

8457

2011-2012 Regular Sessions

I N   A S S E M B L Y

June 16, 2011

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Introduced by M. of A. 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

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

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

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

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

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

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



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

1 1998 and paragraph (c) as amended by chapter 237 of the laws of 2009,  
2 are amended to read as follows:

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

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

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

42 (1) that the patient costs of the proposed health service or procedure  
43 shall be covered by the health care plan either: when a majority of the  
44 panel of reviewers determines, based upon review of the applicable  
45 medical and scientific evidence and, in connection with rare diseases,  
46 the physician's certification required by subdivision seven-g of section  
47 forty-nine hundred of this article and such other evidence as the enrol-  
48 lee, the enrollee's designee or the enrollee's attending physician may  
49 present (or upon confirmation that the recommended treatment is a clin-  
50 ical trial), the enrollee's medical record, and any other pertinent  
51 information, that the proposed health service or treatment (including a  
52 pharmaceutical product within the meaning of subparagraph (B) of para-  
53 graph (b) of subdivision five of section forty-nine hundred of this  
54 article) is likely to be more beneficial than any standard treatment or  
55 treatments for the enrollee's [life-threatening or disabling] condition  
56 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.