

## PPACA Compliance Summary – New York Health

**Please select the appropriate check box below to indicate which product is amended by this filing.**

- INDIVIDUAL HEALTH BENEFIT PLANS** (Complete [SECTIONS A and C](#) only)
- SMALL / LARGE GROUP HEALTH BENEFIT PLANS** (Complete [SECTIONS B and C](#) only)

This form and rate filing compliance summary is to be submitted with your endorsement/policy/contract to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply to hospital/surgical/medical expense policies for health insurance coverage including Comprehensive Coverage, Major Medical, PPO, EPO, HMO, Healthy NY, Basic Hospital, Basic Medical, or limited benefits insurance coverage that provides benefits reimbursed on an expense incurred basis. This summary includes the requirements for grandfathered (coverage in effect on or before March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. *(If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.)*

Check box if this is a paper filing.

### COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
				<input type="checkbox"/> Yes <input type="checkbox"/> No

## PPACA Compliance Summary – New York Health

<b>SECTION A – Individual Health Benefit Plans</b>					
Federal Requirement	Federal Statute Section	New York Requirement	New York Citation/s	Grandfathered	Non-Grandfathered
<b>Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19.</b>	<p>§§2704 and 1255 of the PHS/ §1201 of the PPACA</p> <p>45CFR §§144.103, 146.111(a)(1)(i) and 147.108</p>	<p><b>Pre-existing Condition Exclusion</b> - This contract may include a pre-existing condition provision for enrollees / insureds age 19 and above which:</p> <ul style="list-style-type: none"> <li>• Defines a pre-existing condition as one which relates to a condition (whether physical or mental), regardless of the cause of the condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the enrollment date.</li> <li>• Excludes pre-existing conditions for a period of 12 months from the enrollment date.</li> <li>• Credits the time the individual was covered under creditable coverage.</li> <li>• Does not treat genetic information as a pre-existing condition in the absence of a diagnosis of the condition related to such information.</li> <li>• Does not exclude coverage in the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.</li> <li>• Does not exclude coverage in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of adoption, is covered under creditable coverage.</li> <li>• Does not exclude coverage in the case of an individual, and any dependent of such individual, who is eligible for a federal tax credit under the federal Trade Adjustment Assistance Reform Act of 2002 and who has 3 months or more of creditable coverage.</li> </ul> <p><i>(Note: For compliance with the federal requirements, the pre-existing condition exclusion may not apply to enrollees under age 19 except for grandfathered individual contracts.)</i></p>	<p><a href="#">§3232</a></p> <p><a href="#">§4318</a></p> <p><a href="#">11 NYCRR 52.20</a></p> <p>19 U.S.C. §2401etseq.</p>	N/A	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If <b>no</b>, please explain.</p>

## PPACA Compliance Summary – New York Health

<b>SECTION A – Individual Health Benefit Plans</b>					
Federal Requirement	Federal Statute Section	New York Requirement	New York Citation/s	Grandfathered	Non-Grandfathered

Explanation:  
 Model Language Used?  
 Yes  No

Page Number:

**Eliminate Annual Dollar Limits on Essential Health Benefits** -Except allows for “restricted” annual dollar limits for essential health benefits for plan years prior to January 1, 2014.

For a policy year beginning on or after 9/23/10 but before 9/23/11 the limit is \$750,000.

For a policy year beginning on or after 9/23/11 but before 9/23/12 the limit is \$1,250,000.

For a policy year beginning on or after 9/23/12 but before 9/23/14 the limit is \$2,000,000.

Essential health benefits are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorders, including behavioral health

*§2711 of the PHSA/ §1001 of the PPACA  
 45CFR §147.126*

NY law does not include a similar requirement and the federal standard must be utilized.  
*(Note: The federal requirements do not apply to grandfathered individual contracts.)*

[§3216](#)  
[§4322](#)

N/A

Yes  No  
 If no, please explain.

## PPACA Compliance Summary – New York Health

<b>SECTION A – Individual Health Benefit Plans</b>					
<b>Federal Requirement</b>	<b>Federal Statute Section</b>	<b>New York Requirement</b>	<b>New York Citation/s</b>	<b>Grandfathered</b>	<b>Non-Grandfathered</b>
treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including oral and vision care.					
Explanation: Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Page Number:					
<b>Eliminate Lifetime Dollar Limits on Essential Health Benefits.</b> Essential health benefits are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorders, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including oral and vision care.	<i>§2711 of the PHS/ §1001 of the PPACA  45CFR §147.126</i>	NY law does not include a similar requirement and the federal standard must be utilized, including for out-of-network coverage under individual HMO contracts.  <i>(The federal requirements apply to grandfathered contracts.)</i>	<a href="#">§3216</a> <a href="#">§4322</a>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If <b>no</b> , please explain.	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If <b>no</b> , please explain.

## PPACA Compliance Summary – New York Health

<b>SECTION A – Individual Health Benefit Plans</b>					
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 Yes  No

Page Number:

**Prohibit Rescissions –**  
 Coverage may only be rescinded for fraud or intentional misrepresentation of material fact. Notification must be made to the policyholder 30 calendar days prior to cancellation.

