductibles and coinsurance as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given policy.

(C) For purposes OF SUBPARAGRAPHS (A) AND (B) of this paragraph, mammography screening means an X-ray examination of the breast using dedicated equipment, including X-ray tube, filter, compression device, screens, films and cassettes, with an average glandular radiation dose less than 0.5 rem per view per breast.

(D) IN ADDITION TO SUBPARAGRAPH (A), (B) OR (C) OF THIS PARAGRAPH, EVERY GROUP OR BLANKET POLICY THAT PROVIDES COVERAGE FOR HOSPITAL, SURGICAL OR MEDICAL CARE, EXCEPT FOR A GRANDFATHERED HEALTH PLAN UNDER SUBPARAGRAPH (E) OF THIS PARAGRAPH, SHALL PROVIDE COVERAGE FOR THE FOLLOWING MAMMOGRAPHY SCREENING SERVICES, AND SUCH COVERAGE SHALL NOT BE SUBJECT TO ANNUAL DEDUCTIBLES OR COINSURANCE:

(I) EVIDENCE-BASED ITEMS OR SERVICES FOR MAMMOGRAPHY THAT HAVE IN EFFECT A RATING OF 'A' OR 'B' IN THE CURRENT RECOMMENDATIONS OF THE UNITED STATES PREVENTIVE SERVICES TASK FORCE; AND

(II) WITH RESPECT TO WOMEN, SUCH ADDITIONAL PREVENTIVE CARE AND SCREENINGS FOR MAMMOGRAPHY NOT DESCRIBED IN ITEM (I) OF THIS SUBPARAGRAPH AND AS PROVIDED FOR IN COMPREHENSIVE GUIDELINES SUPPORTED BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION.

(E) FOR PURPOSES OF THIS PARAGRAPH, "GRANDFATHERED HEALTH PLAN" MEANS COVERAGE PROVIDED BY AN INSURER IN WHICH AN INDIVIDUAL WAS ENROLLED ON MARCH TWENTY-THIRD, TWO THOUSAND TEN FOR AS LONG AS THE COVERAGE MAINTAINS GRANDFATHERED STATUS IN ACCORDANCE WITH SECTION 1251(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18011(E).

S 17. Paragraph 14 of subsection (l) of section 3221 of the insurance law, as amended by chapter 554 of the laws of 2002, is amended to read as follows:

(14) (A) Every group or blanket policy delivered or issued for delivery in this state [which] THAT provides hospital, surgical or medical coverage shall provide coverage for an annual cervical cytology screening for cervical cancer and its precursor states for women aged eighteen and older.

(B) For purposes OF SUBPARAGRAPHS (A) AND (C) of this paragraph, cervical cytology screening shall include an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.

(C) Such coverage REQUIRED PURSUANT TO SUBPARAGRAPH (A) OR (B) OF THIS PARAGRAPH may be subject to annual deductibles and coinsurance as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given policy.

(D) IN ADDITION TO SUBPARAGRAPH (A), (B) OR (C) OF THIS PARAGRAPH, EVERY GROUP OR BLANKET POLICY THAT PROVIDES HOSPITAL, SURGICAL OR MEDICAL COVERAGE, EXCEPT FOR A GRANDFATHERED HEALTH PLAN UNDER SUBPARAGRAPH (E) OF THIS PARAGRAPH, SHALL PROVIDE COVERAGE FOR THE FOLLOWING CERVICAL CYTOLOGY SCREENING SERVICES, AND SUCH COVERAGE SHALL NOT BE SUBJECT TO ANNUAL DEDUCTIBLES OR COINSURANCE:

(I) EVIDENCE-BASED ITEMS OR SERVICES FOR CERVICAL CYTOLOGY THAT HAVE IN EFFECT A RATING OF 'A' OR 'B' IN THE CURRENT RECOMMENDATIONS OF THE UNITED STATES PREVENTIVE SERVICES TASK FORCE; AND

(II) WITH RESPECT TO WOMEN, SUCH ADDITIONAL PREVENTIVE CARE AND SCREENINGS FOR CERVICAL CYTOLOGY NOT DESCRIBED IN ITEM (I) OF THIS

SUBPARAGRAPH AND AS PROVIDED FOR IN COMPREHENSIVE GUIDELINES SUPPORTED BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION.

(E) FOR PURPOSES OF THIS PARAGRAPH, "GRANDFATHERED HEALTH PLAN" MEANS COVERAGE PROVIDED BY AN INSURER IN WHICH AN INDIVIDUAL WAS ENROLLED ON MARCH TWENTY-THIRD, TWO THOUSAND TEN FOR AS LONG AS THE COVERAGE MAINTAINS GRANDFATHERED STATUS IN ACCORDANCE WITH SECTION 1251(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18011(E).

S 18. Subparagraph (E) of paragraph 15 of subsection (l) of section 3221 of the insurance law, as added by chapter 506 of the laws of 2001, is amended to read as follows:

(E) As used in this paragraph:

(i) "Prehospital emergency medical services" means the prompt evaluation and treatment of an emergency medical condition, and/or non-air-borne transportation of the patient to a hospital, provided however, where the patient utilizes non-air-borne emergency transportation pursuant to this paragraph, reimbursement [will] SHALL be based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in [(1)] (I) placing the health of the person affected with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; [(2)] (II) serious impairment to such person's bodily functions; [(3)] (III) serious dysfunction of any bodily organ or part of such person; [or (4)] (IV) serious disfigurement of such person; OR (V) A CONDITION DESCRIBED IN CLAUSE (I), (II) OR (III) OF SECTION 1867(E)(1)(A) OF THE SOCIAL SECURITY ACT.

(ii) "Emergency condition" means a medical or behavioral condition[, the onset of which is sudden,] that manifests itself by ACUTE symptoms of sufficient severity, including severe pain, SUCH that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in [(1)] (I) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; [(2)] (II) serious impairment to such person's bodily functions; ([3)] (III) serious dysfunction of any bodily organ or part of such person; [or (4)] (IV) serious disfigurement of such person; OR (V) A CONDITION DESCRIBED IN CLAUSE (I), (II) OR (III) OF SECTION 1867(E)(1)(A) OF THE SOCIAL SECURITY ACT.

S 19. Subsection (m) of section 3221 of the insurance law is amended by adding a new paragraph 8 to read as follows:

(8) FOR PURPOSES OF THIS SUBSECTION, THE TERM "DEPENDENT" SHALL INCLUDE A CHILD AS DESCRIBED IN SUBSECTION (F) OF SECTION FOUR THOUSAND TWO HUNDRED THIRTY-FIVE OF THIS CHAPTER.

S 20. Subsection (p) of section 3221 of the insurance law is amended by adding a new paragraph 6 to read as follows:

(6) FOR PURPOSES OF THIS SUBSECTION, THE TERM "DEPENDENT" SHALL INCLUDE A CHILD AS DESCRIBED IN SUBSECTION (F) OF SECTION FOUR THOUSAND TWO HUNDRED THIRTY-FIVE OF THIS CHAPTER.

S 21. Subsection (q) of section 3221 of the insurance law is amended by adding a new paragraph 7 to read as follows:

(7) FOR PURPOSES OF THIS SUBSECTION, THE TERM "DEPENDENT" SHALL INCLUDE A CHILD AS DESCRIBED IN SUBSECTION (F) OF SECTION FOUR THOUSAND TWO HUNDRED THIRTY-FIVE OF THIS CHAPTER.

S 22. Paragraphs 1 and 2 of subsection (r) of section 3221 of the insurance law, as added by chapter 240 of the laws of 2009, are amended to read as follows:

(1) As used in this subsection, ["dependent child"] "CHILD" means an unmarried child through age twenty-nine of an employee or member insured under a group policy OF HOSPITAL, MEDICAL OR SURGICAL EXPENSE INSURANCE, regardless of financial dependence, who is not insured by or eligible for coverage under any [employee] EMPLOYER health benefit plan as an employee or member, whether insured or self-insured, and who lives, works or resides in New York state or the service area of the insurer and who is not covered under title XVIII of the United States Social Security Act (Medicare).

(2) In addition to the conversion privilege afforded by subsection (e) of this section and the continuation privilege afforded by subsection (m) of this section, every group policy delivered or issued for delivery in this state that provides hospital, [surgical or medical coverage] MEDICAL OR SURGICAL EXPENSE INSURANCE COVERAGE for other than specific diseases or accidents only, and which provides [dependent] coverage OF A CHILD that terminates at a specified age, shall, upon application of the employee, member or [dependent] child, as set forth in [subparagraphs (B) or (C)] SUBPARAGRAPH (B) of this paragraph, provide coverage to the [dependent] child after that specified age and through age twenty-nine without evidence of insurability, subject to all of the terms and conditions of the group policy and the following:

(A) An employer shall not be required to pay all or part of the cost of coverage for a [dependent] child provided pursuant to this subsection;

(B) An employee, member or [dependent] child who wishes to elect continuation of coverage pursuant to this subsection shall request the continuation in writing:

(i) within sixty days following the date coverage would otherwise terminate due to reaching the specified age set forth in the group policy;

(ii) within sixty days after meeting the requirements for [dependent] child status set forth in paragraph one of this subsection when coverage for the [dependent] child previously terminated; or

(iii) during an annual thirty-day open enrollment period, as described in the policy;

(C) [For twelve months after the effective date of this subsection, an employee, member or dependent child may elect prospective coverage under this subsection for a dependent child whose coverage terminated under the terms of the group policy prior to the initial effective date of this subsection;

(D)] An employee, member or [dependent] child electing continuation as described in this subsection shall pay to the group policyholder or employer, but not more frequently than on a monthly basis in advance, the amount of the required premium payment on the due date of each payment. The written election of continuation, together with the first premium payment required to establish premium payment on a monthly basis in advance, shall be given to the group policyholder or employer within the time periods set forth in [subparagraphs (B) and (C)] SUBPARAGRAPH (B) of this paragraph. Any premium received within the thirty-day period after the due date shall be considered timely;

[(E)] (D) For any [dependent] child electing coverage within sixty days of the date the [dependent] child would otherwise lose coverage due to reaching a specified age, the effective date of the continuation

coverage shall be the date coverage would have otherwise terminated. For any [dependent] child electing to resume coverage during an annual open enrollment period [or during the twelve-month initial open enrollment period described in subparagraph (C) of this paragraph], the effective date of the continuation coverage shall be prospective no later than thirty days after the election and payment of first premium;

[(F)] (E) Coverage for a [dependent] child pursuant to this subsection shall consist of coverage that is identical to the coverage provided to the employee or member parent. If coverage is modified under the policy for any group of similarly situated employees or members, then the coverage shall also be modified in the same manner for any [dependent] child;

[(G)] (F) Coverage shall terminate on the first to occur of the following:

(i) the date the [dependent] child no longer meets the requirements of paragraph one of this subsection;

(ii) the end of the period for which premium payments were made, if there is a failure to make payment of a required premium payment within the period of grace described in subparagraph [(D)] (C) of this paragraph; or

(iii) the date on which the group policy is terminated and not replaced by coverage under another group policy; and

[(H)] (G) The insurer shall provide written notification of the continuation privilege described in this subsection and the time period in which to request continuation to the employee or member:

(i) in each certificate of coverage; AND

(ii) at least sixty days prior to termination at the specified age as provided in the policy[; and

(iii) within thirty days of the effective date of this subsection, with respect to information concerning a dependent child's opportunity, for twelve months after the effective date of this subsection, to make a written election to obtain coverage under a policy pursuant to subparagraph (C) of this paragraph].

S 23. Section 3232 of the insurance law is amended by adding four new subsections (f), (g), (h) and (i) to read as follows:

(F) WITH RESPECT TO AN INDIVIDUAL UNDER AGE NINETEEN, AN INSURER MAY NOT IMPOSE ANY PRE-EXISTING CONDITION EXCLUSION IN AN INDIVIDUAL OR GROUP POLICY OF HOSPITAL, MEDICAL, SURGICAL OR PRESCRIPTION DRUG EXPENSE INSURANCE PURSUANT TO THE REQUIREMENTS OF SECTION 2704 OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-3, AS MADE EFFECTIVE BY SECTION 1255(2) OF THE AFFORDABLE CARE ACT, EXCEPT FOR AN INDIVIDUAL UNDER AGE NINETEEN COVERED UNDER AN INDIVIDUAL POLICY OF HOSPITAL, MEDICAL, SURGICAL OR PRESCRIPTION DRUG EXPENSE INSURANCE THAT IS A GRANDFATHERED HEALTH PLAN.

(G) BEGINNING JANUARY FIRST, TWO THOUSAND FOURTEEN, PURSUANT TO SECTION 2704 OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-3, AN INSURER MAY NOT IMPOSE ANY PRE-EXISTING CONDITION EXCLUSION IN AN INDIVIDUAL OR GROUP POLICY OF HOSPITAL, MEDICAL, SURGICAL OR PRESCRIPTION DRUG EXPENSE INSURANCE EXCEPT IN AN INDIVIDUAL POLICY THAT IS A GRANDFATHERED HEALTH PLAN.

(H) THE REQUIREMENTS OF SUBSECTIONS (F) AND (G) OF THIS SECTION SHALL ALSO BE APPLICABLE TO A BLANKET POLICY OF HOSPITAL, MEDICAL, SURGICAL OR PRESCRIPTION DRUG EXPENSE INSURANCE.

