

**NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES**  
**Review Standards for**  
**Basic Medical Insurance for**  
**Group Commercial Insurers Subject to Article 32**  
**As of 10/29/12**

**Instructions for SERFF Checklist:**

- A. For **ALL** filings, the “General Requirements for All Filings” section must be completed:
- B. For a **FORM** filing, completion of additional sections may be required as follows, depending on the type of form being submitted:
- Policy – Also complete all sections except the section entitled “Application Forms.”
  - Application – Also complete the section entitled “Application Forms.”
  - Rider or endorsement – Also complete all items relevant to the form being submitted in all sections.
- C. For filing of initial rates, complete the section entitled “Actuarial Section For Initial Rate Filings Only” in addition to completion of the applicable form sections identified above.
- D. For each item, enter in the last column the form number(s), page number(s) and paragraph(s) where the requirement is met in the filing or insert a bookmark connecting to the appropriate location in the filing.
- E. Do not make any changes or revisions to this checklist.
- F. **Updates to Checklist:** Any items on the checklist that have been updated since the last posting are shaded.
- G. **Instructions for Citations:** All citations to Insurance regulations link to the Department of State’s website and an unofficial copy of the NYCRR. Please select title 11 for Insurance regulations. Most of the pertinent form and rate regulations are located in Chapter III Policy and Certificate Provisions, Subchapter A Life, Accident and Health Insurance. All citations to New York Laws (Insurance Laws or other New York laws) link to the public LRS website. To locate the Insurance Laws, please select the link labeled “ISC”.

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LINE OF BUSINESS: **Basic Medical Insurance**

LINE(S) OF INSURANCE

CODES

CODE: **H15G**

**Health – Hospital/Surgical/Medical Expense**

**H15G.001  
H15G.002  
H15G.003**

IF CHECKLIST IS NOT APPLICABLE, OR IF THE SUBMISSION CONTAINS INSERT PAGES, RIDERS OR ENDORSEMENTS AND THE POLICY IN ITS ENTIRETY DOES NOT COMPLY WITH ALL STATUTORY AND REGULATORY PROVISIONS STATED BELOW, PLEASE EXPLAIN:

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REVIEW REQUIREMENT	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD IN FILING
<b>GENERAL REQUIREMENTS FOR ALL FILINGS</b>	<i>Note: Unless otherwise noted, all references are to Insurance Law, Insurance Regulations, and Department Circular Letters and OGC opinions</i>	<i>Note: This is a checklist for basic medical insurance as defined by 11 NYCRR 52.6. This checklist is intended to provide guidance in the preparation of policy forms for submission and is not intended as a substitute for statute or regulation.</i>	Form/Page/Para Reference
Complete Policy Submission or Pages/Rider/Endorsement		<p>This submission contains a complete policy form. Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If this submission contains insert pages, riders or endorsements, then the policy in its entirety complies with all the statutory and regulatory provisions stated below. Yes <input type="checkbox"/> No <input type="checkbox"/>  (If no is checked, explain in the space provided above.)</p> <p>This rider, insert pages, or endorsements are being attached to a policy that was approved by the Department on _____, submission number _____.</p>	
Form Requirements	<a href="#">11NYCRR52.31(b), (c), (d), (e), (f), (l)</a>	<p>Each form in the filing must meet the following requirements:</p> <ul style="list-style-type: none"> <li>• This form contains no strikeouts. § 52.31(b)</li> <li>• This form is submitted in duplicate. § 52.31(c)</li> <li>• This form is designated by a form number made up of numerical digits and/or letters in the lower left-hand corner of the first page. § 52.31(d)</li> <li>• This form is submitted in the form intended for actual use. § 52.31(e)</li> <li>• All blank spaces are filled in with hypothetical data. § 52.31(f)</li> <li>• If the form contains illustrative material, it does so only for items that may vary from case to case, such as names, dates, eligibility requirements, premiums and schedules for determining</li> </ul>	