*§ 2712 of the PHS/A/§1001 of PPACA*  
  
*45 CFR §147.128*

**Rescissions & Enrollee Representations** - NY law provides that no misrepresentation by an enrollee/insured shall avoid any contract of insurance or defeat any recovery thereunder unless such misrepresentation was material. After two years from the date of issue of the contract no misstatements, except fraudulent misstatements made by the applicant in the application for the contract shall be used to void the contract or deny a claim commencing after the expiration of such two year period. A copy of the application for coverage must be attached to the contract in order for statements in the application to be used to void the contract.

*(Note: The federal provision does not define “material” but refers to intentional misrepresentation “as prohibited by the terms of the plan or coverage.” Accordingly, a contract in NY will remain subject to the definition of material as provided in §3105. However, for compliance with the federal requirements, the misrepresentation must be intentional in order for the contract to be rescinded. A copy of the application for coverage must be attached to the contract in order for statements in the application to be used to void the contract. After two years, the policy can only be rescinded for fraudulent misstatements. The federal requirements apply to grandfathered contracts.)*

[§3105](#)  
[§3204](#)  
[§3216\(d\)\(1\)\(B\)](#)  
[§4306\(e\)](#)

Yes  No  
 If **no**, please explain.

Yes  No  
 If **no**, please explain

Explanation:  
 Model Language Used?  
 Yes  No



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<b>SECTION A – Individual Health Benefit Plans</b>					
Federal Requirement	Federal Statute Section	New York Requirement	New York Citation/s	Grandfathered	Non-Grandfathered
breast cancer screening, mammography and prevention, other than those issued in or around November 2009.)					
Explanation: Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Page Number:					
<b>Extends Dependent Coverage for Children Until age 26</b> – If a policy offers dependent coverage, it must include dependent coverage until age 26. (Coverage is not required for children of dependents.)	<i>§2714 of the PHS/A §1001 of the PPACA</i>  <i>26 CFR §§ 144.101, 146.101, 147.100, and 147.120</i>	<b>Dependent Coverage</b> – Provides for the following dependent coverage. <i>(Note: Pursuant to §2608-a, an HMO or insurer may not deny enrollment to a child under the health coverage of the child’s parent on the ground that the child was born out of wedlock, the child is not claimed as a dependent on the parent’s federal income tax return, or the child does not reside with the parent or in the insurer’s service area. Adopted children, proposed adopted children and stepchildren shall be eligible for coverage on the same basis as natural children.</i>  <b>Extended Dependent Coverage</b> - If family coverage is selected, this contract must make available and if requested by the subscriber, provide coverage for unmarried children through the age of 29 (up to age 30); regardless of financial dependence; who are 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 live, work or reside in New York State or the service area of the insurer. The company must comply with the notice requirements set forth in 4304(d)(1).	<a href="#">§2608-a</a> <a href="#">§3216(a)(4)</a> <a href="#">§4304(d)</a> <a href="#">11 NYCRR 52.17(a)(30)</a> <a href="#">1</a>  <a href="#">§3216(a)(4)(C)</a> <a href="#">§4304(d)(1)(B)</a>  <a href="#">§3216(a)(4)</a>	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.

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Federal Requirement	Federal Statute Section	New York Requirement	New York Citation/s	Grandfathered	Non-Grandfathered
		<p><b>Unmarried Disabled Children</b> - If family coverage is selected, this contract provides coverage for unmarried disabled children, regardless of age, who are 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. Such coverage shall not terminate while the policy remains in effect and the dependent remains in such condition and is chiefly dependent on the subscriber for support and maintenance, if the subscriber has within 31 days of such dependent’s attainment of the limiting age submitted proof of such dependent’s incapacity.</p> <p><i>(Note: The policy must comply with both NY and federal requirements. If family coverage is selected, NY law provides coverage for unmarried dependent children under the age of 19 or under the age of 23 who are full-time students in an accredited educational institution. However, when adding the federal requirements to NY policies these limitations are not permitted and coverage must be provided until age 26 regardless of whether the dependent is (i) a student; (ii) married; or (iii) a natural child, adopted child, proposed adopted child or stepchild. The federal requirements apply to grandfathered contracts.)</i></p>	<a href="#">§4304(d)(1)(A)</a>		
<p>Explanation:                      Model Language Used?                      Yes <input type="checkbox"/> No <input type="checkbox"/></p>					
<p>Page Number:</p>					