(I) FOR PURPOSES OF SUBSECTIONS (F) AND (G) OF THIS SECTION, "GRANDFATHERED HEALTH PLAN" MEANS COVERAGE PROVIDED BY AN INSURER IN WHICH AN INDIVIDUAL WAS ENROLLED ON MARCH TWENTY-THIRD, TWO THOUSAND TEN FOR AS

LONG AS THE COVERAGE MAINTAINS GRANDFATHERED STATUS IN ACCORDANCE WITH SECTION 1251(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18011(E).

S 24. Paragraphs 1 and 2 of subsection (f) of section 4235 of the insurance law, paragraph 1 as amended by chapter 240 of the laws of 2009, and paragraph 2 as amended by chapter 312 of the laws of 2002, are amended to read as follows:

(1) (A) Any policy of group accident, group health or group accident and health insurance may include provisions for the payment by the insurer of benefits for expenses incurred on account of hospital, medical or surgical care or physical and occupational therapy by licensed physical and occupational therapists upon the prescription or referral of a physician for the employee or other member of the insured group, [his] THE EMPLOYEE'S OR MEMBER'S spouse, [his] THE EMPLOYEE'S OR MEMBER'S child or children, or other persons chiefly dependent upon [him] THE EMPLOYEE OR MEMBER for support and maintenance; provided that:

(I) A POLICY OF HOSPITAL, MEDICAL, SURGICAL, OR PRESCRIPTION DRUG EXPENSE INSURANCE THAT PROVIDES COVERAGE FOR CHILDREN SHALL PROVIDE SUCH COVERAGE TO A MARRIED OR UNMARRIED CHILD UNTIL ATTAINMENT OF AGE TWENTY-SIX, WITHOUT REGARD TO FINANCIAL DEPENDENCE, RESIDENCY WITH THE EMPLOYEE OR MEMBER, STUDENT STATUS, OR EMPLOYMENT, EXCEPT A POLICY THAT IS A GRANDFATHERED HEALTH PLAN MAY, FOR PLAN YEARS BEGINNING BEFORE JANUARY FIRST, TWO THOUSAND FOURTEEN, EXCLUDE COVERAGE OF AN ADULT CHILD UNDER AGE TWENTY-SIX WHO IS ELIGIBLE TO ENROLL IN AN EMPLOYER-SPONSORED HEALTH PLAN OTHER THAN A GROUP HEALTH PLAN OF A PARENT. FOR PURPOSES OF THIS ITEM, "GRANDFATHERED HEALTH PLAN" MEANS COVERAGE PROVIDED BY AN INSURER IN WHICH AN INDIVIDUAL WAS ENROLLED ON MARCH TWENTY-THIRD, TWO THOUSAND TEN FOR AS LONG AS THE COVERAGE MAINTAINS GRANDFATHERED STATUS IN ACCORDANCE WITH SECTION 1251(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18011(E); AND

(II) a policy under which coverage [of a dependent of an employee or other member of the insured group] terminates at a specified age shall not so terminate with respect to an unmarried child who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap and who became so incapable prior to attainment of the age at which [dependent] coverage would otherwise terminate and who is chiefly dependent upon such employee or member for support and maintenance, while the insurance of the employee or member remains in force and the [dependent] CHILD remains in such condition, if the insured employee or member has within thirty-one days of such [dependent's] CHILD'S attainment of the termination age submitted proof of such [dependent's] CHILD'S incapacity as described herein.

(B) In addition to the requirements of subparagraph (A) of this paragraph, every insurer issuing a group policy OF HOSPITAL, MEDICAL OR SURGICAL EXPENSE INSURANCE pursuant to this section that provides coverage for [dependent] children, must make available and if requested by the policyholder, extend coverage under the policy to an unmarried child through age twenty-nine, without regard to financial dependence who is not insured by or eligible for coverage under any employer health benefit plan as an employee or member, whether insured or self-insured, and who lives, works or resides in New York state or the service area of the insurer. Such coverage shall be made available at the inception of all new policies and with respect to all other policies at any anniversary date. Written notice of the availability of such coverage shall be delivered to the policyholder prior to the inception of such group policy and annually thereafter.

(2) Notwithstanding any rule, regulation or law to the contrary, any family coverage available under this article shall provide that coverage of newborn infants, including newly born infants adopted by the insured or subscriber if such insured or subscriber takes physical custody of the infant upon such infant's release from the hospital and files a petition pursuant to section one hundred fifteen-c of the domestic relations law within thirty days of birth; and provided further that no notice of revocation to the adoption has been filed pursuant to section one hundred fifteen-b of the domestic relations law and consent to the adoption has not been revoked, shall be effective from the moment of birth for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities including premature birth, except that in cases of adoption, coverage of the initial hospital stay shall not be required where a birth parent has insurance coverage available for the infant's care. In the case of individual coverage the insurer must also permit the person to whom the certificate is issued to elect such coverage of newborn infants from the moment of birth. If notification and/or payment of an additional premium or contribution is required to make coverage effective for a newborn infant, the coverage may provide that such notice and/or payment be made within no less than thirty days of the day of birth to make coverage effective from the moment of birth. This election shall not be required in the case of student insurance or where the group's plan does not provide coverage for [dependent] children.

S 25. Paragraph 2 of subsection (a) of section 4303 of the insurance law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(2) (A) For services to treat an emergency condition in hospital facilities[.]:

(I) WITHOUT THE NEED FOR ANY PRIOR AUTHORIZATION DETERMINATION;

(II) REGARDLESS OF WHETHER THE HEALTH CARE PROVIDER FURNISHING SUCH SERVICES IS A PARTICIPATING PROVIDER WITH RESPECT TO SUCH SERVICES;

(III) IF THE EMERGENCY SERVICES ARE PROVIDED BY A NON-PARTICIPATING PROVIDER, 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 PARTICIPATING PROVIDERS; AND

(IV) IF THE EMERGENCY SERVICES ARE PROVIDED BY A NON-PARTICIPATING PROVIDER, THE COST-SHARING REQUIREMENT (EXPRESSED AS A COPAYMENT OR COINSURANCE) SHALL BE THE SAME REQUIREMENT THAT WOULD APPLY IF SUCH SERVICES WERE PROVIDED BY A PARTICIPATING PROVIDER.

(B) ANY REQUIREMENTS OF SECTION 2719A(B) OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG19A(B) AND REGULATIONS THEREUNDER THAT EXCEED THE REQUIREMENTS OF THIS PARAGRAPH WITH RESPECT TO COVERAGE OF EMERGENCY SERVICES SHALL BE APPLICABLE TO EVERY CONTRACT SUBJECT TO THIS PARAGRAPH.

(C) For the purpose of this provision, "emergency condition" means a medical or behavioral condition[, the onset of which is sudden,] that manifests itself by ACUTE symptoms of sufficient severity, including severe pain, SUCH that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in [(A)] (I) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy[, or (B)]; (II) serious impairment to such person's bodily functions; [(C)] (III) serious dysfunction of any bodily

organ or part of such person; [or (D)] (IV) serious disfigurement of such person; OR (V) A CONDITION DESCRIBED IN CLAUSE (I), (II) OR (III) OF SECTION 1867(E)(1)(A) OF THE SOCIAL SECURITY ACT.

(D) FOR THE PURPOSE OF THIS PROVISION, "EMERGENCY SERVICES" MEANS, WITH RESPECT TO AN EMERGENCY CONDITION: (I) A MEDICAL SCREENING EXAMINATION AS REQUIRED UNDER SECTION 1867 OF THE SOCIAL SECURITY ACT, 42 U.S.C. S 1395DD, WHICH IS WITHIN THE CAPABILITY OF THE EMERGENCY DEPARTMENT OF A HOSPITAL, INCLUDING ANCILLARY SERVICES ROUTINELY AVAILABLE TO THE EMERGENCY DEPARTMENT TO EVALUATE SUCH EMERGENCY MEDICAL CONDITION; AND (II) WITHIN THE CAPABILITIES OF THE STAFF AND FACILITIES AVAILABLE AT THE HOSPITAL, SUCH FURTHER MEDICAL EXAMINATION AND TREATMENT AS ARE REQUIRED UNDER SECTION 1867 OF THE SOCIAL SECURITY ACT, 42 U.S.C. S 1395DD, TO STABILIZE THE PATIENT.

(E) FOR THE PURPOSE OF THIS PROVISION, "TO STABILIZE" MEANS, WITH RESPECT TO AN EMERGENCY CONDITION, TO PROVIDE SUCH MEDICAL TREATMENT OF THE CONDITION AS MAY BE NECESSARY TO ASSURE, WITHIN REASONABLE MEDICAL PROBABILITY, THAT NO MATERIAL DETERIORATION OF THE CONDITION IS LIKELY TO RESULT FROM OR OCCUR DURING THE TRANSFER OF THE SUBSCRIBER FROM A FACILITY OR TO DELIVER A NEWBORN CHILD (INCLUDING THE PLACENTA).

S 26. Subsection (j) of section 4303 of the insurance law, as amended by chapter 728 of the laws of 1993, is amended to read as follows:

(j)(1) A health service corporation or medical expense indemnity corporation [which] THAT provides medical, major-medical or similar comprehensive-type coverage [must] SHALL provide coverage for the provision of preventive and primary care services.

(2) For purposes OF THIS PARAGRAPH AND PARAGRAPH ONE of this subsection, preventive and primary care services shall mean the following services rendered to a [dependent] COVERED child of a subscriber from the date of birth through the attainment of nineteen years of age:

[(i)] (A) an initial hospital check-up and well-child visits scheduled in accordance with the prevailing clinical standards of a national association of pediatric physicians designated by the commissioner of health (except for any standard that would limit the specialty or forum of licensure of the practitioner providing the service other than the limits under state law). Coverage for such services rendered shall be provided only to the extent that such services are provided by or under the supervision of a physician, or other professional licensed under article one hundred thirty-nine of the education law whose scope of practice pursuant to such law includes the authority to provide the specified services. Coverage shall be provided for such services rendered in a hospital, as defined in section twenty-eight hundred one of the public health law, or in an office of a physician or other professional licensed under article one hundred thirty-nine of the education law whose scope of practice pursuant to such law includes the authority to provide the specified services,

[(ii)] (B) at each visit, services in accordance with the prevailing clinical standards of such designated association, including a medical history, a complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests which tests are ordered at the time of the visit and performed in the practitioner's office, as authorized by law, or in a clinical laboratory, and

[(iii)] (C) necessary immunizations, as determined by the superintendent in consultation with the commissioner of health, consisting of at least adequate dosages of vaccine against diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, haemophilus influenzae type b and

hepatitis b, which meet the standards approved by the United States public health service for such biological products.

(D) Such coverage REQUIRED PURSUANT TO THIS PARAGRAPH AND PARAGRAPH ONE OF THIS SUBSECTION shall not be subject to annual deductibles [and/or] OR coinsurance.

(E) Such coverage REQUIRED PURSUANT TO THIS PARAGRAPH AND PARAGRAPH ONE OF THIS SUBSECTION shall not restrict or eliminate existing coverage provided by the contract.

(3) IN ADDITION TO PARAGRAPH ONE OR TWO OF THIS SUBSECTION, EVERY CONTRACT THAT PROVIDES HOSPITAL, SURGICAL OR MEDICAL CARE COVERAGE, EXCEPT FOR A GRANDFATHERED HEALTH PLAN UNDER PARAGRAPH FOUR OF THIS SUBSECTION, SHALL PROVIDE COVERAGE FOR THE FOLLOWING PREVENTIVE CARE AND SCREENINGS FOR SUBSCRIBERS, AND SUCH COVERAGE SHALL NOT BE SUBJECT TO ANNUAL DEDUCTIBLES OR COINSURANCE:

(A) EVIDENCE-BASED ITEMS OR SERVICES FOR PREVENTIVE CARE AND SCREENINGS THAT HAVE IN EFFECT A RATING OF 'A' OR 'B' IN THE CURRENT RECOMMENDATIONS OF THE UNITED STATES PREVENTIVE SERVICES TASK FORCE;

(B) IMMUNIZATIONS THAT HAVE IN EFFECT A RECOMMENDATION FROM THE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION WITH RESPECT TO THE INDIVIDUAL INVOLVED;

(C) WITH RESPECT TO CHILDREN, INCLUDING INFANTS AND ADOLESCENTS, EVIDENCE-INFORMED PREVENTIVE CARE AND SCREENINGS PROVIDED FOR IN COMPREHENSIVE GUIDELINES SUPPORTED BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION; AND

(D) WITH RESPECT TO WOMEN, SUCH ADDITIONAL PREVENTIVE CARE AND SCREENINGS NOT DESCRIBED IN SUBPARAGRAPH (A) OF THIS PARAGRAPH AND AS PROVIDED FOR IN COMPREHENSIVE GUIDELINES SUPPORTED BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION.

(4) FOR PURPOSES OF THIS SUBSECTION, "GRANDFATHERED HEALTH PLAN" MEANS COVERAGE PROVIDED BY A CORPORATION IN WHICH AN INDIVIDUAL WAS ENROLLED ON MARCH TWENTY-THIRD, TWO THOUSAND TEN FOR AS LONG AS THE COVERAGE MAINTAINS GRANDFATHERED STATUS IN ACCORDANCE WITH SECTION 1251(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18011(E).