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		<p>the amount of insurance for each person. § 52.31(l)</p> <ul style="list-style-type: none"> <li>• Portions of other provisions, such as insuring clauses, benefit provisions, restrictions and termination of coverage provisions, may be submitted as variable, if suitably indicated by red ink, bracketing or underlining and an explanatory memorandum must be submitted that clearly indicates the nature and scope of the variations to be used. An explanatory memorandum may not use terms such as “will conform to law” or “as requested by policyholder” to describe the variable material. § 52.31(l)</li> </ul>	
Flesch Score	<a href="#">§ 3102(c)</a>	Provide Flesch score certification (the Flesch score should be at least 45). The number of words, sentences and syllables in the form should be set forth as part of the certification, which must be signed by an officer of the company.	
Letter of Submission	<a href="#">11 NYCRR 52.33</a>  <a href="#">Circular Letter No. 33 (1999)</a>  <a href="#">Supplement 1 to CL No. 33 (1999)</a>	<p>The filing must include a letter of submission in duplicate, signed by a representative of the company authorized to submit forms for filing or approval, that contains the following:</p> <ul style="list-style-type: none"> <li>• The identifying form number of each form submitted. §52.33(a)</li> <li>• If the form is a policy, the letter must indicate that the policy is submitted pursuant to 11 NYCRR 52.7. §52.33(b)</li> <li>• Whether the form is new or supersedes an approved or filed form. § 52.33(c)</li> <li>• If the form supersedes an approved or filed form, the letter must state the form number and date of approval or filing of the superseded form and any material differences from the superseded form. § 52.33(d)</li> <li>• If the approval of the superseded form is still pending, the letter must include the form number, control number assigned by the Department and the submission date. § 52.33(d)</li> <li>• If the form had previously been submitted for preliminary review, the letter must include a reference to the previous submission and a statement setting out either that the form agrees precisely with the previous submission; or the differences from the form submitted for preliminary review. § 52.33(e)</li> <li>• If the form is submitted in accordance with 11 NYCRR 52.32(c), the letter must identify the prefiled group coverage. § 52.33(f)</li> <li>• If the form is other than a policy form, the letter must identify the form number and approval date of the policy or policies with which it will be used. If the form is for general use, the Department may accept a description of the type of policy with which it may be used in lieu of the form number and approval date. §52.33(g)</li> <li>• If the form is a policy, the letter must identify the form numbers and dates of approval of any applications previously approved to be used with the policy unless the application is required to be attached to the policy upon submission. §52.33(h)</li> <li>• If the policy is designed to be used with insert pages, the letter must contain a statement of the insert page forms which must always be included in the policy and a list of all optional pages, together with an explanation of their use. § 52.33(i)</li> </ul> <p><i>Note: Submission letters should advise as to whether the policy is intended for internet sales and should describe any proposed electronic procedures and/or the proposed use of electronic signatures associated with the sale of the policy.</i></p>	
Group Status and Recognition	<a href="#">§ 4235</a> <a href="#">§ 3201(b)(1)</a> <a href="#">11 NYCRR 59</a>	The submission letter should include a statement that policy forms will be sold to a group specified in Insurance Law §4235(c)(1). However, a more detailed statement must be included where discretionary group status is sought under Insurance Law §4235(c)(1)(M). See below. The size of the group should be indicated (small, large or both). The letter should indicate whether the	