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Federal Requirement	Federal Statute Section	New York Requirement	New York Citation/s	Grandfathered	Non-Grandfathered
<p><b>Appeals Process</b> – Requires establishment of an internal claims appeal process and external review process.</p>	<p>§2719 of the PHS/ §1001 of the PPACA 45 CFR §147.136</p>	<p><b>Internal Appeals</b> - The utilization review and grievance process must comply with the Department of Labor Claims Payment Regulation 29 CFR 2560.503-1, 45 CFR 147.136 and with all provisions of the NY Insurance Law and Public Health Law that do not prevent the application of a federal requirement. The policy must include a description of the utilization review and grievance policies and procedures.</p> <p><b>External Appeals</b> – Prior to 7/1/11, the external appeal process must comply with Article 49 of the NY Public Health Law and Insurance Law. For policy years on and after 7/1/11 the external appeal process must also comply with 45 CFR §147.136. The contract must include a notice of the right to an external appeal, together with a description of the external appeal process and the timeframes for such appeals.</p> <p><i>(Note: The federal requirements do not apply to grandfathered contracts.)</i></p>	<p>(For insurance coverage see Ins. Law: <a href="#">§4306-C</a> <a href="#">Article 48</a> <a href="#">Article 49</a>)</p> <p>(For HMO coverage see PHL: <a href="#">Article 49</a> <a href="#">§4408(1)(g)</a> <a href="#">§4408-a</a> <a href="#">10NYCRR9 8-1.14</a>)</p>	N/A	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If <b>no</b>, please explain.</p>
<p>Explanation: Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>					
<p>Page Number:</p>					
<p><b>Emergency Services</b> – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, without imposing any administrative</p>	<p>§2719A of the PHS/ §10101 of the PPACA 45 CFR § 147.138(b)</p>	<p><b>Emergency Services</b> – NY law requires coverage for the treatment of an emergency condition including a definition of emergency services, notice that emergency services are not subject to prior approval, and a description of the financial and other responsibilities of the subscriber regarding obtaining such services including when such services are received outside the plan’s service area.</p>	<p><a href="#">§3216(h)(24)</a> <a href="#">§3217-a(a)(8)</a> <a href="#">§4303(a)(2)</a> <a href="#">§4324(a)(8)</a> <a href="#">§4900(c)</a></p>	N/A	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If <b>no</b>, please explain.</p>

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<b>SECTION A – Individual Health Benefit Plans</b>					
Federal Requirement	Federal Statute Section	New York Requirement	New York Citation/s	Grandfathered	Non-Grandfathered
<p>requirement or limitation that is more restrictive than that required for participating-provider services, and at the in-network cost-sharing level.</p> <p>In addition to the in-network cost-sharing, an enrollee / insured may be required to pay the excess of the amount a non-participating provider charges over the greater of: (i) The amount the plan pays participating providers for such services; (ii) The amount the plan pays non-participating providers for such services, without reduction for out-of-network cost-sharing or; (iii) the amount that would be paid under Medicare.</p> <p><i>Emergency condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to</i></p>		<p>Emergency condition means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy, or (ii) serious impairment to such person’s bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person</p> <p><i>(Note: The contract must comply with both NY and federal requirements. When adding the federal requirements to NY contracts, the contract may not require sudden onset of the emergency condition as currently permitted in NY and in addition to the language above, emergency condition must include a reference to placing the health of a woman or her unborn child in danger. Coverage must also be provided regardless of the participating status of the provider, in a manner that is no more restrictive than that required for participating-provider services, and at the in-network cost-sharing level. Only insureds covered under indemnity (non-HMO) contracts may be required to pay, in addition to the in-network cost-sharing, the excess of the amount a non-participating provider charges over the greater of: (i) The amount the plan pays participating providers for such services; (ii) The amount the plan pays non-participating providers for such services, without reduction for out-of-network cost-sharing or; (iii) the amount that would be paid under Medicare. The federal definition of emergency service should be added to the contract. The federal requirements do not apply to</i></p>	<p><a href="#">Circular Letter No.1 (2002)</a></p> <p><a href="#">10 NYCRR 98-1.13</a></p>		

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<b>Federal Requirement</b>	<b>Federal Statute Section</b>	<b>New York Requirement</b>	<b>New York Citation/s</b>	<b>Grandfathered</b>	<b>Non-Grandfathered</b>
<p><i>result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.</i></p> <p><i>Emergency service means a medical screening examination (as required under §1867 of the Social Security Act) that is within the capability of the emergency department of a hospital; and within the capabilities of the staff and facilities available at the hospital such further examination and treatment as required under §1867 of the Social Security Act to stabilize the patient.</i></p> <p><i>Stabilize means 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</i></p>		<p><i>grandfathered contracts.)</i></p>			

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<i>from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition, to deliver (including the placenta).</i>					
Explanation: Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Page Number:					
<b>Designation of Primary Care Provider (PCP) &amp; Access to Pediatricians</b> – Plans that require or provide for designation of a PCP must permit an enrollee / insured to designate any participating PCP who is available to accept the enrollee / insured. If designation of a PCP for a child is required, the enrollee / insured must be permitted to designate a physician who specializes in pediatrics as the child’s PCP if the provider is in-network and is available to accept the child.	<i>§2719A of the PHSA/ §10101 of the PPACA 45 CFR §147.138(a)</i>	NY law does not include a similar requirement and the federal standard must be utilized.  <i>(Note: The federal requirements do not apply to grandfathered contracts.)</i>	N/A	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No  If <b>no</b> , please explain.
Explanation: Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>					

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<b>SECTION A – Individual Health Benefit Plans</b>					
Federal Requirement	Federal Statute Section	New York Requirement	New York Citation/s	Grandfathered	Non-Grandfathered

Page Number:

<p><b>Access to OB/GYNs</b> – Plans that provide coverage for OB/GYN care and require the designation of a PCP are prohibited from having authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology as long as the professional agrees to otherwise adhere to the plan’s policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing services pursuant to a treatment plan approved by the plan or issuer.</p>	<p><i>§2719A of the PHS/A §10101 of the PPACA</i> <i>45 CFR §147.138(a)</i></p>	<p><b>Access to OB/GYNs</b> – Under NY law if a contract includes coverage for obstetric/gynecologic services, the contract may not limit a female insured’s direct access to primary and preventive obstetric and gynecologic services from a qualified participating provider of such services of her choice to less than 2 examinations annually and to any care related to pregnancy. In addition, an HMO or insurer shall not limit direct access to primary and preventive obstetric and gynecologic services required as a result of such annual examinations or as a result of an acute gynecologic condition, provided that such qualified provider discusses such services and treatment plan with the individual’s primary care practitioner in accordance with the insurer’s requirements.</p> <p><i>(Note: The contract must comply with both NY and federal requirements. When adding the federal requirements to NY contracts, there cannot be a visit limit on direct access to obstetric/gynecologic services otherwise covered under the contract. The federal requirements do not apply to grandfathered contracts.)</i></p>	<p><a href="#">§3217-c</a> <a href="#">§4306-b</a></p>	<p style="text-align: center;">N/A</p>	<p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If <b>no</b>, please explain.</p>
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Explanation:  
Model Language Used?  
Yes  No

Page Number:

## PPACA Compliance Summary – New York Health

<b>SECTION B – Group Health Benefit Plans (Small and Large)</b>					
Federal Requirement	Federal Statute Section	New York Requirement	New York Citation/s	Grandfathered	Non-Grandfathered
<b>Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19</b>	<i>§2704 of the PHS/ §1201 of the PPACA</i>  <i>45 CFR §§144.103, 146.111(a)(1)(i) and 147.108</i>	<p><b>Pre-existing Condition Exclusion</b> - This policy may include a pre-existing condition provision for enrollees / insureds age 19 and above which:</p> <ul style="list-style-type: none"> <li>Defines a pre-existing condition as one which relates to a condition (whether physical or mental), regardless of the cause of the condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the enrollment date.</li> <li>Excludes pre-existing conditions for a period of 12 months from the enrollment date.</li> <li>Credits the time the individual was covered under creditable coverage.</li> <li>Does not treat genetic information as a pre-existing condition in the absence of a diagnosis of the condition related to such information.</li> <li>Does not exclude coverage for pregnancy.</li> <li>Does not exclude coverage in the case of an individual, and any dependent of such individual, who is eligible for a federal tax credit under the federal Trade Adjustment Assistance Reform Act of 2002 and who has 3 months or more of creditable coverage.</li> </ul> <p><i>(Note: For compliance with the federal requirements, the pre-existing condition exclusion may not apply to insureds under age 19. The federal requirements apply to grandfathered contracts.)</i></p>	<a href="#">§3232</a>  <a href="#">§4318</a>  <a href="#">11NYCRR 52.20</a>  42 USC §§300gg et seq.	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
Explanation: Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>					
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<b>SECTION B – Group Health Benefit Plans (Small and Large)</b>					
Federal Requirement	Federal Statute Section	New York Requirement	New York Citation/s	Grandfathered	Non-Grandfathered
<p><b>Eliminate Annual Dollar Limits on Essential Health Benefits</b> -Except allows for “restricted” annual dollar limits for essential health benefits for plan years prior to January 1, 2014.</p> <p>For a policy year beginning on or after 9/23/10 but before 9/23/11 the limit is \$750,000.</p> <p>For a policy year beginning on or after 9/23/11 but before 9/23/12 the limit is \$1,250,000.</p> <p>For a policy year beginning on or after 9/23/12 but before 9/23/14 the limit is \$2,000,000.</p> <p>Essential health benefits are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorders, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive</p>	<p><i>§2711 of the PHS/ §1001 of the PPACA</i></p> <p><i>45 CFR §147.126</i></p>	<p>NY law does not include a similar requirement and the federal standard must be utilized.</p> <p><i>(Note: The federal requirements apply to grandfathered contracts.)</i></p>	<p>N/A</p>	<p><input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b></p> <p>If <b>no</b>, please explain.</p>	<p><input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b></p> <p>If <b>no</b>, please explain.</p>