S 27. Subsection (p) of section 4303 of the insurance law, as amended by chapter 554 of the laws of 2002, is amended to read as follows:

(p) (1) A medical expense indemnity corporation, a hospital service corporation or a health service corporation [which] THAT provides coverage for hospital, surgical or medical care shall provide the following coverage for mammography screening for occult breast cancer:

(A) upon the recommendation of a physician, a mammogram at any age for covered persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer;

(B) a single baseline mammogram for covered persons aged thirty-five through thirty-nine, inclusive; and

(C) an annual mammogram for covered persons aged forty and older.

(D) The coverage required in this paragraph OR PARAGRAPH TWO OF THIS SUBSECTION may be subject to annual deductibles and coinsurance as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given [policy] CONTRACT.

(2) [In no event shall coverage pursuant to this section include more than one annual screening.

(3)] For purposes OF PARAGRAPH ONE of this subsection, mammography screening means an X-ray examination of the breast using dedicated equipment, including X-ray tube, filter, compression device, screens, films and cassettes, with an average glandular radiation dose less than 0.5 rem per view per breast.

(3) IN ADDITION TO PARAGRAPH ONE OR TWO OF THIS SUBSECTION, EVERY CONTRACT THAT PROVIDES COVERAGE FOR HOSPITAL, SURGICAL OR MEDICAL CARE, EXCEPT FOR A GRANDFATHERED HEALTH PLAN UNDER PARAGRAPH FOUR OF THIS SUBSECTION, SHALL PROVIDE COVERAGE FOR THE FOLLOWING MAMMOGRAPHY SCREENING SERVICES, AND SUCH COVERAGE SHALL NOT BE SUBJECT TO ANNUAL DEDUCTIBLES OR COINSURANCE:

(A) EVIDENCE-BASED ITEMS OR SERVICES FOR MAMMOGRAPHY THAT HAVE IN EFFECT A RATING OF 'A' OR 'B' IN THE CURRENT RECOMMENDATIONS OF THE UNITED STATES PREVENTIVE SERVICES TASK FORCE; AND

(B) WITH RESPECT TO WOMEN, SUCH ADDITIONAL PREVENTIVE CARE AND SCREENINGS FOR MAMMOGRAPHY NOT DESCRIBED IN SUBPARAGRAPH (A) OF THIS PARAGRAPH AND AS PROVIDED FOR IN COMPREHENSIVE GUIDELINES SUPPORTED BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION.

(4) FOR PURPOSES OF THIS SUBSECTION, "GRANDFATHERED HEALTH PLAN" MEANS COVERAGE PROVIDED BY A CORPORATION IN WHICH AN INDIVIDUAL WAS ENROLLED ON MARCH TWENTY-THIRD, TWO THOUSAND TEN FOR AS LONG AS THE COVERAGE MAINTAINS GRANDFATHERED STATUS IN ACCORDANCE WITH SECTION 1251(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18011(E).

S 28. Subsection (t) of section 4303 of the insurance law, as amended by chapter 43 of the laws of 1993 and paragraph 1 as amended by chapter 554 of the laws of 2002, is amended to read as follows:

(t) (1) A medical expense indemnity corporation, a hospital service corporation or a health service corporation [which] THAT provides coverage for hospital, surgical, or medical care shall provide coverage for an annual cervical cytology screening for cervical cancer and its precursor states for women aged eighteen and older. Such coverage REQUIRED BY THIS PARAGRAPH may be subject to annual deductibles and coinsurance as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given contract.

(2) For purposes OF PARAGRAPH ONE of this subsection, cervical cytology screening shall include an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.

(3) IN ADDITION TO PARAGRAPH ONE OR TWO OF THIS SUBSECTION, EVERY CONTRACT THAT PROVIDES COVERAGE FOR HOSPITAL, SURGICAL OR MEDICAL CARE, EXCEPT FOR A GRANDFATHERED HEALTH PLAN UNDER PARAGRAPH FOUR OF THIS SUBSECTION, SHALL PROVIDE COVERAGE FOR THE FOLLOWING CERVICAL CYTOLOGY SCREENING SERVICES, AND SUCH COVERAGE SHALL NOT BE SUBJECT TO ANNUAL DEDUCTIBLES OR COINSURANCE:

(A) EVIDENCE-BASED ITEMS OR SERVICES FOR CERVICAL CYTOLOGY THAT HAVE IN EFFECT A RATING OF 'A' OR 'B' IN THE CURRENT RECOMMENDATIONS OF THE UNITED STATES PREVENTIVE SERVICES TASK FORCE; AND

(B) WITH RESPECT TO WOMEN, SUCH ADDITIONAL PREVENTIVE CARE AND SCREENINGS FOR CERVICAL CYTOLOGY NOT DESCRIBED IN SUBPARAGRAPH (A) OF THIS PARAGRAPH AND AS PROVIDED FOR IN COMPREHENSIVE GUIDELINES SUPPORTED BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION.

(4) FOR PURPOSES OF THIS SUBSECTION, "GRANDFATHERED HEALTH PLAN" MEANS COVERAGE PROVIDED BY A CORPORATION IN WHICH AN INDIVIDUAL WAS ENROLLED ON MARCH TWENTY-THIRD, TWO THOUSAND TEN FOR AS LONG AS THE COVERAGE MAINTAINS GRANDFATHERED STATUS IN ACCORDANCE WITH SECTION 1251(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18011(E).

S 29. Paragraph 5 of subsection (aa) of section 4303 of the insurance law, as added by chapter 506 of the laws of 2001, is amended to read as follows:

(5) As used in this subsection:

(A) "Prehospital emergency medical services" means the prompt evaluation and treatment of an emergency medical condition, and/or non-air-borne transportation of the patient to a hospital; provided however, where the patient utilizes non-air-borne emergency transportation pursuant to this subsection, reimbursement [will] SHALL be based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (ii) serious impairment to such person's bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; [or] (iv) serious disfigurement of such person; OR (V) A CONDITION DESCRIBED IN CLAUSE (I), (II) OR (III) OF SECTION 1867(E)(1)(A) OF THE SOCIAL SECURITY ACT.

(B) "Emergency condition" means a medical or behavioral condition[, the onset of which is sudden,] that manifests itself by ACUTE symptoms of sufficient severity, including severe pain, SUCH that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (ii) serious impairment to such person's bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; [or] (iv) serious disfigurement of such person; OR (V) A CONDITION DESCRIBED IN CLAUSE (I), (II) OR (III) OF SECTION 1867(E)(1)(A) OF THE SOCIAL SECURITY ACT.

S 30. Subsection (bb) of section 4303 of the insurance law, as added by chapter 554 of the laws of 2002, is amended to read as follows:

(bb) A health service corporation or a medical service expense indemnity corporation [which] THAT provides major medical or similar comprehensive-type coverage shall provide such coverage for bone mineral density measurements or tests, and if such contract otherwise includes coverage for prescription drugs, drugs and devices approved by the federal food and drug administration or generic equivalents as approved substitutes. In determining appropriate coverage provided by [this paragraph] PARAGRAPHS ONE, TWO AND THREE OF THIS SUBSECTION, the insurer or health maintenance organization shall adopt standards [which] THAT include the criteria of the federal [medicare] MEDICARE program and the criteria of the national institutes of health for the detection of osteoporosis, provided that such coverage shall be further determined as follows:

(1) For purposes OF PARAGRAPHS TWO AND THREE of this subsection, bone mineral density measurements or tests, drugs and devices shall include those covered under the criteria of the federal [medicare] MEDICARE program as well as those in accordance with the criteria of the national institutes of health, including, as consistent with such criteria, dual-energy x-ray absorptiometry.

(2) For purposes OF PARAGRAPHS ONE AND THREE of this subsection, bone mineral density measurements or tests, drugs and devices shall be covered for individuals meeting the criteria for coverage, consistent with the criteria under the federal [medicare] MEDICARE program or the criteria of the national institutes of health; provided that, to the extent consistent with such criteria, individuals qualifying for coverage shall, at a minimum, include individuals:

(i) previously diagnosed as having osteoporosis or having a family history of osteoporosis; or

(ii) with symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis; or

(iii) on a prescribed drug regimen posing a significant risk of osteoporosis; or

(iv) with lifestyle factors to such a degree as posing a significant risk of osteoporosis; or

(v) with such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.

(3) Such coverage REQUIRED PURSUANT TO PARAGRAPH ONE OR TWO OF THIS SUBSECTION may be subject to annual deductibles and coinsurance as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given policy.

(4) IN ADDITION TO PARAGRAPH ONE, TWO OR THREE OF THIS SUBSECTION, EVERY CONTRACT THAT PROVIDES HOSPITAL, SURGICAL OR MEDICAL CARE COVERAGE, EXCEPT FOR A GRANDFATHERED HEALTH PLAN UNDER PARAGRAPH FIVE OF THIS SUBSECTION, SHALL PROVIDE COVERAGE FOR THE FOLLOWING ITEMS OR SERVICES FOR BONE MINERAL DENSITY, AND SUCH COVERAGE SHALL NOT BE SUBJECT TO ANNUAL DEDUCTIBLES OR COINSURANCE:

(A) EVIDENCE-BASED ITEMS OR SERVICES FOR BONE MINERAL DENSITY THAT HAVE IN EFFECT A RATING OF 'A' OR 'B' IN THE CURRENT RECOMMENDATIONS OF THE UNITED STATES PREVENTIVE SERVICES TASK FORCE; AND

(B) WITH RESPECT TO WOMEN, SUCH ADDITIONAL PREVENTIVE CARE AND SCREENINGS FOR BONE MINERAL DENSITY NOT DESCRIBED IN SUBPARAGRAPH (A) OF THIS PARAGRAPH AND AS PROVIDED FOR IN COMPREHENSIVE GUIDELINES SUPPORTED BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION.

(5) FOR PURPOSES OF THIS SUBSECTION, "GRANDFATHERED HEALTH PLAN" MEANS COVERAGE PROVIDED BY A CORPORATION IN WHICH AN INDIVIDUAL WAS ENROLLED ON MARCH TWENTY-THIRD, TWO THOUSAND TEN FOR AS LONG AS THE COVERAGE MAINTAINS GRANDFATHERED STATUS IN ACCORDANCE WITH SECTION 1251(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18011(E).

S 31. Paragraphs 1 and 3 of subsection (d) of section 4304 of the insurance law, paragraph 1 as amended by chapter 240 of the laws of 2009 and paragraph 3 as added by chapter 93 of the laws of 1989, are amended to read as follows:

(1) (A) No contract issued pursuant to this section shall entitle more than one person to benefits except that a contract issued and marked as a "family contract" may provide that benefits will be furnished to [a husband and wife, or husband, wife and their dependent child or children, or] THE CONTRACT HOLDER, SPOUSE, DEPENDENT CHILD OR CHILDREN, OR OTHER PERSON CHIEFLY DEPENDENT UPON THE CONTRACT HOLDER PROVIDED THAT:

(I) A "FAMILY CONTRACT" MAY PROVIDE COVERAGE TO any child or children not over nineteen years of age, provided that an unmarried student at an accredited institution of learning may be considered a dependent until [he] THE CHILD becomes twenty-three years of age, AND provided ALSO that the coverage of any such "family contract" may include, at the option of the [insurer] CORPORATION, any unmarried child until attaining age twenty-five[, and provided also that the]. HOWEVER, A "FAMILY CONTRACT" OF HOSPITAL, MEDICAL, SURGICAL, OR PRESCRIPTION DRUG EXPENSE INSURANCE THAT PROVIDES COVERAGE FOR DEPENDENT CHILDREN SHALL PROVIDE SUCH COVERAGE TO A MARRIED OR UNMARRIED CHILD UNTIL ATTAINMENT OF AGE TWENTY-SIX WITHOUT REGARD TO FINANCIAL DEPENDENCE, RESIDENCY WITH THE CONTRACT HOLDER, STUDENT STATUS, OR EMPLOYMENT.

(II) THE coverage of any such "family contract" shall include any other unmarried child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or phys-

ical handicap and who became so incapable prior to attainment of the age at which [dependent] coverage would otherwise terminate[, so that such child may be considered a dependent].

(B) In addition to the requirements of subparagraph (A) of this paragraph, every corporation issuing a contract OF HOSPITAL, MEDICAL OR SURGICAL EXPENSE INSURANCE that provides coverage for [dependent] children must make available and if requested by the contractholder, extend coverage under the contract to an unmarried child through age twenty-nine, without regard to financial dependence who is not insured by or eligible for coverage under any [employee] EMPLOYER health benefit plan as an employee or member, whether insured or self-insured, and who lives, works or resides in New York state or the service area of the corporation. Such coverage shall be made available at the inception of all new contracts, [at the first anniversary date of a policy following the effective date of this subparagraph,] and for group remittance contracts at any anniversary date. Written notice of the availability of such coverage shall be delivered to the contractholder prior to the inception of such [group] contract, [thirty days prior to the first anniversary date of a policy following the effective date of this subparagraph,] and for group remittance contracts annually thereafter.

(C) Notwithstanding any rule, regulation or law to the contrary, any "family contract" shall provide that coverage of newborn infants, including newly born infants adopted by the [insured or] subscriber if such [insured or] subscriber takes physical custody of the infant upon such infant's release from the hospital and files a petition pursuant to section one hundred fifteen-c of the domestic relations law within thirty days of birth; and provided further that no notice of revocation to the adoption has been filed pursuant to section one hundred fifteen-b of the domestic relations law and consent to the adoption has not been revoked, shall be effective from the moment of birth for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities including premature birth, except that in cases of adoption, coverage of the initial hospital stay shall not be required where a birth parent has insurance coverage available for the infant's care. This provision regarding coverage of newborn infants shall not apply to two person coverage. In the case of individual or two person coverages the corporation must also permit the person to whom the [policy] CONTRACT is issued to elect such coverage of newborn infants from the moment of birth. If notification and/or payment of an additional premium or contribution is required to make coverage effective for a newborn infant, the coverage may provide that such notice and/or payment be made within no less than thirty days of the day of birth to make coverage effective from the moment of birth. This election shall not be required in the case of student insurance or where the group remitting agent's plan does not provide coverage for [dependent] children.