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		<p>submission is for general use or is submitted on a one case basis. If the submission is for use on a one case basis, the group must be identified along with the subpart of Insurance Law §4235(c)(1) in which the group fits and a confirmation that the group meets all of the requirements of the identified subpart.</p> <p>Requests for discretionary group recognition, pursuant to Insurance Law §4235(c)(1)(M), must be accompanied by written documentation that demonstrates that the proposed group meets each and every element stated in the named statute. The documentation must also make clear that the request for discretionary group recognition is not a subterfuge, evasion technique, or a marketing tool to avoid compliance with other statutory or regulatory requirements and recognized marketing mechanisms. This provision is not intended to allow approval of groups recognized in the various subparagraphs of §4235(c)(1) or §4237(a)(3), but for which the proposed discretionary group does not meet one or more of the requisites specifically required or proscribed by §4235 or §4237. The request for allowance of a discretionary group must be granted before it may be used.</p> <p>Pursuant to §3201(b)(1) and Insurance Regulation 123, an accident and health certificate is deemed delivered in New York and subject to review and approval regardless of the actual place of delivery, if the policy is issued to certain groups. In these cases, the group certificate is reviewed for compliance with New York Law. The group policy that is delivered out-of-state is not reviewed.</p>	
Prefiled Group Coverage	<a href="#">11 NYCRR 52.32</a>	<p>A copy of the letter of confirmation sent to the policyholder by the insurer must be submitted to the Department within 30 days after the date the insurer agrees to provide insurance and must include the following:</p> <ul style="list-style-type: none"> <li>• The effective date of coverage. § 52.32(a)(1)</li> <li>• The nature and extent of the benefits or change in benefits as then known. § 52.32(a)(2)</li> <li>• That the contractual forms may be executed and issued for delivery only after filing with or approval by the Department. §52.32(a)(3)</li> <li>• That if the forms are not filed or approved or are disapproved, the parties will be returned to the status quo insofar as possible, or the coverage will be modified retroactively to meet all requirements necessary for approval. §52.32(a)(4)</li> </ul> <p><i>Note: At the time the insurer agrees to provide insurance, it cannot have been reasonably possible to obtain approval prior to the effective date of coverage because the policyholder requested the insurer provide immediate coverage. Also, the actual forms must be submitted for approval within six months from the date the insurer agrees to provide insurance. § 52.32(c). Failure to meet any of the conditions within the time specified shall be a violation of the Insurance Law, unless reasons for delay, including its probable extent, satisfactory to the Department are submitted to the Department within the respective times specified.</i></p>	
Table of Contents	<a href="#">§ 3102(c)(1)(G)</a>	A table of contents is required for policies that are over 3,000 words or more than 3 pages regardless of the number of words.	
Discrimination	<a href="#">§ 2606</a> , <a href="#">§ 2607</a> , & <a href="#">§ 2608</a>	This form does not contain any unfair discrimination provisions because of race, color, creed, national origin, disability (including treatment of mental disability), sex, and marital status.	
<b>APPLICATION FORMS</b>			Form/Page/Para Reference
Authorization	<a href="#">11NYCRR420.18(b)</a>	If the application includes an authorization to disclose non-public personal health information, the authorization specifies the length of time the authorization will remain valid. The maximum	