## PPACA Compliance Summary – New York Health

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<b>Federal Requirement</b>	<b>Federal Statute Section</b>	<b>New York Requirement</b>	<b>New York Citation/s</b>	<b>Grandfathered</b>	<b>Non-Grandfathered</b>
and wellness services and chronic disease management; pediatric services, including oral and vision care.					
Explanation: Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>					
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<b>Eliminate Lifetime Dollar Limits on Essential Health Benefits.</b> Essential health benefits are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorders, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including oral and vision care.	<i>§ 2711 of the PHSA/ §1001 of the PPACA 45 CFR §147.126</i>	NY law does not include a similar requirement and the federal standard must be utilized.  <i>(Note: The federal requirements apply to grandfathered contracts.)</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.
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Federal Requirement	Federal Statute Section	New York Requirement	New York Citation/s	Grandfathered	Non-Grandfathered
<p><b>Prohibit Rescissions –</b> Coverage may only be rescinded for fraud or intentional misrepresentation of material fact. Notification must be made to the policyholder 30 calendar days prior to cancellation.</p>	<p>§2712 of the PHS/ §1001 of PPACA 45 CFR §147.128</p>	<p><b>Rescissions &amp; Enrollee Representations</b> - NY law provides that no misrepresentation by an enrollee/insured shall avoid any contract of insurance or defeat any recovery thereunder unless such misrepresentation was material. A copy of the application for coverage must be attached to the contract in order for statements in the application to be used to void the contract.</p> <p><i>(Note: The federal provision does not define “material” but refers to intentional misrepresentation “as prohibited by the terms of the plan or coverage.” Accordingly, a contract in NY will remain subject to the definition of material as provided in §3105. However, for compliance with the federal requirements, the misrepresentation must be intentional in order for the contract to be rescinded. A copy of the application for coverage must be attached to the contract in order for statements in the application to be used to void the contract. The federal requirements apply to grandfathered contracts.)</i></p>	<p><a href="#">§3105</a> <a href="#">§3204</a> <a href="#">§4306(e)</a></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b>, please explain.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b>, please explain.</p>
<p>Explanation:</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>					
<p>Page Number:</p>					
<p><b>Preventive Services –</b> Requires coverage and prohibits the imposition of cost-sharing for:</p> <ul style="list-style-type: none"> <li>• Evidence-based items or services for children and adults with a rating of A or B by the U.S. Preventive Services Task Force.</li> </ul>	<p>§ 2713 of the PHS/ § 1001 of the PPACA 45 CFR §147.130</p>	<p><b>Preventive Services –</b> NY law requires coverage of the services listed below for children and adults.</p> <p><b>Dependent Children</b> - Coverage for the following primary and preventive health services for a dependent child from the date of birth through the attainment of age 19:</p> <ul style="list-style-type: none"> <li>• An initial hospital check-up and well child visits scheduled in accordance with the American Academy of Pediatrics.</li> </ul>	<p><a href="#">§3221(d)(8)</a> <a href="#">§4303(j)</a> <a href="#">Circular Letter No. 3</a></p>	<p>N/A</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b>, please explain.</p>

## PPACA Compliance Summary – New York Health

<b>SECTION B – Group Health Benefit Plans (Small and Large)</b>					
Federal Requirement	Federal Statute Section	New York Requirement	New York Citation/s	Grandfathered	Non-Grandfathered
<ul style="list-style-type: none"> <li>• Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.</li> <li>• Preventive care and screenings for infants, children and adolescents in guidelines supported by the Health Resources and Services Administration.</li> <li>• Preventive care and screenings for women in guidelines supported by the Health Resources and Services Administration.</li> </ul> <p>(The current recommendations of the U.S. Preventive Services Task Force shall be considered the most current regarding breast cancer screening, mammography and prevention, other than those issued in or around November 2009.)</p>		<ul style="list-style-type: none"> <li>• At each visit, services in accordance with the American Academy of Pediatrics, including a medical history, complete physical examination, developmental assessment, anticipatory guidance, laboratory tests and necessary immunizations in accordance with the Advisory Committee on Immunization Practices.</li> </ul> <p>Such coverage shall not be subject to annual deductibles and/or coinsurance.</p> <p><b>Mammography Screening</b> - Coverage for the following mammography screening for occult breast cancer:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• A single, baseline mammogram for covered persons aged 35-39, inclusive.</li> <li>• An annual mammogram for covered persons aged 40 and older.</li> <li>• Mammography screening means an X-ray examination of the breast using dedicated equipment.</li> </ul> <p><b>Cervical Cytology Screening</b> - Coverage for an annual cervical cytology screening for cervical cancer and its precursor states for women aged eighteen and older. Cervical cytology screening includes 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.</p> <p><b>Bone Mineral Density Measurements or Tests, Drugs and Devices</b> -Coverage for bone mineral density measurements or tests, and if the policy otherwise includes coverage for</p>	<p><a href="#">(1994)</a></p> <p><a href="#">Circular Letter No. 13 (2006)</a></p> <p><a href="#">§3221(l)(11)</a></p> <p><a href="#">§4303(p)(1)</a></p> <p><a href="#">§3221(l)(14)</a></p> <p><a href="#">§4303(t)(1)</a></p> <p><a href="#">§3221(k)(13)</a></p> <p><a href="#">4303(bb)</a></p>		

## PPACA Compliance Summary – New York Health

<b>SECTION B – Group Health Benefit Plans (Small and Large)</b>					
Federal Requirement	Federal Statute Section	New York Requirement	New York Citation/s	Grandfathered	Non-Grandfathered
		<p>prescription drugs, drugs and devices approved by the FDA or generic equivalents as approved substitutes. Bone mineral density measurements or tests, drugs or devices shall include those covered and for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. Individuals qualifying for coverage, at a minimum, include individuals:</p> <ul style="list-style-type: none"> <li>• Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or</li> <li>• With symptoms or conditions indicative of the presence or significant risk of osteoporosis; or</li> <li>• On a prescribed drug regimen posing a significant risk of osteoporosis; or</li> <li>• With lifestyle factors to a degree as posing a significant risk of osteoporosis; or,</li> <li>• With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.</li> </ul> <p><b>Prostate Cancer Screening</b> - Coverage for the diagnostic screening for prostate cancer including:</p> <ul style="list-style-type: none"> <li>• Standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer; and</li> <li>• An annual standard diagnostic examination for men age 50 and over who are asymptomatic and for men age 40 or older with a family history of prostate cancer or other prostate cancer risk factors.</li> </ul> <p><i>(Note: The policy must comply with both NY and federal requirements. When adding the federal requirements to NY contracts additional preventive services must now be covered for adults and children consistent with the federal standards. In</i></p>	<p><a href="#">§3221(l)(14)</a> <a href="#">§4303(z-1)</a></p>		