(3) Coverage of an unmarried dependent child who is incapable of self-sustaining employment by reason of mental illness, developmental disability or mental retardation, as defined in the mental hygiene law, or physical handicap and who became so incapable prior to attainment of the age at which [dependent] coverage would otherwise terminate and who is chiefly dependent upon the contract holder for support and maintenance, shall not terminate while the [policy] CONTRACT remains in force and the [dependent] CHILD remains in such condition, if the [policyholder] CONTRACT HOLDER has within thirty-one days of such [dependent's] CHILD'S

attainment of the limiting age submitted proof of such [dependent's] CHILD'S incapacity as described herein.

S 32. Subsection (e) of section 4304 of the insurance law is amended by adding a new paragraph 5 to read as follows:

(5) FOR PURPOSES OF THIS SUBSECTION, THE TERM "DEPENDENT" SHALL INCLUDE A CHILD AS DESCRIBED IN SUBSECTION (D) OF THIS SECTION.

S 33. Paragraph 5 of subsection (k) of section 4304 of the insurance law, as added by chapter 236 of the laws of 2009, is renumbered paragraph 6 and a new paragraph 7 is added to read as follows:

(7) FOR PURPOSES OF THIS SUBSECTION, THE TERM "DEPENDENT" SHALL INCLUDE A CHILD AS DESCRIBED IN SUBSECTION (D) OF THIS SECTION.

S 34. Paragraphs 1 and 2 of subsection (m) of section 4304 of the insurance law, as added by chapter 240 of the laws of 2009, are amended to read as follows:

(1) As used in this subsection, ["dependent child"] "CHILD" means an unmarried child through age twenty-nine of an employee or member insured under a group remittance contract OF HOSPITAL, MEDICAL OR SURGICAL EXPENSE INSURANCE, regardless of financial dependence, who is not insured by or eligible for coverage under any [employee] EMPLOYER health benefit plan AS AN EMPLOYEE OR MEMBER, whether insured or self-insured, and who lives, works or resides in New York state or the service area of the corporation and who is not covered under title XVIII of the United States Social Security Act (Medicare).

(2) In addition to the conversion privilege afforded by subsection (e) of this section and the continuation privilege afforded by subsections (e) and (k) of this section, a hospital service, health service or medical expense corporation or health maintenance organization that provides HOSPITAL, MEDICAL OR SURGICAL EXPENSE INSURANCE coverage for which the premiums are paid by the remitting agent of a group that provides [dependent] coverage OF A CHILD that terminates at a specified age shall, upon application of the employee, member or [dependent] child, as set forth in subparagraph (B) [or (C)] of this paragraph, provide coverage to the [dependent] child after that specified age and through age twenty-nine without evidence of insurability, subject to all of the terms and conditions of the group remittance contract and the following:

(A) An employer shall not be required to pay all or part of the cost of coverage for a [dependent] child provided pursuant to this subsection;

(B) An employee, member or [dependent] child who wishes to elect continuation of coverage pursuant to this subsection shall request the continuation in writing:

(i) within sixty days following the date coverage would otherwise terminate due to reaching the specified age set forth in the group contract;

(ii) within sixty days after meeting the requirements for [dependent] child status set forth in paragraph one of this subsection when coverage for the [dependent] child previously terminated; or

(iii) during an annual thirty-day open enrollment period as described in the contract.

(C) [For twelve months after the effective date of this subsection, an employee, member or dependent child may elect prospective continuation coverage under this subsection for a dependent child whose coverage terminated under the terms of the group remittance contract prior to the initial effective date of this subsection;

(D)] An employee, member or [dependent] child electing continuation as described in this subsection shall pay to the group remitting agent or employer, but not more frequently than on a monthly basis in advance, the amount of the required premium payment on the due date of each payment. The written election of continuation, together with the first premium payment required to establish premium payment on a monthly basis in advance, shall be given to the group remitting agent or employer within the time periods set forth in [subparagraphs (B) and (C)] SUBPARAGRAPH (B) of this paragraph. Any premium received within the thirty-day period after the due date shall be considered timely;

[(E)] (D) For any [dependent] child electing coverage within sixty days of the date the [dependent] child would otherwise lose coverage due to reaching a specified age, the effective date of the continuation coverage shall be the date coverage would have otherwise terminated. For any [dependent] child electing to resume coverage during an annual open enrollment period [or during the twelve-month initial open enrollment period described in subparagraph (C) of this paragraph], the effective date of the continuation coverage shall be prospective no later than thirty days after the election and payment of first premium;

[(F)] (E) Coverage for a [dependent] child pursuant to this subsection shall consist of coverage that is identical to the coverage provided to the employee or member parent. If coverage is modified under the contract for any group of similarly situated employees or members, then the coverage shall also be modified in the same manner for any [dependent] child;

[(G)] (F) Coverage shall terminate on the first to occur of the following:

(i) the date the [dependent] child no longer meets the requirements of paragraph one of this subsection;

(ii) the end of the period for which premium payments were made, if there is a failure to make payment of a required premium payment within the period of grace described in subparagraph [(D)] (C) of this paragraph; or

(iii) the date on which the group remittance contract is terminated and not replaced by coverage under another group or group remittance contract; and

[(H)] (G) The corporation or health maintenance organization shall provide written notification of the continuation privilege described in this subsection and the time period in which to request continuation to the employee or member:

(i) in each certificate of coverage; AND

(ii) at least sixty days prior to termination at the specified age as provided in the contract[;

(iii) within thirty days of the effective date of this subsection, with respect to information concerning a dependent child's opportunity, for twelve months after the effective date of this subsection, to make a written election to obtain coverage under a contract pursuant to subparagraph (C) of this paragraph].

S 35. Paragraph 1 of subsection (c) of section 4305 of the insurance law, as amended by chapter 240 of the laws of 2009, is amended to read as follows:

(1)(A) Any such contract may provide that benefits will be furnished to a member of a covered group, for [himself] THE MEMBER, [his] THE MEMBER'S spouse, [his] child or children, or other persons chiefly dependent upon [him] THE MEMBER for support and maintenance; provided that:

(I) A CONTRACT OF HOSPITAL, MEDICAL, SURGICAL, OR PRESCRIPTION DRUG EXPENSE INSURANCE THAT PROVIDES COVERAGE FOR CHILDREN SHALL PROVIDE SUCH COVERAGE TO A MARRIED OR UNMARRIED CHILD UNTIL ATTAINMENT OF AGE TWENTY-SIX, WITHOUT REGARD TO FINANCIAL DEPENDENCE, RESIDENCY WITH THE MEMBER, STUDENT STATUS, OR EMPLOYMENT, EXCEPT A CONTRACT THAT IS A GRANDFATHERED HEALTH PLAN MAY, FOR PLAN YEARS BEGINNING BEFORE JANUARY FIRST, TWO THOUSAND FOURTEEN, EXCLUDE COVERAGE OF AN ADULT CHILD UNDER AGE TWENTY-SIX WHO IS ELIGIBLE TO ENROLL IN AN EMPLOYER-SPONSORED HEALTH PLAN OTHER THAN A GROUP HEALTH PLAN OF A PARENT. FOR PURPOSES OF THIS ITEM, "GRANDFATHERED HEALTH PLAN" MEANS COVERAGE PROVIDED BY A CORPORATION IN WHICH AN INDIVIDUAL WAS ENROLLED ON MARCH TWENTY-THIRD, TWO THOUSAND TEN FOR AS LONG AS THE COVERAGE MAINTAINS GRANDFATHERED STATUS IN ACCORDANCE WITH SECTION 1251(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18011(E); AND

(II) a contract under which coverage [of a dependent of a member] terminates at a specified age shall, with respect to an unmarried child who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap and who became so incapable prior to attainment of the age at which [dependent] coverage would otherwise terminate and who is chiefly dependent upon such member for support and maintenance, not so terminate while the contract remains in force and the [dependent] CHILD remains in such condition, if the member has within thirty-one days of such [dependent's] CHILD'S attainment of the termination age submitted proof of such [dependent's] CHILD'S incapacity as described herein.

(B) In addition to the requirements of subparagraph (A) of this paragraph, every corporation issuing a group contract OF HOSPITAL, MEDICAL OR SURGICAL EXPENSE INSURANCE pursuant to this section that provides coverage for [dependent] children, must make available and if requested by the contractholder, extend coverage under that contract to an unmarried child through age twenty-nine, without regard to financial dependence who is not insured by or eligible for coverage under any [employee] EMPLOYER health benefit plan as an employee or member, whether insured or self-insured, and who lives, works or resides in New York state or the service area of the corporation. Such coverage shall be made available at the inception of all new contracts and with respect to all other contracts at any anniversary date. Written notice of the availability of such coverage shall be delivered to the contractholder prior to the inception of such group contract and annually thereafter.

(C) Notwithstanding any rule, regulation or law to the contrary, any contract under which a member elects coverage for [himself, his spouse, his] THE MEMBER, THE MEMBER'S SPOUSE, children or other persons chiefly dependent upon [him] THE MEMBER for support and maintenance shall provide that coverage of newborn infants, including newly born infants adopted by the [insured or subscriber] MEMBER if such [insured or subscriber] MEMBER takes physical custody of the infant upon such infant's release from the hospital and files a petition pursuant to section one hundred fifteen-c of the domestic relations law within thirty days of birth; and provided further that no notice of revocation to the adoption has been filed pursuant to section one hundred fifteen-b of the domestic relations law and consent to the adoption has not been revoked, shall be effective from the moment of birth for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities including premature birth, except that in cases of adoption, coverage of the initial hospital stay

shall not be required where a birth parent has insurance coverage available for the infant's care. This provision regarding coverage of newborn infants shall not apply to two person coverage. In the case of individual or two person coverages the corporation must also permit the person to whom the certificate is issued to elect such coverage of newborn infants from the moment of birth. If notification and/or payment of an additional premium or contribution is required to make coverage effective for a newborn infant, the coverage may provide that such notice and/or payment be made within no less than thirty days of the day of birth to make coverage effective from the moment of birth. This election shall not be required in the case of student insurance or where the group's plan does not provide coverage for [dependent] children.

S 36. Subsection (d) of section 4305 of the insurance law is amended by adding a new paragraph 5 to read as follows:

(5) FOR PURPOSES OF THIS SUBSECTION, THE TERM "DEPENDENT" SHALL INCLUDE A CHILD AS DESCRIBED IN SUBSECTION (C) OF THIS SECTION.

S 37. Subsection (e) of section 4305 of the insurance law is amended by adding a new paragraph 9 to read as follows:

(9) FOR PURPOSES OF THIS SUBSECTION, THE TERM "DEPENDENT" SHALL INCLUDE A CHILD AS DESCRIBED IN SUBSECTION (C) OF THIS SECTION.

S 38. Subsection (k) of section 4305 of the insurance law is amended by adding a new paragraph 7 to read as follows:

(7) FOR PURPOSES OF THIS SUBSECTION, THE TERM "DEPENDENT" SHALL INCLUDE A CHILD AS DESCRIBED IN SUBSECTION (C) OF THIS SECTION.

S 39. Subsection (l) of section 4305 of the insurance law, as added by chapter 237 of the laws of 2009, is relettered subsection (m) and paragraphs 1 and 2 of subsection (l) of section 4305 of the insurance law, as added by chapter 240 of the laws of 2009, are amended to read as follows:

(1) As used in this subsection, ["dependent child"] "CHILD" means an unmarried child through age twenty-nine of an employee or member insured under a group contract OF HOSPITAL, MEDICAL OR SURGICAL EXPENSE INSURANCE, regardless of financial dependence, who is not insured by or eligible for coverage under any [employee] EMPLOYER health benefit plan AS AN EMPLOYEE OR MEMBER, whether insured or self-insured, and who lives, works or resides in New York state or the service area of the corporation and who is not covered under title XVIII of the United States Social Security Act (Medicare).

