

Name of Plan Sponsor or Government Agency	Name of Plan/Policy (Use new row for each plan/policy application)	Applicant (Plan/Policy Situs) City	Applicant (Plan/ Policy Situs) State	Plan/ Policy Effective Date (mm/dd/yyyy)	Name of Person Providing Certification	Title of Individual Providing Certification

Contact information for the individual providing certification						
Street Address	City	State	Zip Code	Phone Number (including area code) (xxx-xxx-xxx)	Total Number of Individuals Covered by Plan/Policy (include all dependents covered)	Eligibility criteria (describe briefly)

Health Insurance Market Reforms (list the document that demonstrates that the coverage complies with each provision of Title I of the Affordable Care Act listed below)

<p>Fair Health Insurance Premiums (2701)</p>	<p>Guaranteed availability of coverage (2702)</p>	<p>Guaranteed renewability of coverage (2703)</p>	<p>Prohibition of preexisting condition exclusions or other discrimination based on health status (2704)</p>	<p>Prohibiting discrimination against individual participants and beneficiaries based on health status (2705)</p>	<p>Non-discrimination in health care (2706)</p>	<p>Coverage for individuals participating in approved clinical trials (2709)</p>
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Does the coverage provided the essential health benefits listed below? (yes/no)

Ambulatory	Emergency	Hospitalization	Laboratory	Pediatric	Maternity/ Newborn	Mental Health/ Substance Abuse	Rehabilitative/ Devices	Preventive/ Wellness	Prescription
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		Office Visit Copays/Coinsurance		Hospital Inpatient Copay/Coinsurance	
Plan Deductible	Out-of- pocket maximum limit	Copay (if applicable)	Coinsurance (if applicable)	Copay (if applicable)	Coinsurance (if applicable)

Emergency Room Copay/Coinsurance		Rx Copay/Coninsurance	
Copay (if applicable)	Coinsurance (if applicable)	Copay (if applicable)	Coinsurance (if applicable)