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		allowable period is 24 months.	
Fraud Warning Statement	<a href="#">§ 403(d)</a>	The application contains the prescribed fraud warning statement.	
Pre-Existing Conditions	<a href="#">11NYCRR52.51(j)</a>	If the application is used with a policy that contains a “pre-existing conditions” provision, the application must include a statement describing the provision.	
Prohibited Questions and Provisions	<a href="#">§ 3221(q)(1)</a> <a href="#">§ 3204</a> <a href="#">11NYCRR52.51</a>	The application does NOT contain: Questions as to the applicant’s health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of domestic violence), disability or the applicant’s race. A provision that changes the terms of the policy to which it is attached. A statement that the applicant has not withheld any information or concealed any facts. An agreement that an untrue or false answer material to the risk will render the policy void. An agreement that acceptance of any policy issued upon the application will constitute a ratification of any changes or amendments made by the insurer and inserted in the application, except to conform to §3204(d).	
<b>POLICY FORM PROVISIONS</b>			Form/Page/Para Reference
<b>COVER PAGE</b>			
Insurer name		This policy contains the name and full address of the issuing insurer on the front or back cover.	
Signature of Company Officer		The signature of company officer(s) appears prominently on the policy (such as on the cover).	
<b>DEFINITIONS</b>		<i>If definitions are included in the policy the definitions must comply with the following.</i>	
Continuous Hospital Confinement	<a href="#">11NYCRR52.2(f)</a>	The definition of “continuous hospital confinement” complies with §52.2(f).	
Creditable Coverage	<a href="#">§3232(c)</a> <a href="#">11NYCRR52.20</a>	The definition of “creditable coverage” complies with §3232(c) and §52.20.	
Emergency Condition	<a href="#">§3221(k)(4)(B)</a> <a href="#">§4900(c)</a>	The definition of “emergency condition” complies with §3221(k)(4)(B) and 4900(c).	
Enrollment Date	<a href="#">§3232(b)</a> <a href="#">11NYCRR52.20</a>	The definition of “enrollment date” complies with §3232(b) and §52.20.	
Hospital	<a href="#">11NYCRR52.2(m)</a>	The definition of “Hospital” complies with §52.2(m).	
<b>ELIGIBILITY</b>			
Spouse  Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	<a href="#">§ 4235(f)(1)(A)</a> <a href="#">Circular Letter No. 27 (2008)</a>  <a href="#">Model Language</a>	If dependent coverage is selected by the policyholder, this policy provides coverage for the lawful spouse, unless there is a divorce or annulment of the marriage. This includes the recognition of marriages between same-sex partners legally performed in this state and in other jurisdictions.	
Dependents	<a href="#">§ 4235(f)(1)(A)(i)</a> <a href="#">§ 3221(a)(7)</a>  42 USC § 300gg-14 26 CFR §§ 144.101, 146.101, 147.100 and 147.120 <a href="#">Model Language</a>	If dependent coverage is selected by the policyholder, this policy provides coverage of children until age 26.  <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.</i>	

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	<a href="#">(PPACA Rider)</a>		
Extended Dependent Coverage  Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	<a href="#">§ 4235(f)(1)(B)</a>  <a href="#">Model Language</a>	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).	
Unmarried Students on Medical Leave of Absence	<a href="#">§ 3237</a>  42 USC § 300gg-28	If this policy provides coverage for dependent children who are full-time students to a higher age than other dependent children, then coverage shall continue when such dependent takes a medical leave of absence from school due to illness or injury for a period of 12 months from the last day of attendance at school, provided, however, that coverage of a dependent student is not required beyond the age at which coverage would otherwise terminate. To qualify for such coverage, the insurer may require that the medical necessity of the leave be certified to by the student's attending physician who is licensed to practice in the state of New York.	
Unmarried Disabled Children  Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	<a href="#">§ 4235(f)(1)(A)(ii)</a>  <a href="#">Model Language</a>	If dependent coverage is selected by the policyholder, 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 within 31 days of such dependent's attainment of the limiting age submitted proof of such dependent's incapacity.</i>	
Newborn Infants	<a href="#">§ 4235(f)(2)</a>	If dependent coverage is selected by the policyholder, this policy provides coverage of newborn infants, including newly born infants adopted by the insured if the insured takes physical custody of the infant upon the infant's release from the hospital and files a petition pursuant to §115-c of the domestic relations law within 30 days of birth; and provided further that no notice of revocation to the adoption has been filed and consent to the adoption has not been revoked, shall be effective from the moment of birth, except that in cases of adoption, coverage of the initial hospital stay shall not be required where a birth parent has insurance coverage available for the infant's care.  <i>Note: In the case of individual or two-person coverage, the insurer must permit the insured to elect such coverage of newborn infants from the moment of birth. If notification and/or payment of an additional premium is required to make coverage effective for a newborn infant, the coverage may provide that such notice and/or payment be made within no less than 30 days of the day of birth to make coverage effective from the moment of birth.</i>	
Adopted Children and Step-Children	<a href="#">11NYCRR52.18(e)(2); (3)</a>	If dependent coverage is selected by the policyholder, this policy provides that adopted children and stepchildren dependent upon the insured are eligible for coverage on the same basis as natural children. Further, a family policy covering a proposed adoptive parent, on whom the child is dependent, shall provide that such child be eligible for coverage on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption.	
Domestic Partners	<a href="#">§ 4235(f)(1)(A)</a>	This policy may cover domestic partners, who are financially interdependent on the employee or member, but such coverage is not required.	