(2) In addition to the conversion privilege afforded by subsection (d) of this section and the continuation privilege afforded by subsection (e) of this section, a hospital service, health service or medical expense corporation or health maintenance organization that provides group HOSPITAL, MEDICAL OR SURGICAL coverage under which [dependent] coverage OF A CHILD terminates at a specified age shall, upon application of the employee, member or [dependent] child, as set forth in subparagraph (B) [or (C)] of this paragraph, provide coverage to the [dependent] child after that specified age and through age twenty-nine without evidence of insurability, subject to all of the terms and conditions of the group contract and the following:

(A) An employer shall not be required to pay all or part of the cost of coverage for a [dependent] child provided pursuant to this subsection;

(B) An employee, member or [dependent] child who wishes to elect continuation of coverage pursuant to this subsection shall request the continuation in writing:

(i) within sixty days following the date coverage would otherwise terminate due to reaching the specified age set forth in the group contract;

(ii) within sixty days after meeting the requirements for [dependent] child status set forth in paragraph one of this subsection when coverage for the [dependent] child previously terminated; or

(iii) during an annual thirty-day open enrollment period, as described in the contract;

(C) [For twelve months after the effective date of this subsection, an employee, member or dependent child may elect prospective continuation coverage under this subsection for a dependent child whose coverage terminated under the terms of the group contract prior to the effective date of this subsection;

(D)] An employee, member or [dependent] child electing continuation as described in this subsection shall pay to the group contractholder or employer, but not more frequently than on a monthly basis in advance, the amount of the required premium payment on the due date of each payment. The written election of continuation, together with the first premium payment required to establish premium payment on a monthly basis in advance, shall be given to the group contractholder or employer within the time periods set forth in [subparagraphs (B) and (C)] SUBPARAGRAPH (B) of this paragraph. Any premium received within the thirty-day period after the due date shall be considered timely;

[(E)] (D) For any [dependent] child electing coverage within sixty days of the date the [dependent] child would otherwise lose coverage due to reaching a specified age, the effective date of the continuation coverage shall be the date coverage would have otherwise terminated. For any [dependent] child electing to resume coverage during an annual open enrollment period [or during the twelve-month initial open enrollment period described in subparagraph (C) of this paragraph], the effective date of the continuation coverage shall be prospective no later than thirty days after the election and payment of first premium;

[(F)] (E) Coverage for a [dependent] child pursuant to this subsection shall consist of coverage that is identical to the coverage provided to the employee or member parent. If coverage is modified under the contract for any group of similarly situated employees or members, then the coverage shall also be modified in the same manner for any [dependent] child;

[(G)] (F) Coverage shall terminate on the first to occur of the following:

(i) the date the [dependent] child no longer meets the requirements of paragraph one of this subsection;

(ii) the end of the period for which premium payments were made, if there is a failure to make payment of a required premium payment within the period of grace described in subparagraph [(D)] (C) of this paragraph; or

(iii) the date on which the group contract is terminated and not replaced by coverage under another group contract; and

[(H)] (G) The corporation or health maintenance organization shall provide written notification of the continuation privilege described in this subsection and the time period in which to request continuation to the employee or member:

(i) in each certificate of coverage; AND

(ii) at least sixty days prior to termination at the specified age as provided in the contract[;

(iii) within thirty days of the effective date of this subsection, with respect to information concerning a dependent child's opportunity, for twelve months after the effective date of this subsection, to make a written election to obtain coverage under a contract pursuant to subparagraph (C) of this paragraph].

S 40. Section 4306-b of the insurance law, as added by chapter 554 of the laws of 2002, is amended to read as follows:

S 4306-b. Primary and preventive obstetric and gynecologic care. (a) No corporation subject to the provisions of this article shall by contract, written policy or procedure limit a female subscriber's direct access to primary and preventive obstetric and gynecologic services, INCLUDING ANNUAL EXAMINATIONS, CARE RESULTING FROM SUCH ANNUAL EXAMINATIONS, AND TREATMENT OF ACUTE GYNECOLOGIC CONDITIONS, from a qualified provider of such services of her choice from within the plan [to less than two examinations annually for such services] or [to] FOR any care related to a pregnancy[. In addition, no corporation subject to this article shall by contract, written policy or procedure limit direct access to primary and preventive obstetric and gynecologic services required as a result of such annual examinations or as a result of an acute gynecologic condition], provided that: (1) such qualified provider discusses such services and treatment plan with the subscriber's primary care practitioner in accordance with the requirements of the corporation; AND (2) SUCH QUALIFIED PROVIDER AGREES TO ADHERE TO THE CORPORATION'S POLICIES AND PROCEDURES, INCLUDING ANY APPLICABLE PROCEDURES REGARDING REFERRALS AND OBTAINING PRIOR AUTHORIZATION FOR SERVICES OTHER THAN OBSTETRIC AND GYNECOLOGIC SERVICES RENDERED BY SUCH QUALIFIED PROVIDER, AND AGREES TO PROVIDE SERVICES PURSUANT TO A TREATMENT PLAN (IF ANY) APPROVED BY THE CORPORATION.

(b) A CORPORATION SHALL TREAT THE PROVISION OF OBSTETRIC AND GYNECOLOGIC CARE, AND THE ORDERING OF RELATED OBSTETRIC AND GYNECOLOGIC ITEMS AND SERVICES, PURSUANT TO THE DIRECT ACCESS DESCRIBED IN SUBSECTION (A) OF THIS SECTION BY A PARTICIPATING QUALIFIED PROVIDER OF SUCH SERVICES, AS THE AUTHORIZATION OF THE PRIMARY CARE PROVIDER.

(C) It shall be the duty of the administrative officer or other person in charge of each corporation subject to the provisions of this article to advise each female subscriber, in writing, of the provisions of this section.

S 41. The insurance law is amended by adding a new section 4306-d to read as follows:

S 4306-D. CHOICE OF HEALTH CARE PROVIDER. A CORPORATION THAT IS SUBJECT TO THE PROVISIONS OF THIS ARTICLE AND REQUIRES OR PROVIDES FOR DESIGNATION BY A SUBSCRIBER OF A PARTICIPATING PRIMARY CARE PROVIDER SHALL PERMIT THE SUBSCRIBER TO DESIGNATE ANY PARTICIPATING PRIMARY CARE PROVIDER WHO IS AVAILABLE TO ACCEPT SUCH INDIVIDUAL, AND IN THE CASE OF A CHILD, SHALL PERMIT THE SUBSCRIBER TO DESIGNATE A PHYSICIAN (ALLOPATHIC OR OSTEOPATHIC) WHO SPECIALIZES IN PEDIATRICS AS THE CHILD'S PRIMARY CARE PROVIDER IF SUCH PROVIDER PARTICIPATES IN THE NETWORK OF THE CORPORATION.

S 42. The insurance law is amended by adding a new section 4306-e to read as follows:

S 4306-E. PROHIBITION ON LIFETIME AND ANNUAL LIMITS. (A) A CORPORATION SHALL NOT ESTABLISH A LIFETIME LIMIT ON THE DOLLAR AMOUNT OF ESSENTIAL HEALTH BENEFITS IN AN INDIVIDUAL, GROUP OR BLANKET CONTRACT OF HOSPITAL, MEDICAL, SURGICAL OR PRESCRIPTION DRUG EXPENSE INSURANCE.

(B) A CORPORATION SHALL NOT ESTABLISH AN ANNUAL LIMIT ON THE DOLLAR AMOUNT OF ESSENTIAL HEALTH BENEFITS IN AN INDIVIDUAL, GROUP OR BLANKET

CONTRACT OF HOSPITAL, MEDICAL, SURGICAL OR PRESCRIPTION DRUG EXPENSE INSURANCE FOR CONTRACT YEARS BEGINNING ON AND AFTER JANUARY ONE, TWO THOUSAND FOURTEEN.

(C) FOR CONTRACT YEARS BEGINNING PRIOR TO JANUARY ONE, TWO THOUSAND FOURTEEN, A CORPORATION MAY ESTABLISH RESTRICTED ANNUAL LIMITS ON THE DOLLAR AMOUNT OF ESSENTIAL HEALTH BENEFITS IN AN INDIVIDUAL, GROUP OR BLANKET CONTRACT OF HOSPITAL, MEDICAL, SURGICAL OR PRESCRIPTION DRUG EXPENSE INSURANCE CONSISTENT WITH SECTION 2711 OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-11 OR ANY REGULATIONS THEREUNDER.

(D) THE REQUIREMENTS OF SUBSECTIONS (B) AND (C) OF THIS SECTION SHALL NOT BE APPLICABLE TO ANY INDIVIDUAL CONTRACT THAT IS A GRANDFATHERED HEALTH PLAN. FOR PURPOSES OF THIS SECTION, "GRANDFATHERED HEALTH PLAN" MEANS COVERAGE PROVIDED BY A CORPORATION IN WHICH AN INDIVIDUAL WAS ENROLLED ON MARCH TWENTY-THIRD, TWO THOUSAND TEN FOR AS LONG AS THE COVERAGE MAINTAINS GRANDFATHERED STATUS IN ACCORDANCE WITH SECTION 1251(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18011(E).

(E) FOR PURPOSES OF THIS SECTION, "ESSENTIAL HEALTH BENEFITS" SHALL HAVE THE MEANING ASCRIBED BY SECTION 1302(B) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(B).

S 43. Section 4318 of the insurance law is amended by adding four new subsections (f), (g), (h) and (i) to read as follows:

(F) WITH RESPECT TO AN INDIVIDUAL UNDER AGE NINETEEN, A CORPORATION MAY NOT IMPOSE ANY PRE-EXISTING CONDITION EXCLUSION IN AN INDIVIDUAL OR GROUP CONTRACT OF HOSPITAL, MEDICAL, SURGICAL OR PRESCRIPTION DRUG EXPENSE INSURANCE PURSUANT TO THE REQUIREMENTS OF SECTION 2704 OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-3, AS MADE EFFECTIVE BY SECTION 1255(2) OF THE AFFORDABLE CARE ACT, EXCEPT FOR AN INDIVIDUAL UNDER AGE NINETEEN COVERED UNDER AN INDIVIDUAL CONTRACT OF HOSPITAL, MEDICAL, SURGICAL OR PRESCRIPTION DRUG EXPENSE INSURANCE THAT IS A GRANDFATHERED HEALTH PLAN.

(G) BEGINNING JANUARY FIRST, TWO THOUSAND FOURTEEN, PURSUANT TO SECTION 2704 OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-3, A CORPORATION MAY NOT IMPOSE ANY PRE-EXISTING CONDITION EXCLUSION IN AN INDIVIDUAL OR GROUP CONTRACT OF HOSPITAL, MEDICAL, SURGICAL OR PRESCRIPTION DRUG EXPENSE INSURANCE EXCEPT IN AN INDIVIDUAL CONTRACT THAT IS A GRANDFATHERED HEALTH PLAN.

(H) THE REQUIREMENTS OF SUBSECTIONS (F) AND (G) OF THIS SECTION SHALL ALSO BE APPLICABLE TO A BLANKET CONTRACT OF HOSPITAL, MEDICAL, SURGICAL OR PRESCRIPTION DRUG EXPENSE INSURANCE.

(I) FOR PURPOSES OF SUBSECTIONS (F) AND (G) OF THIS SECTION, "GRANDFATHERED HEALTH PLAN" MEANS COVERAGE PROVIDED BY A CORPORATION IN WHICH AN INDIVIDUAL WAS ENROLLED ON MARCH TWENTY-THIRD, TWO THOUSAND TEN FOR AS LONG AS THE COVERAGE MAINTAINS GRANDFATHERED STATUS IN ACCORDANCE WITH SECTION 1251(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18011(E).

S 44. Subsection (c) of section 4321 of the insurance law, as added by chapter 504 of the laws of 1995, is amended to read as follows:

(c) The health maintenance organization shall impose a fifteen dollar copayment on all visits to a physician or other provider with the exception of visits for pre-natal and post-natal care [or], well child visits provided pursuant to paragraph two of subsection (j) of section four thousand three hundred three of this article, PREVENTIVE HEALTH SERVICES PROVIDED PURSUANT TO SUBPARAGRAPH (F) OF PARAGRAPH FOUR OF SUBSECTION (B) OF SECTION FOUR THOUSAND THREE HUNDRED TWENTY-TWO OF THIS ARTICLE, OR ITEMS OR SERVICES FOR BONE MINERAL DENSITY PROVIDED PURSUANT TO SUBPARAGRAPH (D) OF PARAGRAPH TWENTY-SIX OF SUBSECTION (B) OF SECTION FOUR THOUSAND THREE HUNDRED TWENTY-TWO OF THIS ARTICLE for which no

copayment shall apply. A copayment of fifteen dollars shall be imposed on equipment, supplies and self-management education for the treatment of diabetes. A fifty dollar copayment shall be imposed on emergency services rendered in the emergency room of a hospital; however, this copayment must be waived if hospital admission results. Surgical services shall be subject to a copayment of the lesser of twenty percent of the cost of such services or two hundred dollars per occurrence. A five hundred dollar copayment shall be imposed on inpatient hospital services per continuous hospital confinement. Ambulatory surgical services shall be subject to a facility copayment charge of seventy-five dollars. Coinsurance of ten percent shall apply to visits for the diagnosis and treatment of mental, nervous or emotional disorders or ailments.

S 45. Subparagraphs (D) and (E) of paragraph 4 of subsection (b) of section 4322 of the insurance law, as amended by chapter 554 of the laws of 2002, are amended and a new subparagraph (F) is added to read as follows:

(D) mammography screening, as provided in subsection (p) of section four thousand three hundred three of this article; [and]

(E) cervical cytology screening as provided in subsection (t) of section four thousand three hundred three of this article[.]; AND

(F) FOR A CONTRACT THAT IS NOT A GRANDFATHERED HEALTH PLAN, THE FOLLOWING ADDITIONAL PREVENTIVE HEALTH SERVICES:

(I) EVIDENCE-BASED ITEMS OR SERVICES THAT HAVE IN EFFECT A RATING OF 'A' OR 'B' IN THE CURRENT RECOMMENDATIONS OF THE UNITED STATES PREVENTIVE SERVICES TASK FORCE;

(II) IMMUNIZATIONS THAT HAVE IN EFFECT A RECOMMENDATION FROM THE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION WITH RESPECT TO THE INDIVIDUAL INVOLVED;

(III) WITH RESPECT TO CHILDREN, INCLUDING INFANTS AND ADOLESCENTS, EVIDENCE-INFORMED PREVENTIVE CARE AND SCREENINGS PROVIDED FOR IN THE COMPREHENSIVE GUIDELINES SUPPORTED BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION; AND

(IV) WITH RESPECT TO WOMEN, SUCH ADDITIONAL PREVENTIVE CARE AND SCREENINGS NOT DESCRIBED IN ITEM (I) OF THIS SUBPARAGRAPH AND AS PROVIDED FOR IN COMPREHENSIVE GUIDELINES SUPPORTED BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION.

