

8460

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:

- 1 Section 1. Subsection (b) of section 3105 of the insurance law is
2 amended to read as follows:
3 (b)(1) No misrepresentation shall avoid any contract of insurance or
4 defeat recovery thereunder unless such misrepresentation was material.
5 No misrepresentation shall be deemed material unless knowledge by the
6 insurer of the facts misrepresented would have led to a refusal by the
7 insurer to make such contract.
8 (2) WITH RESPECT TO A POLICY OF HOSPITAL, MEDICAL, SURGICAL, OR
9 PRESCRIPTION DRUG EXPENSE INSURANCE SUBJECT TO ARTICLES THIRTY-TWO OR
10 FORTY-THREE OF THIS CHAPTER, NO MISREPRESENTATION SHALL AVOID ANY
11 CONTRACT OF INSURANCE OR DEFEAT RECOVERY THEREUNDER UNLESS THE MISREPRE-
12 SENTATION WAS ALSO INTENTIONAL.
13 S 2. Subsection (a) of section 3216 of the insurance law, paragraph 4
14 as amended by section 65-d of part A of chapter 58 of the laws of 2007,
15 and subparagraph (C) of paragraph 4 as added by chapter 240 of the laws
16 of 2009, is amended to read as follows:
17 (a) In this section the term:
18 (1) "Policy of accident and health insurance" includes any individual
19 policy or contract covering the kind or kinds of insurance described in
20 paragraph three of subsection (a) of section one thousand one hundred
21 thirteen of this chapter.
22 (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-

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

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

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

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

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

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

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

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

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

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

54 (I) EVIDENCE-BASED ITEMS OR SERVICES FOR PREVENTIVE CARE AND SCREEN-
55 INGS THAT HAVE IN EFFECT A RATING OF 'A' OR 'B' IN THE CURRENT RECOMMEN-
56 DATIONS 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-airborne 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

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

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

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

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

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

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

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

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

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

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

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

3 (E) FOR PURPOSES OF THIS SECTION, "ESSENTIAL HEALTH BENEFITS" SHALL
4 HAVE THE MEANING ASCRIBED BY SECTION 1302(B) OF THE AFFORDABLE CARE ACT,
5 42 U.S.C. S 18022(B).

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

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

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

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

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

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

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

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

32 (III) IF THE EMERGENCY SERVICES ARE PROVIDED BY A NON-PARTICIPATING
33 PROVIDER, WITHOUT IMPOSING ANY ADMINISTRATIVE REQUIREMENT OR LIMITATION
34 ON COVERAGE THAT IS MORE RESTRICTIVE THAN THE REQUIREMENTS OR LIMITA-
35 TIONS THAT APPLY TO EMERGENCY SERVICES RECEIVED FROM PARTICIPATING
36 PROVIDERS; AND

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

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

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

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

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

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

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

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

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

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

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

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

50 (iii) on a prescribed drug regimen posing a significant risk of osteo-
51 porosis; or

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

54 (v) with such age, gender and/or other physiological characteristics
55 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 INSURED, 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 (1) 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

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

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

8 S 18. Subparagraph (E) of paragraph 15 of subsection (1) of section
9 3221 of the insurance law, as added by chapter 506 of the laws of 2001,
10 is amended to read as follows:

11 (E) As used in this paragraph:

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

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

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

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

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

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

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

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

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

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

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

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

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

31 (i) within sixty days following the date coverage would otherwise
32 terminate due to reaching the specified age set forth in the group poli-
33 cy;

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

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

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

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

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

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

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

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

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

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

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

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

26 (i) in each certificate of coverage; AND

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

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

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

36 (F) WITH RESPECT TO AN INDIVIDUAL UNDER AGE NINETEEN, AN INSURER MAY
37 NOT IMPOSE ANY PRE-EXISTING CONDITION EXCLUSION IN AN INDIVIDUAL OR
38 GROUP POLICY OF HOSPITAL, MEDICAL, SURGICAL OR PRESCRIPTION DRUG EXPENSE
39 INSURANCE PURSUANT TO THE REQUIREMENTS OF SECTION 2704 OF THE PUBLIC
40 HEALTH SERVICE ACT, 42 U.S.C. S 300GG-3, AS MADE EFFECTIVE BY SECTION
41 1255(2) OF THE AFFORDABLE CARE ACT, EXCEPT FOR AN INDIVIDUAL UNDER AGE
42 NINETEEN COVERED UNDER AN INDIVIDUAL POLICY OF HOSPITAL, MEDICAL, SURGI-
43 CAL OR PRESCRIPTION DRUG EXPENSE INSURANCE THAT IS A GRANDFATHERED
44 HEALTH PLAN.