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<p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p><a href="#">OGC Opinion 01-11-23</a> <a href="#">Model Language</a></p>	<p>If such coverage is provided, the policy shall require the applicant to provide the following:</p> <ul style="list-style-type: none"> <li>• Registration as a domestic partner or an affidavit of domestic partnership</li> <li>• Proof of cohabitation</li> <li>• Proof of financial interdependency by evidence of two or more of the following: joint bank account; joint credit or charge card; joint obligation on a loan; status as authorized signatory on the partner's bank account, credit card or charge card; joint ownership or holding of investments; joint ownership of residence; joint ownership of real estate other than residence; listing of both partners as tenants on lease; shared rental payments; shared household expenses; shared household budget for purposes of receiving government benefits; joint ownership of major items of personal property; joint ownership of a motor vehicle; joint responsibility for child care; shared child-care expenses; execution of wills naming each other as executor and/or beneficiary; designation as beneficiary under the other's life insurance policy or retirement benefits account; mutual grant of durable power of attorney; mutual grant of authority to make health care decisions; affidavit by creditor or other individual able to testify to partners' financial interdependence; other items of sufficient proof to establish economic interdependency under the circumstances of the particular case.</li> </ul>	
<p>New Family Members</p>		<p>The policy describes the requirements to add new family members to the policy.</p>	
<p>New Employees</p>	<p><a href="#">§ 3221(a)(3)</a></p>	<p>New employees or members of the class must be added to the class for which they are eligible.</p>	
<p>Open Enrollment Period</p>	<p><a href="#">11NYCRR52.70(e)(3)</a></p>	<p>This policy must insure all persons without evidence of insurability, provided that coverage is elected during an initial period of eligibility of at least 30 days. Rules may be established limiting future enrollment to specific time periods. However, specified periods of open enrollment must be provided once every 12 months, for a period of not less than 30 days. No enrollment limitation shall apply to insureds who apply for coverage under the conditions described in Section 3221(q)(5).</p>	
<p><b>MANDATORY COVERED BENEFITS</b></p>		<p><i>The following benefits must be included in the policy.</i> <i>Note: All accident and health insurance products whether indemnity or expense incurred that meet or exceed the level of benefits described in 11 NYCRR 52.6 require the mandated benefits listed below.</i></p>	
<p>Surgical Services</p>	<p><a href="#">11NYCRR52.6(a)</a></p>	<p>This policy includes coverage for services rendered by a physician to each insured for sickness or injury for surgical services, consisting of operating and cutting procedures for the treatment of a sickness or injury, and endoscopic procedures, including any pre- and post-operative care usually rendered in connection with such operation or procedure, in an amount:</p> <ul style="list-style-type: none"> <li>• not less than 80 percent of the reasonable charges; or</li> <li>• if specified in dollar amounts, a fee schedule providing amounts for any procedure at least equal to those provided for in a fee schedule with a maximum of \$2,600 based on the relative values contained in the State of New York Certified Surgical Fee Schedule, or an equivalent fee schedule approved by the superintendent.</li> </ul>	
<p>Anesthetic Services</p>	<p><a href="#">11NYCRR52.6(b)</a></p>	<p>This policy includes coverage for services rendered by a physician to each insured for sickness or injury for anesthetic services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a physician, other than the physician performing the surgical service or his assistant, in an amount not less than 80 percent of the reasonable charges or 15 percent of the benefit provided in 11NYCRR52.6(a)(2).</p>	
<p>In-Hospital Medical Services</p>	<p><a href="#">11NYCRR52.6(c)</a></p>	<p>This policy includes coverage for in-hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical or pregnancy care is required, in an amount not less than 80 percent of the reasonable charges or \$25 per day for not less than 60 days.</p>	
<p>Second Surgical Opinion</p>	<p><a href="#">§ 3221(k)(3)</a></p>	<p>This policy includes coverage for a second surgical opinion by a qualified physician on the need for</p>	