(V) FOR PURPOSES OF THIS SUBPARAGRAPH, "GRANDFATHERED HEALTH PLAN" MEANS COVERAGE PROVIDED BY A CORPORATION IN WHICH AN INDIVIDUAL WAS ENROLLED ON MARCH TWENTY-THIRD, TWO THOUSAND TEN FOR AS LONG AS THE COVERAGE MAINTAINS GRANDFATHERED STATUS IN ACCORDANCE WITH SECTION 1251(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18011(E).

S 46. Paragraph 26 of subsection (b) of section 4322 of the insurance law, as added by chapter 554 of the laws of 2002, is amended to read as follows:

(26) Bone mineral density measurements or tests and, if such contract otherwise includes coverage for prescription drugs, drugs and devices approved by the federal food and drug administration or generic equivalents as approved substitutes.

In determining appropriate coverage provided by SUBPARAGRAPHS (A), (B) AND (C) OF this paragraph, the insurer or health maintenance organization shall adopt standards [which] THAT include the criteria of the federal [medicare] MEDICARE program and the criteria of the national institutes of health for the detection of osteoporosis, provided that such coverage shall be further determined as follows:

(A) For purposes of SUBPARAGRAPHS (B) AND (C) OF this paragraph, bone mineral density measurements or tests, drugs and devices shall include those covered under the criteria of the federal [medicare] MEDICARE program as well as those in accordance with the criteria, of the national institutes of health, including, as consistent with such criteria dual-energy x-ray absorptiometry.

(B) For purposes of SUBPARAGRAPHS (A) AND (C) OF this paragraph, bone mineral density measurements or tests, drugs and devices shall be covered for individuals meeting the criteria for coverage consistent with the criteria under the federal [medicare] MEDICARE program or the criteria of the national institutes of health; provided that, to the extent consistent with such criteria, individuals qualifying for coverage shall at a minimum, include individuals:

(i) previously diagnosed as having osteoporosis or having a family history of osteoporosis; or

(ii) with symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis; or

(iii) on a prescribed drug regimen posing a significant risk of osteoporosis; or

(iv) with lifestyle factors to such a degree as posing a significant risk of osteoporosis; or

(v) with such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.

(C) Such coverage REQUIRED PURSUANT TO SUBPARAGRAPH (A) OR (B) OF THIS PARAGRAPH may be subject to annual deductibles and coinsurance as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given policy.

(D) IN ADDITION TO SUBPARAGRAPH (A), (B) OR (C) OF THIS PARAGRAPH, EXCEPT FOR A GRANDFATHERED HEALTH PLAN UNDER SUBPARAGRAPH (E) OF THIS PARAGRAPH, COVERAGE SHALL BE PROVIDED FOR THE FOLLOWING ITEMS OR SERVICES FOR BONE MINERAL DENSITY, AND SUCH COVERAGE SHALL NOT BE SUBJECT TO ANNUAL DEDUCTIBLES OR COINSURANCE:

(I) EVIDENCE-BASED ITEMS OR SERVICES FOR BONE MINERAL DENSITY THAT HAVE IN EFFECT A RATING OF 'A' OR 'B' IN THE CURRENT RECOMMENDATIONS OF THE UNITED STATES PREVENTIVE SERVICES TASK FORCE; AND

(II) WITH RESPECT TO WOMEN, SUCH ADDITIONAL PREVENTIVE CARE AND SCREENINGS FOR BONE MINERAL DENSITY NOT DESCRIBED IN ITEM (I) OF THIS SUBPARAGRAPH AND AS PROVIDED FOR IN COMPREHENSIVE GUIDELINES SUPPORTED BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION.

(E) FOR PURPOSES OF THIS PARAGRAPH, "GRANDFATHERED HEALTH PLAN" MEANS COVERAGE PROVIDED BY A CORPORATION IN WHICH AN INDIVIDUAL WAS ENROLLED ON MARCH TWENTY-THIRD, TWO THOUSAND TEN FOR AS LONG AS THE COVERAGE MAINTAINS GRANDFATHERED STATUS IN ACCORDANCE WITH SECTION 1251(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18011(E).

S 47. Subsections (c) and (d) of section 4322 of the insurance law, as added by chapter 504 of the laws of 1995, are amended to read as follows:

(c) The in-plan benefit system shall impose a ten dollar copayment on all visits to a physician or other provider with the exception of visits for pre-natal and post-natal care [or], well child visits provided pursuant to paragraph two of subsection (j) of section four thousand three hundred three of this article, PREVENTIVE HEALTH SERVICES PROVIDED PURSUANT TO SUBPARAGRAPH (F) OF PARAGRAPH FOUR OF SUBSECTION (B) OF THIS SECTION OR ITEMS OR SERVICES FOR BONE MINERAL DENSITY PROVIDED PURSUANT TO SUBPARAGRAPH (D) OF PARAGRAPH TWENTY-SIX OF SUBSECTION (B) OF THIS SECTION for which no copayment shall apply. A copayment of ten dollars

shall be imposed on equipment, supplies and self-management education for the treatment of diabetes. Coinsurance of ten percent shall apply to visits for the diagnosis and treatment of mental, nervous or emotional disorders or ailments. A thirty-five dollar copayment shall be imposed on emergency services rendered in the emergency room of a hospital; however, this copayment must be waived if hospital admission results.

(d) The out-of-plan benefit system shall have an annual deductible established at one thousand dollars per calendar year for an individual and two thousand dollars per year for a family. Coinsurance shall be established at twenty percent with the health maintenance organization or insurer paying eighty percent of the usual, customary and reasonable charges, or eighty percent of the amounts listed on a fee schedule filed with and approved by the superintendent which provides a comparable level of reimbursement. Coinsurance of ten percent shall apply to outpatient visits for the diagnosis and treatment of mental, nervous or emotional disorders or ailments. The benefits described in subparagraph (F) of paragraph three and paragraphs seventeen and eighteen of subsection (b) of this section shall not be subject to the deductible or coinsurance. The benefits described in paragraph nine of subsection (b) of this section shall not be subject to the deductible. The out-of-plan out-of-pocket maximum deductible and coinsurance shall be established at three thousand dollars per calendar year for an individual and five thousand dollars per calendar year for a family. The out-of-plan lifetime benefit maximum shall be established at five hundred thousand dollars FOR BENEFITS THAT ARE NOT ESSENTIAL HEALTH BENEFITS. A LIFETIME LIMIT ON THE DOLLAR AMOUNT OF ESSENTIAL HEALTH BENEFITS FOR ANY INDIVIDUAL SHALL NOT BE ESTABLISHED. FOR PURPOSES OF THIS SUBSECTION, "ESSENTIAL HEALTH BENEFITS" SHALL HAVE THE MEANING ASCRIBED BY SECTION 1302(B) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(B).

S 48. Paragraphs 13 and 14 of subsection (d) of section 4326 of the insurance law, as added by chapter 1 of the laws of 1999, are amended and a new paragraph 15 is added to read as follows:

(13) blood and blood products furnished in connection with surgery or inpatient hospital services; [and]

(14) prescription drugs obtained at a participating pharmacy. In addition to providing coverage at a participating pharmacy, health maintenance organizations may utilize a mail order prescription drug program. Health maintenance organizations may provide prescription drugs pursuant to a drug formulary; however, health maintenance organizations must implement an appeals process so that the use of non-formulary prescription drugs may be requested by a physician[.]; AND

(15) FOR A CONTRACT THAT IS NOT A GRANDFATHERED HEALTH PLAN, THE FOLLOWING ADDITIONAL PREVENTIVE HEALTH SERVICES:

(A) EVIDENCE-BASED ITEMS OR SERVICES THAT HAVE IN EFFECT A RATING OF 'A' OR 'B' IN THE CURRENT RECOMMENDATIONS OF THE UNITED STATES PREVENTIVE SERVICES TASK FORCE;

(B) IMMUNIZATIONS THAT HAVE IN EFFECT A RECOMMENDATION FROM THE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION WITH RESPECT TO THE INDIVIDUAL INVOLVED;

(C) WITH RESPECT TO CHILDREN, INCLUDING INFANTS AND ADOLESCENTS, EVIDENCE-INFORMED PREVENTIVE CARE AND SCREENINGS PROVIDED FOR IN THE COMPREHENSIVE GUIDELINES SUPPORTED BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION; AND

(D) WITH RESPECT TO WOMEN, SUCH ADDITIONAL PREVENTIVE CARE AND SCREENINGS NOT DESCRIBED IN SUBPARAGRAPH (A) OF THIS PARAGRAPH AS PROVIDED FOR

IN COMPREHENSIVE GUIDELINES SUPPORTED BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION.

(E) FOR PURPOSES OF THIS PARAGRAPH, "GRANDFATHERED HEALTH PLAN" MEANS COVERAGE PROVIDED BY A CORPORATION IN WHICH AN INDIVIDUAL WAS ENROLLED ON MARCH TWENTY-THIRD, TWO THOUSAND TEN FOR AS LONG AS THE COVERAGE MAINTAINS GRANDFATHERED STATUS IN ACCORDANCE WITH SECTION 1251(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18011(E).

S 49. Paragraphs 6 and 7 of subsection (e) of section 4326 of the insurance law, as added by chapter 1 of the laws of 1999, are amended to read as follows:

(6) (A) the maximum coverage for prescription drugs IN AN INDIVIDUAL CONTRACT THAT IS A GRANDFATHERED HEALTH PLAN shall be three thousand dollars per individual in a calendar year; and

(B) THE MAXIMUM DOLLAR AMOUNT ON COVERAGE FOR PRESCRIPTION DRUGS IN AN INDIVIDUAL CONTRACT THAT IS NOT A GRANDFATHERED HEALTH PLAN OR IN ANY GROUP CONTRACT SHALL BE CONSISTENT WITH SECTION 2711 OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-11 OR ANY REGULATIONS THEREUNDER.

(C) FOR PURPOSES OF THIS PARAGRAPH, "GRANDFATHERED HEALTH PLAN" MEANS COVERAGE PROVIDED BY A CORPORATION IN WHICH AN INDIVIDUAL WAS ENROLLED ON MARCH TWENTY-THIRD, TWO THOUSAND TEN FOR AS LONG AS THE COVERAGE MAINTAINS GRANDFATHERED STATUS IN ACCORDANCE WITH SECTION 1251(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18011(E); AND

(7) all other services shall have a twenty dollar copayment with the exception of prenatal care which shall have a ten dollar copayment OR PREVENTIVE HEALTH SERVICES PROVIDED PURSUANT TO PARAGRAPH FIFTEEN OF SUBSECTION (D) OF THIS SECTION, FOR WHICH NO COPAYMENT SHALL APPLY.

S 50. Subsection (k) of section 4326 of the insurance law, as added by chapter 1 of the laws of 1999, is amended to read as follows:

(k) (1) All coverage under a qualifying group health insurance contract or a qualifying individual health insurance contract must be subject to a pre-existing condition limitation provision as set forth in sections three thousand two hundred thirty-two of this chapter and four thousand three hundred eighteen of this article, including the crediting requirements thereunder. The underwriting of such contracts may not involve more than the imposition of a pre-existing condition limitation. HOWEVER, AS PROVIDED IN SECTIONS THREE THOUSAND TWO HUNDRED THIRTY-TWO OF THIS CHAPTER AND FOUR THOUSAND THREE HUNDRED EIGHTEEN OF THIS ARTICLE, A CORPORATION SHALL NOT IMPOSE A PRE-EXISTING CONDITION LIMITATION PROVISION ON ANY PERSON UNDER AGE NINETEEN, EXCEPT MAY IMPOSE SUCH A LIMITATION ON THOSE PERSONS COVERED BY A QUALIFYING INDIVIDUAL HEALTH INSURANCE CONTRACT THAT IS A GRANDFATHERED HEALTH PLAN.

(2) BEGINNING JANUARY FIRST, TWO THOUSAND FOURTEEN, PURSUANT TO SECTION 2704 OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-3, A CORPORATION SHALL NOT IMPOSE ANY PRE-EXISTING CONDITION LIMITATION IN A QUALIFYING GROUP HEALTH INSURANCE CONTRACT OR A QUALIFYING INDIVIDUAL HEALTH INSURANCE CONTRACT EXCEPT MAY IMPOSE SUCH A LIMITATION IN A QUALIFYING INDIVIDUAL HEALTH INSURANCE CONTRACT THAT IS A GRANDFATHERED HEALTH PLAN.

(3) FOR PURPOSES OF PARAGRAPHS ONE AND TWO OF THIS SUBSECTION, "GRANDFATHERED HEALTH PLAN" MEANS COVERAGE PROVIDED BY A CORPORATION IN WHICH AN INDIVIDUAL WAS ENROLLED ON MARCH TWENTY-THIRD, TWO THOUSAND TEN FOR AS LONG AS THE COVERAGE MAINTAINS GRANDFATHERED STATUS IN ACCORDANCE WITH SECTION 1251(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18011(E).