## PPACA Compliance Summary – New York Health

<b>SECTION B – Group Health Benefit Plans (Small and Large)</b>					
Federal Requirement	Federal Statute Section	New York Requirement	New York Citation/s	Grandfathered	Non-Grandfathered
		<i>addition, in-network preventive services for adults may not be subject to a copayment, coinsurance or deductible. The federal requirements do not apply to grandfathered contracts.)</i>			
Explanation: Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Page Number:					
<b>Extends Dependent Coverage for Children Until age 26</b> – If a policy offers dependent coverage, it must include dependent coverage until age 26. (Coverage is not required for children of dependents.)	§2714 of the PHS/ §1001 of the PPACA  26 CFR §§ 144.101, 146.101, 147.100, and 147.120	<b>Dependent Coverage</b> - If dependent coverage is selected by the policyholder, this policy provides coverage of dependents, and states the age restrictions for the insurance provided. <i>Note: Pursuant to §2608-a, an insurer may not deny enrollment to a child under the health coverage of the child’s parent on the ground that the child was born out of wedlock, the child is not claimed as a dependent on the parent’s federal income tax return, or the child does not reside with the parent or in the insurer’s service area. Adopted children, proposed adopted children and stepchildren shall be eligible for coverage on the same basis as natural children.</i>  <b>Unmarried Disabled Children</b> - If dependent coverage is selected by the policyholder, and dependent coverage terminates at a specified age, this policy provides coverage for unmarried disabled children, regardless of age, who are 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. <i>Note: Such coverage shall not terminate while the policy remains in effect and the dependent remains in such condition and is chiefly dependent on the insured for support and maintenance, if the insured has</i>	<a href="#">§3221(a)(7)</a> <a href="#">§4305(c)(1)</a> <a href="#">§2608-a</a> <a href="#">11 NYCRR 52.18(e)</a>  <a href="#">§4235(f)(1)(A)</a>	<input type="checkbox"/> Yes <sup>◇</sup> <input type="checkbox"/> No If <b>no</b> , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b> , please explain.

## PPACA Compliance Summary – New York Health

<b>SECTION B – Group Health Benefit Plans (Small and Large)</b>					
Federal Requirement	Federal Statute Section	New York Requirement	New York Citation/s	Grandfathered	Non-Grandfathered
		<p><i>within 31 days of such dependent's attainment of the limiting age submitted proof of such dependent's incapacity.</i></p> <p><b>Young adult option-</b> This policy must provide notice of a young adult's right, through the age of 29 (up to age 30), to independently purchase coverage through a parent group member's policy, regardless of whether the parent's coverage includes coverage for dependents, as described in 3221(r) &amp; 4305(l). If a young adult or the young adult's parent elects this coverage, the young adult is issued a separate individual policy. The company must comply with the notice requirements to each employee or member as set forth in 3221(r) &amp; 4305(l).</p> <p><b>Extended Dependent Coverage</b> - If dependent coverage is selected by the policyholder, this policy must make available and if requested by the policyholder, provide coverage for unmarried children through the age of 29 (up to age 30); regardless of financial dependence; who are 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 live, work or reside in New York State or the service area of the insurer. The company must comply with the notice requirements set forth in 4235(f).  <i>(Note: The policy must comply with both NY and federal requirements. When adding the federal requirements to NY policies, coverage must be provided until age 26 regardless of whether the dependent: (i) is "chiefly dependent" on the policyholder; (ii) is a student; (iii) is married; or is a natural child, adopted child, proposed adopted child or stepchild. The federal requirements apply to grandfathered contracts.)</i></p>	<p><a href="#">§3221(r)</a> <a href="#">4305(l)</a></p> <p><a href="#">§4235(f)(1)(B)</a></p>		
Explanation: Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>					