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	<p><a href="#">Circular Letter No. 29 (1979)</a></p>	<p>surgery, subject to the following:</p> <ul style="list-style-type: none"> <li>• A qualified physician must be a board-certified specialist who by reason of his specialty is an appropriate physician to consider the surgical procedure being proposed.</li> <li>• Obtaining the second surgical opinion is at the option of the insured.</li> <li>• The benefit is applicable to all in-patient surgical procedures of a non-emergency nature covered by the policy.</li> <li>• The benefit is payable only if the insured is examined in person by the physician rendering the second surgical opinion and a written report is submitted to the insurer.</li> <li>• If the board certified specialist who renders the second surgical opinion also performs the surgery, no second surgical opinion benefit is payable.</li> </ul>	
<p>Maternity Care</p>	<p><a href="#">§ 3221(k)(5)</a></p>	<p>This policy includes coverage for maternity care, to the same extent as coverage provided for illness or disease under the policy.</p> <ul style="list-style-type: none"> <li>• Such coverage, other than for perinatal complications, includes inpatient hospital coverage for mother and newborn for at least 48 hours after childbirth for any delivery other than a caesarean section, and for at least 96 hours following a caesarean section.</li> <li>• The mother has the option to be discharged earlier than the time periods listed above, and, in such cases, is entitled to one home care visit in addition to any home care provided under § 3221(k)(1). Such home care is not subject to deductibles, coinsurance or co-payments.</li> <li>• Maternity coverage also includes coverage of the services of a midwife licensed pursuant to Article 140 of the Education Law, practicing consistent with a collaborative relationship with a physician or a hospital licensed pursuant to Article 28 of the Public Health Law, consistent with the requirements §6951 of the Education Law</li> <li>• Maternity coverage also includes parent education, training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments.</li> </ul>	
<p>Treatment of Correctable Medical Conditions that Cause Infertility/Infertility Treatments</p>	<p><a href="#">§ 3221(k)(6)</a> <a href="#">11 NYCRR 52.18(a)(10)</a> <a href="#">Definition of Infertility</a> <a href="#">OGC Opinion 05-11-10</a></p>	<p>This policy shall not exclude coverage for surgical or medical care for the diagnosis and treatment of correctable medical conditions otherwise covered under the policy solely because the medical condition results in infertility.</p> <ul style="list-style-type: none"> <li>• Coverage shall not exclude surgical or medical procedures which would correct malformation, disease or dysfunction resulting in infertility.</li> <li>• Coverage shall not exclude diagnostic tests and procedures including hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysterogram, post coital tests, testis biopsy, semen analysis, blood tests, ultrasound and artificial insemination, or prescription drugs if prescription drug coverage is otherwise provided under the policy.</li> <li>• Coverage shall be provided for persons aged 21-44 years; however, coverage beyond this age range is not precluded. Such coverage may be subject to annual deductibles and coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy.</li> <li>• This mandate does not require coverage of the following treatments in connection with infertility: in vitro fertilization; gamete intrafallopian tube transfers; zygote intrafallopian tube transfers; the reversal of elective sterilizations; sex change procedures; cloning; or medical or surgical services or procedures determined to be experimental. These services are the only infertility treatments that may be expressly excluded in the policy.</li> </ul>	