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

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

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

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

3 S 24. Paragraphs 1 and 2 of subsection (f) of section 4235 of the
4 insurance law, paragraph 1 as amended by chapter 240 of the laws of
5 2009, and paragraph 2 as amended by chapter 312 of the laws of 2002, are
6 amended to read as follows:

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

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

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

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

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

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

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

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

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

33 (III) IF THE EMERGENCY SERVICES ARE PROVIDED BY A NON-PARTICIPATING
34 PROVIDER, WITHOUT IMPOSING ANY ADMINISTRATIVE REQUIREMENT OR LIMITATION
35 ON COVERAGE THAT IS MORE RESTRICTIVE THAN THE REQUIREMENTS OR LIMITA-
36 TIONS THAT APPLY TO EMERGENCY SERVICES RECEIVED FROM PARTICIPATING
37 PROVIDERS; AND

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

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

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

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

4 (D) FOR THE PURPOSE OF THIS PROVISION, "EMERGENCY SERVICES" MEANS,
5 WITH RESPECT TO AN EMERGENCY CONDITION: (I) A MEDICAL SCREENING EXAMINA-
6 TION AS REQUIRED UNDER SECTION 1867 OF THE SOCIAL SECURITY ACT, 42
7 U.S.C. S 1395DD, WHICH IS WITHIN THE CAPABILITY OF THE EMERGENCY DEPART-
8 MENT OF A HOSPITAL, INCLUDING ANCILLARY SERVICES ROUTINELY AVAILABLE TO
9 THE EMERGENCY DEPARTMENT TO EVALUATE SUCH EMERGENCY MEDICAL CONDITION;
10 AND (II) WITHIN THE CAPABILITIES OF THE STAFF AND FACILITIES AVAILABLE
11 AT THE HOSPITAL, SUCH FURTHER MEDICAL EXAMINATION AND TREATMENT AS ARE
12 REQUIRED UNDER SECTION 1867 OF THE SOCIAL SECURITY ACT, 42 U.S.C. S
13 1395DD, TO STABILIZE THE PATIENT.

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

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

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

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

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

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

53 [(iii)] (C) necessary immunizations, as determined by the superinten-
54 dent in consultation with the commissioner of health, consisting of at
55 least adequate dosages of vaccine against diphtheria, pertussis, teta-
56 nus, polio, measles, rubella, mumps, haemophilus influenzae type b and

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

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

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

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

15 (A) EVIDENCE-BASED ITEMS OR SERVICES FOR PREVENTIVE CARE AND SCREEN-
16 INGS THAT HAVE IN EFFECT A RATING OF 'A' OR 'B' IN THE CURRENT RECOMMEN-
17 DATIONS OF THE UNITED STATES PREVENTIVE SERVICES TASK FORCE;

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

21 (C) WITH RESPECT TO CHILDREN, INCLUDING INFANTS AND ADOLESCENTS,
22 EVIDENCE-INFORMED PREVENTIVE CARE AND SCREENINGS PROVIDED FOR IN COMPRE-
23 HENSIVE GUIDELINES SUPPORTED BY THE HEALTH RESOURCES AND SERVICES ADMIN-
24 ISTRATION; AND

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

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

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

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

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

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

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

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

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

52 (3)] For purposes OF PARAGRAPH ONE of this subsection, mammography
53 screening means an X-ray examination of the breast using dedicated
54 equipment, including X-ray tube, filter, compression device, screens,
55 films and cassettes, with an average glandular radiation dose less than
56 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:

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

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

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

29 (bb) A health service corporation or a medical service expense indem-
30 nity corporation [which] THAT provides major medical or similar compre-
31 hensive-type coverage shall provide such coverage for bone mineral
32 density measurements or tests, and if such contract otherwise includes
33 coverage for prescription drugs, drugs and devices approved by the
34 federal food and drug administration or generic equivalents as approved
35 substitutes. In determining appropriate coverage provided by [this para-
36 graph] PARAGRAPHS ONE, TWO AND THREE OF THIS SUBSECTION, the insurer or
37 health maintenance organization shall adopt standards [which] THAT
38 include the criteria of the federal [medicare] MEDICARE program and the
39 criteria of the national institutes of health for the detection of
40 osteoporosis, provided that such coverage shall be further determined as
41 follows:

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

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

55 (i) previously diagnosed as having osteoporosis or having a family
56 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-

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

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

21 (C) Notwithstanding any rule, regulation or law to the contrary, any
22 "family contract" shall provide that coverage of newborn infants,
23 including newly born infants adopted by the [insured or] subscriber if
24 such [insured or] subscriber takes physical custody of the infant upon
25 such infant's release from the hospital and files a petition pursuant to
26 section one hundred fifteen-c of the domestic relations law within thir-
27 ty days of birth; and provided further that no notice of revocation to
28 the adoption has been filed pursuant to section one hundred fifteen-b of
29 the domestic relations law and consent to the adoption has not been
30 revoked, shall be effective from the moment of birth for injury or sick-
31 ness including the necessary care and treatment of medically diagnosed
32 congenital defects and birth abnormalities including premature birth,
33 except that in cases of adoption, coverage of the initial hospital stay
34 shall not be required where a birth parent has insurance coverage avail-
35 able for the infant's care. This provision regarding coverage of newborn
36 infants shall not apply to two person coverage. In the case of individ-
37 ual or two person coverages the corporation must also permit the person
38 to whom the [policy] CONTRACT is issued to elect such coverage of
39 newborn infants from the moment of birth. If notification and/or payment
40 of an additional premium or contribution is required to make coverage
41 effective for a newborn infant, the coverage may provide that such
42 notice and/or payment be made within no less than thirty days of the day
43 of birth to make coverage effective from the moment of birth. This
44 election shall not be required in the case of student insurance or where
45 the group remitting agent's plan does not provide coverage for [depend-
46 ent] children.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

41 (i) in each certificate of coverage; AND

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

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

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

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

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

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

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

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

1 shall not be required where a birth parent has insurance coverage avail-
2 able for the infant's care. This provision regarding coverage of newborn
3 infants shall not apply to two person coverage. In the case of individ-
4 ual or two person coverages the corporation must also permit the person
5 to whom the certificate is issued to elect such coverage of newborn
6 infants from the moment of birth. If notification and/or payment of an
7 additional premium or contribution is required to make coverage effec-
8 tive for a newborn infant, the coverage may provide that such notice
9 and/or payment be made within no less than thirty days of the day of
10 birth to make coverage effective from the moment of birth. This election
11 shall not be required in the case of student insurance or where the
12 group's plan does not provide coverage for [dependent] children.

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

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

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

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

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

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

25 S 39. Subsection (l) of section 4305 of the insurance law, as added by
26 chapter 237 of the laws of 2009, is relettered subsection (m) and para-
27 graphs 1 and 2 of subsection (l) of section 4305 of the insurance law,
28 as added by chapter 240 of the laws of 2009, are amended to read as
29 follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

53 (i) in each certificate of coverage; AND

54 (ii) at least sixty days prior to termination at the specified age as
55 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

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

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

10 (D) THE REQUIREMENTS OF SUBSECTIONS (B) AND (C) OF THIS SECTION SHALL
11 NOT BE APPLICABLE TO ANY INDIVIDUAL CONTRACT THAT IS A GRANDFATHERED
12 HEALTH PLAN. FOR PURPOSES OF THIS SECTION, "GRANDFATHERED HEALTH PLAN"
13 MEANS COVERAGE PROVIDED BY A CORPORATION IN WHICH AN INDIVIDUAL WAS
14 ENROLLED ON MARCH TWENTY-THIRD, TWO THOUSAND TEN FOR AS LONG AS THE
15 COVERAGE MAINTAINS GRANDFATHERED STATUS IN ACCORDANCE WITH SECTION
16 1251(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18011(E).