S 51. Subsection (c) of section 4900 of the insurance law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(c) "Emergency condition" means a medical or behavioral condition, [the onset of which is sudden,] that manifests itself by ACUTE symptoms of sufficient severity, including severe pain, SUCH that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (2) serious impairment to such person's bodily functions; (3) serious dysfunction of any bodily organ or part of such person; [or] (4) serious disfigurement of such person; OR (5) A CONDITION DESCRIBED IN CLAUSE (I), (II) OR (III) OF SECTION 1867(E)(1)(A) OF THE SOCIAL SECURITY ACT.

S 52. Subsection (g-7) of section 4900 of the insurance law, as added by chapter 237 of the laws of 2009, is amended to read as follows:

(g-7) "Rare disease" means a [life threatening or disabling] condition or disease that (1)(A) is currently or has been subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network; or (B) affects fewer than two hundred thousand United States residents per year; and (2) for which there does not exist a standard health service or procedure covered by the health care plan that is more clinically beneficial than the requested health service or treatment. A physician, other than the insured's treating physician, shall certify in writing that the condition is a rare disease as defined in this subsection. The certifying physician shall be a licensed, board-certified or board-eligible physician who specializes in the area of practice appropriate to treat the insured's rare disease. The certification shall provide either: (1) that the insured's rare disease is currently or has been subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network; or (2) that the insured's rare disease affects fewer than two hundred thousand United States residents per year. The certification shall rely on medical and scientific evidence to support the requested health service or procedure, if such evidence exists, and shall include a statement that, based on the physician's credible experience, there is no standard treatment that is likely to be more clinically beneficial to the insured than the requested health service or procedure and the requested health service or procedure is likely to benefit the insured in the treatment of the insured's rare disease and that such benefit to the insured outweighs the risks of such health service or procedure. The certifying physician shall disclose any material financial or professional relationship with the provider of the requested health service or procedure as part of the application for external appeal of denial of a rare disease treatment. If the provision of the requested health service or procedure at a health care facility requires prior approval of an institutional review board, an insured or insured's designee shall also submit such approval as part of the external appeal application.

S 53. Subparagraphs (A) and (B) of paragraph 1 of subsection (b) of section 4910 of the insurance law, as added by chapter 586 of the laws of 1998, are amended to read as follows:

(A) the insured has had coverage of the health care service, which would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal, in whole or in part, pursuant to title one of this article on the grounds that such health care service [is not medically necessary] DOES NOT MEET THE HEALTH CARE PLAN'S REQUIREMENTS FOR MEDICAL NECESSITY, APPROPRIATENESS,

HEALTH CARE SETTING, LEVEL OF CARE, OR EFFECTIVENESS OF A COVERED BENEFIT, and

(B) the health care plan has rendered a final adverse determination with respect to such health care service or both the plan and the insured have jointly agreed to waive any internal appeal, OR THE INSURED IS DEEMED TO HAVE EXHAUSTED OR IS NOT REQUIRED TO COMPLETE ANY INTERNAL APPEAL PURSUANT TO SECTION 2719 OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-19; or

S 54. Subparagraphs (A), (B) and (C) of paragraph 2 of subsection (b) of section 4910 of the insurance law, subparagraph (A) as added by chapter 586 of the laws of 1998, and subparagraphs (B) and (C) as amended by chapter 237 of the laws of 2009, are amended to read as follows:

(A) the insured has had coverage of a health care service denied on the basis that such service is experimental or investigational, and such denial has been upheld on appeal under [section four thousand nine hundred four] TITLE ONE of this article, or both the plan and the insured have jointly agreed to waive any internal appeal, OR THE INSURED IS DEEMED TO HAVE EXHAUSTED OR IS NOT REQUIRED TO COMPLETE ANY INTERNAL APPEAL PURSUANT TO SECTION 2719 OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-19, and

(B) the insured's attending physician has certified that the insured has a [life-threatening or disabling] condition or disease (a) for which standard health services or procedures have been ineffective or would be medically inappropriate, or (b) for which there does not exist a more beneficial standard health service or procedure covered by the health care plan, or (c) for which there exists a clinical trial or rare disease treatment, and

(C) the insured's attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the insured's [life-threatening or disabling] condition or disease, must have recommended either (a) a health service or procedure (including a pharmaceutical product within the meaning of subparagraph (B) of paragraph two of subsection (e) of section four thousand nine hundred of this article) that, based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the insured than any covered standard health service or procedure or, in the case of a rare disease, based on the physician's certification required by subsection (g-7) of section four thousand nine hundred of this article and such other evidence as the insured, the insured's designee or the insured's attending physician may present, that the requested health service or procedure is likely to benefit the insured in the treatment of the insured's rare disease and that such benefit to the insured outweighs the risks of such health service or procedure; or (b) a clinical trial for which the insured is eligible. Any physician certification provided under this section shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation, and

S 55. Subsection (c) of section 4910 of the insurance law, as added by chapter 586 of the laws of 1998, is amended to read as follows:

(c) (1) The health care plan may charge the insured a fee of up to [fifty] TWENTY-FIVE dollars per external appeal WITH AN ANNUAL LIMIT ON FILING FEES FOR AN INSURED NOT TO EXCEED SEVENTY-FIVE DOLLARS WITHIN A SINGLE PLAN YEAR; provided that, in the event the external appeal agent overturns the final adverse determination of the plan, such fee shall be refunded to the insured. Notwithstanding the foregoing, the health plan shall not require the enrollee to pay any such fee if the enrollee is a

recipient of medical assistance or is covered by a policy pursuant to title one-A of article twenty-five of the public health law. Notwithstanding the foregoing, the health plan shall not require the insured to pay any such fee if such fee shall pose a hardship to the [enrollee] INSURED as determined by the plan.

(2) THE HEALTH CARE PLAN MAY CHARGE THE INSURED'S HEALTH CARE PROVIDER A FEE OF UP TO FIFTY DOLLARS PER EXTERNAL APPEAL, OTHER THAN FOR AN EXTERNAL APPEAL REQUESTED PURSUANT TO PARAGRAPH TWO OR THREE OF SUBSECTION (D) OF SECTION FOUR THOUSAND NINE HUNDRED FOURTEEN OF THIS ARTICLE; PROVIDED THAT, IN THE EVENT THE EXTERNAL APPEAL AGENT OVERTURNS THE FINAL ADVERSE DETERMINATION OF THE PLAN, SUCH FEE SHALL BE REFUNDED TO THE INSURED'S HEALTH CARE PROVIDER.

S 56. Paragraphs 4 and 5 of subsection (b) of section 4912 of the insurance law, as added by chapter 586 of the laws of 1998, are amended and a new paragraph 6 is added to read as follows:

(4) establish a toll-free telephone service to receive information on a 24-hour-a-day 7-day-a-week basis relating to external appeals pursuant to this title. Such system shall be capable of accepting, recording or providing instruction to incoming telephone calls during other than normal business hours[, and];

(5) develop procedures to ensure that:

(i) appropriate personnel are reasonably accessible not less than forty hours per week during normal business hours to discuss patient care and to allow response to telephone requests, and

(ii) response to accepted or recorded messages shall be made not less than one business day after the date on which the call was received[.]; AND

(6) BE ACCREDITED BY A NATIONALLY RECOGNIZED PRIVATE ACCREDITING ORGANIZATION.

S 57. Paragraphs 1 and 3 of subsection (b) of section 4914 of the insurance law, paragraph 1 as added by chapter 586 of the laws of 1998 and paragraph 3 as amended by chapter 237 of the laws of 2009, are amended to read as follows:

(1) The insured shall have [forty-five days] FOUR MONTHS to initiate an external appeal after the insured receives notice from the health care plan, or such plan's utilization review agent if applicable, of a final adverse determination or denial, or after both the plan and the [enrollee] INSURED have jointly agreed to waive any internal appeal, OR AFTER THE INSURED IS DEEMED TO HAVE EXHAUSTED OR IS NOT REQUIRED TO COMPLETE ANY INTERNAL APPEAL PURSUANT TO SECTION 2719 OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-19. WHERE APPLICABLE, THE INSURED'S HEALTH CARE PROVIDER SHALL HAVE FORTY-FIVE DAYS TO INITIATE AN EXTERNAL APPEAL AFTER THE INSURED OR THE INSURED'S HEALTH CARE PROVIDER, AS APPLICABLE, RECEIVES NOTICE FROM THE HEALTH CARE PLAN, OR SUCH PLAN'S UTILIZATION REVIEW AGENT IF APPLICABLE, OF A FINAL ADVERSE DETERMINATION OR DENIAL OR AFTER BOTH THE PLAN AND THE INSURED HAVE JOINTLY AGREED TO WAIVE ANY INTERNAL APPEAL. Such request shall be in writing in accordance with the instructions and in such form prescribed by subsection (e) of this section. The insured, and the insured's health care provider where applicable, shall have the opportunity to submit additional documentation with respect to such appeal to the external appeal agent within [such forty-five-day period] THE APPLICABLE TIME PERIOD ABOVE; provided however that when such documentation represents a material change from the documentation upon which the utilization review agent based its adverse determination or upon which the health plan based its

denial, the health plan shall have three business days to consider such documentation and amend or confirm such adverse determination.

(3) Notwithstanding the provisions of paragraphs one and two of this subsection, if the insured's attending physician states that a delay in providing the health care service would pose an imminent or serious threat to the health of the insured, OR IF THE INSURED IS ENTITLED TO AN EXPEDITED EXTERNAL APPEAL PURSUANT TO SECTION 2719 OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-19, the external appeal shall be completed within [three days] NO MORE THAN SEVENTY-TWO HOURS of the request therefor and the external appeal agent shall make every reasonable attempt to immediately notify the insured, the insured's health care provider where appropriate, and the health plan of its determination by telephone or facsimile, followed immediately by written notification of such determination.

S 58. Clause (a) of item (ii) of subparagraph (B) of paragraph 4 of subsection (b) of section 4914 of the insurance law, as amended by chapter 237 of the laws of 2009, is amended to read as follows:

(a) that the patient costs of the proposed health service or procedure shall be covered by the health care plan either: when a majority of the panel of reviewers determines, based upon review of the applicable medical and scientific evidence and, in connection with rare diseases, the physician's certification required by subsection (g-7) of section four thousand nine hundred of this article and such other evidence as the insured, the insured's designee or the insured's attending physician may present (or upon confirmation that the recommended treatment is a clinical trial), the insured's medical record, and any other pertinent information, that the proposed health service or treatment (including a pharmaceutical product within the meaning of subparagraph (B) of paragraph two of subsection (e) of section four thousand nine hundred of this article) is likely to be more beneficial than any standard treatment or treatments for the insured's [life-threatening or disabling] condition or disease or, for rare diseases, that the requested health service or procedure is likely to benefit the insured in the treatment of the insured's rare disease and that such benefit to the insured outweighs the risks of such health service or procedure (or, in the case of a clinical trial, is likely to benefit the insured in the treatment of the insured's condition or disease); or when a reviewing panel is evenly divided as to a determination concerning coverage of the health service or procedure, or

S 59. Section 4403 of the public health law is amended by adding a new subdivision 7 to read as follows:

7. A HEALTH MAINTENANCE ORGANIZATION THAT REQUIRES OR PROVIDES FOR DESIGNATION BY AN ENROLLEE OF A PARTICIPATING PRIMARY CARE PROVIDER SHALL PERMIT THE ENROLLEE TO DESIGNATE ANY PARTICIPATING PRIMARY CARE PROVIDER WHO IS AVAILABLE TO ACCEPT SUCH INDIVIDUAL, AND IN THE CASE OF A CHILD, SHALL PERMIT THE ENROLLEE TO DESIGNATE A PHYSICIAN (ALLOPATHIC OR OSTEOPATHIC) WHO SPECIALIZES IN PEDIATRICS AS THE CHILD'S PRIMARY CARE PROVIDER IF SUCH PROVIDER PARTICIPATES IN THE NETWORK OF THE HEALTH MAINTENANCE ORGANIZATION.

S 60. Subdivisions 1 and 2 of section 4406-b of the public health law, as added by chapter 645 of the laws of 1994, are amended to read as follows:

1. The health maintenance organization shall not limit a female enrollee's direct access to primary and preventive obstetric and gynecologic services, INCLUDING ANNUAL EXAMINATIONS, CARE RESULTING FROM SUCH ANNUAL EXAMINATIONS, AND TREATMENT OF ACUTE GYNECOLOGIC CONDITIONS, from

a qualified provider of such services of her choice from within the plan [to less than two examinations annually for such services] or [to] FOR any care related to a pregnancy[. In addition, the health maintenance organization shall not limit direct access to primary and preventive obstetric and gynecologic services required as a result of such annual examinations or as a result of an acute gynecologic condition], provided that: (A) such qualified provider discusses such services and treatment plan with the enrollee's primary care practitioner in accordance with the requirements of the health maintenance organization; AND (B) SUCH QUALIFIED PROVIDER AGREES TO ADHERE TO THE HEALTH MAINTENANCE ORGANIZATION'S POLICIES AND PROCEDURES, INCLUDING ANY APPLICABLE PROCEDURES REGARDING REFERRALS AND OBTAINING PRIOR AUTHORIZATION FOR SERVICES OTHER THAN OBSTETRIC AND GYNECOLOGIC SERVICES RENDERED BY SUCH QUALIFIED PROVIDER, AND AGREES TO PROVIDE SERVICES PURSUANT TO A TREATMENT PLAN (IF ANY) APPROVED BY THE HEALTH MAINTENANCE ORGANIZATION.