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<p>Diabetes Equipment, Supplies and Self-Management Education</p>	<p><a href="#">§ 3221(k)(7)</a></p>	<p>This policy includes coverage for equipment, supplies and self-management education described in § 3221(k)(7) for the treatment of diabetes. Such coverage may be subject to annual deductibles and coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy.</p> <p><i>Note: This benefit must appear in the base policy and may not be addressed through a prescription drug rider unless the prescription drug rider would provide a more generous benefit than the base policy (i.e. lower cost sharing).</i></p> <p><i>Note: Since the statute refers to equipment, supplies and self-management education that is prescribed by a physician “or other licensed health care provider legally authorized to prescribe under title eight of the education law...,” the policy may not limit coverage to care prescribed by a physician.</i></p>	
<p>Second Medical Opinion for Cancer Diagnosis</p>	<p><a href="#">§ 3221(k)(9)</a></p>	<p>This policy includes coverage for a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer.</p> <ul style="list-style-type: none"> <li>• This benefit includes coverage for a second medical opinion from a non-participating specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer when the attending physician provides a written referral to the non-participating specialist, at no additional cost to the insured beyond what such insured would have paid for services from a participating specialist.</li> <li>• This benefit also includes coverage for a second medical opinion by a non-participating specialist where there is no referral from the attending physician and where the insurer has not pre-authorized the service. In such cases, the insurer is responsible for covering the medically necessary services at a usual, customary and reasonable rate.</li> </ul> <p>Such coverage may be subject to annual deductibles and coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy.</p>	
<p>Post Mastectomy Reconstruction</p>	<p><a href="#">§ 3221(k)(10)</a> Women’s Health and Cancer Rights Act of 1999, 29 USC 1185(b)</p>	<p>This policy includes coverage for breast reconstruction surgery after a mastectomy or partial mastectomy including all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of mastectomy including lymphedemas in the manner determined by the attending physician and the patient to be appropriate. Such coverage may be subject to annual deductibles and coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy.</p>	
<p>Chiropractic Care</p>	<p><a href="#">§ 3221(k)(11)</a></p>	<p>This policy includes coverage for chiropractic care in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment, or subluxation in the vertebral column.</p> <p>Chiropractic care and services may be subject to reasonable deductible, copayment and coinsurance amounts, reasonable fee or benefit limits, and reasonable utilization review, provided that any such amounts, limits and review: shall not function to direct treatment in a manner discriminative against chiropractic care and individually and collectively shall be no more restrictive than those applicable under the policy to care or services provided by other health care professionals in the diagnosis, treatment and management of the same or similar conditions, injuries, complaints, disorders or</p>	

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		<p>ailments even if differing nomenclature is used to describe the condition, injury, complaint, disorder or ailment.</p> <p><i>Note: The Department interprets this mandate to mean that a policy may not subject a visit to a chiropractor or to a provider of chiropractic care to higher cost sharing than that which applies to other specialty office visits under the policy. Additionally, a policy may not impose a greater level of utilization review to chiropractic care and services than that which applies to specialty office care in general under the policy. This means, for example, that a policy may not require pre-certification or preauthorization of chiropractic care and services if it does not require the same for specialty office visits in general.</i></p>	
Experimental/Investigational Services Recommended by an External Appeal Agent	<p><a href="#">§ 3221(k)(12)</a></p> <p><a href="#">Article 49</a></p>	<p>This policy shall not exclude coverage of a health care service on the basis that it is experimental or investigational, or rendered as part of a clinical trial, if coverage of the service has been recommended by an external appeal agent pursuant to an external appeal performed according to Title II of Article 49.</p>	
Services Performed at Comprehensive Care Center for Eating Disorders	<p><a href="#">§ 3221(k)(14)</a></p>	<p>This policy may not exclude coverage for services covered under the policy when provided by a comprehensive care center for eating disorders pursuant to Article 27-J of the Public Health Law. Reimbursement for services provided through such comprehensive care centers shall, to the extent possible or practicable, be structured in a manner to facilitate the individualized, comprehensive and integrated plans of care which such centers' network of practitioners and providers are required to provide.</p>	
Mental, Nervous and Emotional Disorders	<p><a href="#">§ 3221(l)(5)</a></p> <p><a href="#">Circular Letter No. 20 (2009)</a></p> <p><a href="#">Supplement No. 1 to Circular Letter No. 20 (2009)</a></p> <p>Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343</p> <p>45 CFR 146.136</p>	<p>This policy includes coverage for the diagnosis and treatment of mental, nervous and emotional disorders, at least equal to the following:</p> <ul style="list-style-type: none"> <li>• 20 outpatient visits in any contract, plan or calendar year for outpatient care provided by a psychiatrist or psychologist, a licensed clinical social worker, or a professional corporation or university faculty practice corporation.</li> <li>• Coverage for adults and children with biologically based mental illnesses as defined in 3221(l)(5)(B)(ii) and for children with serious emotional disturbances, as defined in 3221(l)(5)(C) must be comparable to other coverage provided under the policy. However, this provision is not mandatory for groups with fifty or fewer employees, but must be made available to the policyholder for purchase.</li> </ul> <p>Such coverage may be subject to annual deductibles, co-pays and coinsurance as may be deemed appropriate by the Superintendent and shall be consistent with those imposed on other benefits under the policy.</p> <p><i>Note: If a group has more than 50 total employees, regardless of eligibility, the Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) applies and the above 30/20 treatment limits will typically be impermissible. Under MHPAEA, group health policies that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy. The MHPAEA also prohibits such policies from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy provides coverage for out-of-network services, such policy must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.</i></p>	