## PPACA Compliance Summary – New York Health

<b>SECTION B – Group Health Benefit Plans (Small and Large)</b>					
Federal Requirement	Federal Statute Section	New York Requirement	New York Citation/s	Grandfathered	Non-Grandfathered
Page Number:					
<p><b>Appeals Process</b> – Requires establishment of an internal claims appeal process and external review process.</p>	<p><i>§ 2719 of the PHS/ § 1001 of the PPACA</i> <i>45 CFR §147.136</i></p>	<p><b>Internal Appeals</b> - The utilization review and grievance process must comply with the Department of Labor Claims Payment Regulation 29 CFR 2560.503-1, 45 CFR 147.136 , and with all provisions of the NY Insurance Law and Public Health Law that do not prevent the application of a federal requirement. The policy must include a description of the utilization review and grievance policies and procedures.</p> <p><b>External Appeals</b> - Prior to 7/1/11, the external appeal process must comply with Article 49 of the NY Public Health Law and Insurance Law. For plan years on and after 7/1/11 the external appeal process must also comply with 45 CFR §147.136. The contract must include a notice of the right to an external appeal, together with a description of the external appeal process and the timeframes for such appeals.</p> <p><i>(Note: The federal requirements do not apply to grandfathered contracts.)</i></p>	<p>(For insurance coverage see Ins. Law: <a href="#">§4306-C Article 48</a> <a href="#">Article 49</a> )</p> <p>(For HMO coverage see PHL: <a href="#">Article 49 §4408(1)(g) §4408-a 10NYCRR98-1.14</a>))</p> <p>(For HMO and insurance coverage see: 29 CFR 2560.503-1)</p>	N/A	<p><input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b></p> <p>If <b>no</b>, please explain.</p>
<p>Explanation: Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>					
Page Number:					
<p><b>Emergency Services</b>-Requires plans that cover emergency services to provide such</p>	<p><i>§2719A of the PHS/ §10101</i></p>	<p><b>Emergency Services</b> - Requires coverage for the treatment of an emergency condition including a definition of emergency services, notice that emergency services are not subject to prior</p>	<p><a href="#">§3221(k)(4)</a> <a href="#">§3217-</a></p>	N/A	<p><input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b></p> <p>If <b>no</b>, please</p>

## PPACA Compliance Summary – New York Health

<b>SECTION B – Group Health Benefit Plans (Small and Large)</b>					
Federal Requirement	Federal Statute Section	New York Requirement	New York Citation/s	Grandfathered	Non-Grandfathered
<p>coverage without the need for prior authorization, regardless of the participating status of the provider, without imposing any administrative requirement or limitation that is more restrictive than that required for participating-provider services, and at the in-network cost-sharing level.</p> <p>In addition to the in-network cost-sharing, an enrollee / insured may be required to pay the excess of the amount a non-participating provider charges over the greater of: (i) The amount the plan pays participating providers for such services; (ii) The amount the plan pays non-participating providers for such services, without reduction for out-of-network cost-sharing or; (iii) the amount that would be paid under Medicare.</p> <p><i>Emergency condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who</i></p>	<p><i>of the PPACA</i></p> <p>45 CFR § 147.138(b)</p>	<p>approval, and a description of the financial and other responsibilities of the insured regarding obtaining such services including when such services are received outside the insurer’s service area.</p> <p><i>Emergency condition means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy, or (ii) serious impairment to such person’s bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.</i></p> <p><i>(Note: The policy must comply with both NY and federal requirements. When adding the federal requirements to NY policies, the policy may not require sudden onset of the emergency condition as currently permitted in NY and in addition to the language above, emergency condition must include a reference to placing the health of a woman or her unborn child in danger. Coverage must also be provided regardless of the participating status of the provider, in a manner that is no more restrictive than that required for participating-provider services, and at the in-network cost-sharing level. Only insureds covered under indemnity (non-HMO) contracts may be required to pay, in addition to the in-network cost-sharing, the excess of the amount a non-participating provider charges over the greater of: (i) The amount the plan pays participating providers for such services;</i></p>	<p><a href="#">a(a)(8)</a></p> <p><a href="#">§4303(a)(2)</a></p> <p><a href="#">§4324(a)(8)</a></p> <p><a href="#">§4900(c)</a></p> <p><a href="#">Circular Letter No.1 (2002)</a></p>		<p>explain.</p>

## PPACA Compliance Summary – New York Health

<b>SECTION B – Group Health Benefit Plans (Small and Large)</b>					
<b>Federal Requirement</b>	<b>Federal Statute Section</b>	<b>New York Requirement</b>	<b>New York Citation/s</b>	<b>Grandfathered</b>	<b>Non-Grandfathered</b>
<p><i>possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.</i></p> <p><i>Emergency service means a medical screening examination (as required under §1867 of the Social Security Act) that is within the capability of the emergency department of a hospital; and within the capabilities of the staff and facilities available at the hospital such further examination and treatment as required under §1867 of the Social Security Act to stabilize the patient.</i></p> <p><i>Stabilize means to provide such medical treatment of the</i></p>		<p><i>(ii) The amount the plan pays non-participating providers for such services, without reduction for out-of-network cost-sharing or; (iii) the amount that would be paid under Medicare. The federal definition of emergency service should be added to the contract. The federal requirements do not apply to grandfathered contracts.)</i></p>			

## PPACA Compliance Summary – New York Health

<b>SECTION B – Group Health Benefit Plans (Small and Large)</b>					
<b>Federal Requirement</b>	<b>Federal Statute Section</b>	<b>New York Requirement</b>	<b>New York Citation/s</b>	<b>Grandfathered</b>	<b>Non-Grandfathered</b>
<p><i>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 individual from a facility, or, with respect to an emergency medical condition, to deliver (including the placenta).</i></p>					
<p>Explanation: Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>					
<p>Page Number:</p>					
<p><b>Designation of Primary Care Provider (PCP) &amp; Access to Pediatricians</b> – Plans that require or provide for designation of a PCP must permit an enrollee / insured to designate any participating PCP who is available to accept the enrollee / insured.</p> <p>If designation of a PCP for a child is required, the enrollee / insured must be permitted to designate a physician who specializes in pediatrics as the child’s PCP if the provider is in-network and is available to</p>	<p>§2719A of the PHSA/ §10101 of the PPACA 45 CFR §147.138(a)</p>	<p>NY law does not include a similar requirement and the federal standard must be utilized.  <i>(Note: The federal requirements do not apply to grandfathered contracts.)</i></p>	<p>N/A</p>	<p>N/A</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No  If no, please explain.</p>

