OMB Control No. 0938-1189
Expiration Date: 08/31/2019

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**

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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)

Early Market Reforms (list the document that demonstrates that the coverage complies with each provision of Title I of the Affordable Care Act listed below)								
Lifetime limits (2711)	Prohibition on recissions (2712)	Coverage of preventive health services (2713)	Extenstion of dependent coverage (2714)	Development and utilization of coverage documents and standardized definitions (2715)	Ensuring the quality of care (2717)	Bringing down the cost of health care coverage (2718)	Appeals process (2719)	Patient protections (2719A)

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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)						
Fair Health Insurance Premiums (2701)	**Guaranteed availablility of coverage (2702)**	**Guaranteed renewability of coverage (2703)**	**Prohibition of preexisting condition exclusions or other discrimination based on health status (2704)**	**Prohibiting discrimination against indvidual participants and beneficiaries based on health status (2705)**	**Non-discrimination in health care (2706)**	**Coverage for individuals participaing in approved clinical trials (2709)**

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)**

PRA Disclosure Statement:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1189. The time required to complete this information collection is estimated to average 5.25 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.