17 (E) FOR PURPOSES OF THIS SECTION, "ESSENTIAL HEALTH BENEFITS" SHALL
18 HAVE THE MEANING ASCRIBED BY SECTION 1302(B) OF THE AFFORDABLE CARE ACT,
19 42 U.S.C. S 18022(B).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

50 In determining appropriate coverage provided by SUBPARAGRAPHS (A), (B)
51 AND (C) OF this paragraph, the insurer or health maintenance organiza-
52 tion shall adopt standards [which] THAT include the criteria of the
53 federal [medicare] MEDICARE program and the criteria of the national
54 institutes of health for the detection of osteoporosis, provided that
55 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

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

7 (d) The out-of-plan benefit system shall have an annual deductible
8 established at one thousand dollars per calendar year for an individual
9 and two thousand dollars per year for a family. Coinsurance shall be
10 established at twenty percent with the health maintenance organization
11 or insurer paying eighty percent of the usual, customary and reasonable
12 charges, or eighty percent of the amounts listed on a fee schedule filed
13 with and approved by the superintendent which provides a comparable
14 level of reimbursement. Coinsurance of ten percent shall apply to outpa-
15 tient visits for the diagnosis and treatment of mental, nervous or
16 emotional disorders or ailments. The benefits described in subparagraph
17 (F) of paragraph three and paragraphs seventeen and eighteen of
18 subsection (b) of this section shall not be subject to the deductible or
19 coinsurance. The benefits described in paragraph nine of subsection (b)
20 of this section shall not be subject to the deductible. The out-of-plan
21 out-of-pocket maximum deductible and coinsurance shall be established at
22 three thousand dollars per calendar year for an individual and five
23 thousand dollars per calendar year for a family. The out-of-plan life-
24 time benefit maximum shall be established at five hundred thousand
25 dollars FOR BENEFITS THAT ARE NOT ESSENTIAL HEALTH BENEFITS. A LIFETIME
26 LIMIT ON THE DOLLAR AMOUNT OF ESSENTIAL HEALTH BENEFITS FOR ANY INDIVID-
27 UAL SHALL NOT BE ESTABLISHED. FOR PURPOSES OF THIS SUBSECTION, "ESSEN-
28 TIAL HEALTH BENEFITS" SHALL HAVE THE MEANING ASCRIBED BY SECTION 1302(B)
29 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(B).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 (g-7) "Rare disease" means a [life threatening or disabling] condition
16 or disease that (1)(A) is currently or has been subject to a research
17 study by the National Institutes of Health Rare Diseases Clinical
18 Research Network; or (B) affects fewer than two hundred thousand United
19 States residents per year; and (2) for which there does not exist a
20 standard health service or procedure covered by the health care plan
21 that is more clinically beneficial than the requested health service or
22 treatment. A physician, other than the insured's treating physician,
23 shall certify in writing that the condition is a rare disease as defined
24 in this subsection. The certifying physician shall be a licensed, board-
25 certified or board-eligible physician who specializes in the area of
26 practice appropriate to treat the insured's rare disease. The certif-
27 ication shall provide either: (1) that the insured's rare disease is
28 currently or has been subject to a research study by the National Insti-
29 tutes of Health Rare Diseases Clinical Research Network; or (2) that the
30 insured's rare disease affects fewer than two hundred thousand United
31 States residents per year. The certification shall rely on medical and
32 scientific evidence to support the requested health service or proce-
33 dure, if such evidence exists, and shall include a statement that, based
34 on the physician's credible experience, there is no standard treatment
35 that is likely to be more clinically beneficial to the insured than the
36 requested health service or procedure and the requested health service
37 or procedure is likely to benefit the insured in the treatment of the
38 insured's rare disease and that such benefit to the insured outweighs
39 the risks of such health service or procedure. The certifying physician
40 shall disclose any material financial or professional relationship with
41 the provider of the requested health service or procedure as part of the
42 application for external appeal of denial of a rare disease treatment.
43 If the provision of the requested health service or procedure at a
44 health care facility requires prior approval of an institutional review
45 board, an insured or insured's designee shall also submit such approval
46 as part of the external appeal application.

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

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

1 HEALTH CARE SETTING, LEVEL OF CARE, OR EFFECTIVENESS OF A COVERED BENE-
2 FIT, and

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

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

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

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

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

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

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

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

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

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

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

21 (5) develop procedures to ensure that:

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

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

27 AND

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

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

34 (1) The insured shall have [forty-five days] FOUR MONTHS to initiate
35 an external appeal after the insured receives notice from the health
36 care plan, or such plan's utilization review agent if applicable, of a
37 final adverse determination or denial, or after both the plan and the
38 [enrollee] INSURED have jointly agreed to waive any internal appeal, OR
39 AFTER THE INSURED IS DEEMED TO HAVE EXHAUSTED OR IS NOT REQUIRED TO
40 COMPLETE ANY INTERNAL APPEAL PURSUANT TO SECTION 2719 OF THE PUBLIC
41 HEALTH SERVICE ACT, 42 U.S.C. S 300GG-19. WHERE APPLICABLE, THE
42 INSURED'S HEALTH CARE PROVIDER SHALL HAVE FORTY-FIVE DAYS TO INITIATE AN
43 EXTERNAL APPEAL AFTER THE INSURED OR THE INSURED'S HEALTH CARE PROVIDER,
44 AS APPLICABLE, RECEIVES NOTICE FROM THE HEALTH CARE PLAN, OR SUCH PLAN'S
45 UTILIZATION REVIEW AGENT IF APPLICABLE, OF A FINAL ADVERSE DETERMINATION
46 OR DENIAL OR AFTER BOTH THE PLAN AND THE INSURED HAVE JOINTLY AGREED TO
47 WAIVE ANY INTERNAL APPEAL. Such request shall be in writing in accord-
48 ance with the instructions and in such form prescribed by subsection (e)
49 of this section. The insured, and the insured's health care provider
50 where applicable, shall have the opportunity to submit additional
51 documentation with respect to such appeal to the external appeal agent
52 within [such forty-five-day period] THE APPLICABLE TIME PERIOD ABOVE;
53 provided however that when such documentation represents a material
54 change from the documentation upon which the utilization review agent
55 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

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

16 2. A HEALTH MAINTENANCE ORGANIZATION SHALL TREAT THE PROVISION OF
17 OBSTETRIC AND GYNECOLOGIC CARE, AND THE ORDERING OF RELATED OBSTETRIC
18 AND GYNECOLOGIC ITEMS AND SERVICES, PURSUANT TO THE DIRECT ACCESS
19 DESCRIBED IN SUBDIVISION ONE OF THIS SECTION BY A PARTICIPATING QUALI-
20 FIED PROVIDER OF SUCH SERVICES, AS THE AUTHORIZATION OF THE PRIMARY CARE
21 PROVIDER.

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

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

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

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

41 7-g. "Rare disease" means a [life threatening or disabling] condition
42 or disease that (1)(A) is currently or has been subject to a research
43 study by the National Institutes of Health Rare Diseases Clinical
44 Research Network or (B) affects fewer than two hundred thousand United
45 States residents per year, and (2) for which there does not exist a
46 standard health service or procedure covered by the health care plan
47 that is more clinically beneficial than the requested health service or
48 treatment. A physician, other than the enrollee's treating physician,
49 shall certify in writing that the condition is a rare disease as defined
50 in this subsection. The certifying physician shall be a licensed, board-
51 certified or board-eligible physician who specializes in the area of
52 practice appropriate to treat the enrollee's rare disease. The certif-
53 ication shall provide either: (1) that the insured's rare disease is
54 currently or has been subject to a research study by the National Insti-
55 tutes of Health Rare Diseases Clinical Research Network; or (2) that the
56 insured's rare disease affects fewer than two hundred thousand United

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

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

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

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

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

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

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

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

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

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

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

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

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

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

46 (e) develop procedures to ensure that:

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

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

52 AND

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

55 S 67. Paragraphs (a) and (c) of subdivision 2 of section 4914 of the
56 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

1 procedure is likely to benefit the enrollee in the treatment of the
2 enrollee's rare disease and that such benefit to the enrollee outweighs
3 the risks of such health service or procedure (or, in the case of a
4 clinical trial, is likely to benefit the enrollee in the treatment of
5 the enrollee's condition or disease); or when a reviewing panel is even-
6 ly divided as to a determination concerning coverage of the health
7 service or procedure, or

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

12 S 70. This act shall take effect immediately:

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

16 2. provided, however, that sections eight, nine, ten, fourteen,
17 fifteen, sixteen, seventeen, eighteen, twenty-three, twenty-six, twen-
18 ty-seven, twenty-eight, twenty-nine, thirty, forty, forty-one, forty-two
19 and forty-three of this act shall, with respect to blanket policies of
20 hospital, medical, surgical or prescription drug expense insurance
21 covering students pursuant to subparagraph (C) of paragraph 3 of
22 subsection (a) of section 4237 of the insurance law, take effect January
23 1, 2012 and apply to policies issued or renewed on and after such date;
24 and

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