## PPACA Compliance Summary – New York Health

<b>SECTION B – Group Health Benefit Plans (Small and Large)</b>					
Federal Requirement	Federal Statute Section	New York Requirement	New York Citation/s	Grandfathered	Non-Grandfathered
accept the child.					
Explanation: Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Page Number:					
<p><b>Access to OB/GYNs</b> –Plans that provide coverage for OB/GYN care and require the designation of a PCP are prohibited from having authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology as long as the professional agrees to otherwise adhere to the plan’s policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing services pursuant to a treatment plan approved by the plan or issuer.</p>	<p>§ 2719A of the PHS/ § 10101 of the PPACA  45 CFR §147.138(a)</p>	<p><b>Access to OB/GYNs</b> – Under NY law, if a policy includes coverage for obstetric/gynecologic services, the policy may not limit a female insured’s direct access to primary and preventive obstetric and gynecologic services from a qualified participating provider of such services of her choice to less than 2 examinations annually and to any care related to pregnancy. In addition, an insurer shall not limit direct access to primary and preventive obstetric and gynecologic services required as a result of such annual examinations or as a result of an acute gynecologic condition, provided that such qualified provider discusses such services and treatment plan with the individual’s primary care practitioner in accordance with the insurer’s requirements. <i>(Note: The policy must comply with both NY and federal requirements. When adding the federal requirements to NY policies, there cannot be a visit limit on direct access to obstetric/gynecologic services otherwise covered under the policy. The federal requirements do not apply to grandfathered contracts.)</i></p>	<p><a href="#">§3217-c</a> <a href="#">§4306-b</a></p>	<p>N/A</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No If <b>no</b>, please explain.</p>
Explanation: Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Page Number:					

## PPACA Compliance Summary – New York Health

<b>SECTION C – RATE FILING REQUIREMENTS</b>				
<b>Category</b>	<b>New York Citation/s</b>	<b>New York Requirement</b>	<b>Grandfathered</b>	<b>Non-Grandfathered</b>
<b>Actuarial Qualifications</b>		<ul style="list-style-type: none"> <li>a. Member of the Society of Actuaries or the American Academy of Actuaries; and</li> <li>b. Meets the “Qualification Standards of Actuarial Opinion” as adopted by the American Academy of Actuaries.</li> </ul>		
<b>Actuarial Certification</b>	11NYCRR52.40(a)(1)	Provide an actuarial certification that: <ul style="list-style-type: none"> <li>a. The filing is in compliance with all applicable laws and regulations.</li> <li>b. The filing is in compliance with Actuarial Standard of Practice No. 8 “Regulatory Filings for Rates and Financial Projections for Health Plans” as adopted by the Actuarial Standards Board.</li> <li>c. The expected loss ratio meets the minimum requirements of the State of New York.</li> <li>d. The benefits are reasonable in relation to the premiums charged.</li> <li>e. The rates are not unfairly discriminatory.</li> </ul>		
<b>Actuarial Memorandum and Justification of Rates</b>	11NYCRR52.40(a)(1) 11NYCRR52.40(c) 11NYCRR52.40(d) 11NYCRR52.40(e) 11NYCRR360.11	<ul style="list-style-type: none"> <li>a. For each benefit, provide a detailed description of the existing benefit and the new benefit.</li> <li>b. For each benefit, provide a detailed explanation and justification of the derivation of rates, including the methods, assumptions, and underlying experience data used.</li> <li>c. Provide a summary of each rating factor and the total of all rating factors.</li> <li>d. Provide a list of all base policy forms or products to which the form/rider will apply. Specify if the form/rider applies to grandfathered plans only or non-grandfathered plans only, or to both.</li> <li>e. Provide the breakdown of the non-claims expense component into administrative expenses, commissions, contribution to statutory reserve and surplus, etc.</li> <li>f. Expected loss ratio (percentage): <span style="background-color: gray; color: gray;">          </span></li> </ul>		
<b>Rate Manual</b>	11NYCRR52.40(c)(2) 11NYCRR52.40(e)(2)	<ul style="list-style-type: none"> <li>a. Table of contents</li> <li>b. Consecutively numbered rate manual pages</li> <li>c. Insurer name on each page</li> <li>d. Description of each benefit changing under PPACA</li> <li>e. List of all base policy forms or products to which the form/rider will apply</li> </ul>		

## PPACA Compliance Summary – New York Health

<b>SECTION C – RATE FILING REQUIREMENTS</b>				
<b>Category</b>	<b>New York Citation/s</b>	<b>New York Requirement</b>	<b>Grandfathered</b>	<b>Non-Grandfathered</b>
<b>Loss Ratios</b>	11NYCRR52.45	Expected loss ratio/s (percentage): <span style="background-color: #cccccc; display: inline-block; width: 50px; height: 15px; vertical-align: middle;"></span>		