2. A HEALTH MAINTENANCE ORGANIZATION SHALL TREAT THE PROVISION OF OBSTETRIC AND GYNECOLOGIC CARE, AND THE ORDERING OF RELATED OBSTETRIC AND GYNECOLOGIC ITEMS AND SERVICES, PURSUANT TO THE DIRECT ACCESS DESCRIBED IN SUBDIVISION ONE OF THIS SECTION BY A PARTICIPATING QUALIFIED PROVIDER OF SUCH SERVICES, AS THE AUTHORIZATION OF THE PRIMARY CARE PROVIDER.

3. It shall be the duty of the administrative officer or other person in charge of each health maintenance organization to advise each female enrollee, in writing, of the provisions of this section.

S 61. Subdivision 3 of section 4900 of the public health law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

3. "Emergency condition" means a medical or behavioral condition, [the onset of which is sudden,] that manifests itself by ACUTE symptoms of sufficient severity, including severe pain, SUCH that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; [or] (d) serious disfigurement of such person; OR (E) A CONDITION DESCRIBED IN CLAUSE (I), (II) OR (III) OF SECTION 1867(E)(1)(A) OF THE SOCIAL SECURITY ACT.

S 62. Subdivision 7-g of section 4900 of the public health law, as added by chapter 237 of the laws of 2009, is amended to read as follows:

7-g. "Rare disease" means a [life threatening or disabling] condition or disease that (1)(A) is currently or has been subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network or (B) affects fewer than two hundred thousand United States residents per year, and (2) for which there does not exist a standard health service or procedure covered by the health care plan that is more clinically beneficial than the requested health service or treatment. A physician, other than the enrollee's treating physician, shall certify in writing that the condition is a rare disease as defined in this subsection. The certifying physician shall be a licensed, board-certified or board-eligible physician who specializes in the area of practice appropriate to treat the enrollee's rare disease. The certification shall provide either: (1) that the insured's rare disease is currently or has been subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network; or (2) that the insured's rare disease affects fewer than two hundred thousand United

States residents per year. The certification shall rely on medical and scientific evidence to support the requested health service or procedure, if such evidence exists, and shall include a statement that, based on the physician's credible experience, there is no standard treatment that is likely to be more clinically beneficial to the enrollee than the requested health service or procedure and the requested health service or procedure is likely to benefit the enrollee in the treatment of the enrollee's rare disease and that such benefit to the enrollee outweighs the risks of such health service or procedure. The certifying physician shall disclose any material financial or professional relationship with the provider of the requested health service or procedure as part of the application for external appeal of denial of a rare disease treatment. If the provision of the requested health service or procedure at a health care facility requires prior approval of an institutional review board, an enrollee or enrollee's designee shall also submit such approval as part of the external appeal application.

S 63. Subparagraphs (i) and (ii) of paragraph (a) of subdivision 2 of section 4910 of the public health law, as added by chapter 586 of the laws of 1998, are amended to read as follows:

(i) the enrollee has had coverage of a health care service, which would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal, in whole or in part, pursuant to title one of this article on the grounds that such health care service [is not medically necessary] DOES NOT MEET THE HEALTH CARE PLAN'S REQUIREMENTS FOR MEDICAL NECESSITY, APPROPRIATENESS, HEALTH CARE SETTING, LEVEL OF CARE, OR EFFECTIVENESS OF A COVERED BENEFIT, and

(ii) the health care plan has rendered a final adverse determination with respect to such health care service or both the plan and the enrollee have jointly agreed to waive any internal appeal, OR THE ENROLLEE IS DEEMED TO HAVE EXHAUSTED OR IS NOT REQUIRED TO COMPLETE ANY INTERNAL APPEAL PURSUANT TO SECTION 2719 OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-19; or

S 64. Subparagraphs (i), (ii) and (iii) of paragraph (b) of subdivision 2 of section 4910 of the public health law, subparagraph (i) as added by chapter 586 of the laws of 1998, and subparagraphs (ii) and (iii) as amended by chapter 237 of the laws of 2009, are amended to read as follows:

(i) the enrollee has had coverage of a health care service denied on the basis that such service is experimental or investigational, and such denial has been upheld on appeal under title one of this article, or both the plan and the enrollee have jointly agreed to waive any internal appeal, OR THE ENROLLEE IS DEEMED TO HAVE EXHAUSTED OR IS NOT REQUIRED TO COMPLETE ANY INTERNAL APPEAL PURSUANT TO SECTION 2719 OF THE FEDERAL PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-19, and

(ii) the enrollee's attending physician has certified that the enrollee has a [life-threatening or disabling] condition or disease (a) for which standard health services or procedures have been ineffective or would be medically inappropriate, or (b) for which there does not exist a more beneficial standard health service or procedure covered by the health care plan, or (c) for which there exists a clinical trial or rare disease treatment, and

(iii) the enrollee's attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the enrollee's [life threatening or disabling] condition or disease, must have recommended either (a) a

health service or procedure (including a pharmaceutical product within the meaning of subparagraph (B) of paragraph (b) of subdivision five of section forty-nine hundred of this article) that, based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the enrollee than any covered standard health service or procedure or, in the case of a rare disease, based on the physician's certification required by subdivision seven-g of section forty-nine hundred of this article and such other evidence as the enrollee, the enrollee's designee or the enrollee's attending physician may present, that the requested health service or procedure is likely to benefit the enrollee in the treatment of the enrollee's rare disease and that such benefit to the enrollee outweighs the risks of such health service or procedure; or (b) a clinical trial for which the enrollee is eligible. Any physician certification provided under this section shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation, and

S 65. Subdivision 3 of section 4910 of the public health law, as added by chapter 586 of the laws of 1998, is amended to read as follows:

3. (A) The health care plan may charge the enrollee a fee of up to [fifty] TWENTY-FIVE dollars per external appeal WITH AN ANNUAL LIMIT ON FILING FEES FOR AN ENROLLEE NOT TO EXCEED SEVENTY-FIVE DOLLARS WITHIN A SINGLE PLAN YEAR; provided that, in the event the external appeal agent overturns the final adverse determination of the plan, such fee shall be refunded to the enrollee. Notwithstanding the foregoing, the health plan shall not require the enrollee to pay any such fee if the enrollee is a recipient of medical assistance or is covered by a policy pursuant to title one-A of article twenty-five of this chapter. Notwithstanding the foregoing, the health plan shall not require the enrollee to pay any such fee if such fee shall pose a hardship to the enrollee as determined by the plan.

(B) THE HEALTH CARE PLAN MAY CHARGE THE ENROLLEE'S HEALTH CARE PROVIDER A FEE OF UP TO FIFTY DOLLARS PER EXTERNAL APPEAL, OTHER THAN FOR AN EXTERNAL APPEAL REQUESTED PURSUANT TO PARAGRAPH (B) OR (C) OF SUBDIVISION FOUR OF SECTION FORTY-NINE HUNDRED FOURTEEN OF THIS ARTICLE; PROVIDED THAT, IN THE EVENT THE EXTERNAL APPEAL AGENT OVERTURNS THE FINAL ADVERSE DETERMINATION OF THE PLAN, SUCH FEE SHALL BE REFUNDED TO THE ENROLLEE'S HEALTH CARE PROVIDER.

S 66. Paragraphs (d) and (e) of subdivision 2 of section 4912 of the public health law, as added by chapter 586 of the laws of 1998, are amended and a new paragraph (f) is added to read as follows:

(d) establish a toll-free telephone service to receive information on a 24-hour-a-day 7-day-a-week basis relating to external appeals pursuant to this title. Such system shall be capable of accepting, recording or providing instruction to incoming telephone calls during other than normal business hours[, and];

(e) develop procedures to ensure that:

(i) appropriate personnel are reasonably accessible not less than forty hours per week during normal business hours to discuss patient care and to allow response to telephone requests, and

(ii) response to accepted or recorded messages shall be made not less than one business day after the date on which the call was received[.]; AND

(F) BE ACCREDITED BY A NATIONALLY RECOGNIZED PRIVATE ACCREDITING ORGANIZATION.

S 67. Paragraphs (a) and (c) of subdivision 2 of section 4914 of the public health law, paragraph (a) as added by chapter 586 of the laws of

1998 and paragraph (c) as amended by chapter 237 of the laws of 2009, are amended to read as follows:

(a) The enrollee shall have [forty-five days] FOUR MONTHS to initiate an external appeal after the enrollee receives notice from the health care plan, or such plan's utilization review agent if applicable, of a final adverse determination or denial or after both the plan and the enrollee have jointly agreed to waive any internal appeal, OR AFTER THE ENROLLEE IS DEEMED TO HAVE EXHAUSTED OR IS NOT REQUIRED TO COMPLETE ANY INTERNAL APPEAL PURSUANT TO SECTION 2719 OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-19. WHERE APPLICABLE, THE ENROLLEE'S HEALTH CARE PROVIDER SHALL HAVE FORTY-FIVE DAYS TO INITIATE AN EXTERNAL APPEAL AFTER THE ENROLLEE OR THE ENROLLEE'S HEALTH CARE PROVIDER, AS APPLICABLE, RECEIVES NOTICE FROM THE HEALTH CARE PLAN, OR SUCH PLAN'S UTILIZATION REVIEW AGENT IF APPLICABLE, OF A FINAL ADVERSE DETERMINATION OR DENIAL OR AFTER BOTH THE PLAN AND THE ENROLLEE HAVE JOINTLY AGREED TO WAIVE ANY INTERNAL APPEAL. Such request shall be in writing in accordance with the instructions and in such form prescribed by subdivision five of this section. The enrollee, and the enrollee's health care provider where applicable, shall have the opportunity to submit additional documentation with respect to such appeal to the external appeal agent within [such forty-five-day period] THE APPLICABLE TIME PERIOD ABOVE; provided however that when such documentation represents a material change from the documentation upon which the utilization review agent based its adverse determination or upon which the health plan based its denial, the health plan shall have three business days to consider such documentation and amend or confirm such adverse determination.

(c) Notwithstanding the provisions of paragraphs (a) and (b) of this subdivision, if the enrollee's attending physician states that a delay in providing the health care service would pose an imminent or serious threat to the health of the enrollee, OR IF THE ENROLLEE IS ENTITLED TO AN EXPEDITED EXTERNAL APPEAL PURSUANT TO SECTION 2719 OF THE FEDERAL PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-19, the external appeal shall be completed within [three days] NO MORE THAN SEVENTY-TWO HOURS of the request therefor and the external appeal agent shall make every reasonable attempt to immediately notify the enrollee, the enrollee's health care provider where appropriate, and the health plan of its determination by telephone or facsimile, followed immediately by written notification of such determination.

S 68. Item 1 of clause (ii) of subparagraph (B) of paragraph (d) of subdivision 2 of section 4914 of the public health law, as amended by chapter 237 of the laws of 2009, is amended to read as follows:

(1) that the patient costs of the proposed health service or procedure shall be covered by the health care plan either: when a majority of the panel of reviewers determines, based upon review of the applicable medical and scientific evidence and, in connection with rare diseases, the physician's certification required by subdivision seven-g of section forty-nine hundred of this article and such other evidence as the enrollee, the enrollee's designee or the enrollee's attending physician may present (or upon confirmation that the recommended treatment is a clinical trial), the enrollee's medical record, and any other pertinent information, that the proposed health service or treatment (including a pharmaceutical product within the meaning of subparagraph (B) of paragraph (b) of subdivision five of section forty-nine hundred of this article) is likely to be more beneficial than any standard treatment or treatments for the enrollee's [life-threatening or disabling] condition or disease or, for rare diseases, that the requested health service or

procedure is likely to benefit the enrollee in the treatment of the enrollee's rare disease and that such benefit to the enrollee outweighs the risks of such health service or procedure (or, in the case of a clinical trial, is likely to benefit the enrollee in the treatment of the enrollee's condition or disease); or when a reviewing panel is evenly divided as to a determination concerning coverage of the health service or procedure, or

S 69. If any provision of this act or the application thereof shall be held to be invalid, such invalidity shall not affect other provisions of this act which can be given effect without the invalid provision; and to that end, the provisions of this act are severable.

S 70. This act shall take effect immediately:

1. provided, that for policies renewed on or after such date but before September 23, 2011, this act shall take effect upon the renewal date;

2. provided, however, that sections eight, nine, ten, fourteen, fifteen, sixteen, seventeen, eighteen, twenty-three, twenty-six, twenty-seven, twenty-eight, twenty-nine, thirty, forty, forty-one, forty-two and forty-three of this act shall, with respect to blanket policies of hospital, medical, surgical or prescription drug expense insurance covering students pursuant to subparagraph (C) of paragraph 3 of subsection (a) of section 4237 of the insurance law, take effect January 1, 2012 and apply to policies issued or renewed on and after such date; and

3. provided, further, that sections fifty-two, fifty-three, fifty-four, fifty-five, fifty-six, fifty-seven, fifty-eight, sixty-two, sixty-three, sixty-four, sixty-five, sixty-six, sixty-seven and sixty-eight of this act shall take effect on the later of July 1, 2011, or the date the external appeal requirements of section 2719 of the Public Health Service Act, 42 U.S.C. S 300gg-19 are determined to be effective by the Secretary of Health and Human Services and apply to a final adverse determination issued on and after such date.