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<p>Primary and Preventive Health Services</p> <p>Explanation: Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p><a href="#">§ 3221(1)(8)</a></p> <p><a href="#">Circular Letter No. 3 (1994)</a></p> <p><a href="#">Circular Letter No. 13 (2006)</a></p> <p><a href="#">Required Immunizations</a></p> <p>42 USC §300gg-13 45 CFR §147.130</p> <p><a href="#">Model Language (PPACA Rider)</a></p>	<p>This policy includes the following coverage for primary and preventive health services for a dependent child from the date of birth through 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> <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>If the policy is not “grandfathered” pursuant to 42 U.S.C. §18011(e) it must also provide coverage for the following preventive care and screenings for children and adults with no cost-sharing:</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> <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>Mammography Screening</p>	<p><a href="#">§ 3221(1)(11)</a></p> <p>42 USC § 300gg-13 45 CFR § 147.130</p>	<p>This policy includes the following coverage for 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>Such coverage may be subject to annual deductibles and coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy.</p> <p>If the policy is not “grandfathered” pursuant to 42 U.S.C. §18011(e) it must also provide coverage for the following mammography screening services with no cost-sharing:</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> <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>Prostate Cancer Screening</p>	<p><a href="#">§ 3221(1)(11-a)</a></p>	<p>This policy includes coverage for 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</li> </ul>	

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		<p>factors.</p> <p>Such coverage may be subject to annual deductibles and coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy.</p>	
Cervical Cytology Screening	<p><a href="#">§ 3221(1)(14)</a></p> <p>42 USC §300gg-13 45 CFR §147.130</p>	<p>This policy includes coverage for 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. Such coverage may be subject to annual deductibles and coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy.</p> <p>If the policy is not “grandfathered” pursuant to 42 U.S.C. §18011(e) it must also provide coverage for the following cervical cytology screening services with no cost-sharing:</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> <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>	
Autism Spectrum Disorder	<p><a href="#">§ 3221(1)(17)</a></p>	<p>This policy includes coverage for the screening, diagnosis and treatment of autism spectrum disorder, including the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist:</p> <ul style="list-style-type: none"> <li>• behavioral health treatment;</li> <li>• psychiatric care;</li> <li>• psychological care;</li> <li>• medical care provided by a licensed health care provider;</li> <li>• therapeutic care, including therapeutic care which is deemed habilitative or nonrestorative, in the event that the policy provides coverage for therapeutic care; and</li> <li>• pharmacy care in the event that the policy provides coverage for prescription drugs.</li> </ul> <p>This policy shall include a definition of “autism spectrum disorder” which means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder; Asperger’s disorder; Rett’s disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS).</p> <p>The policy shall include a definition of “behavioral health treatment” which means counseling and treatment programs, when provided by a licensed provider and applied behavior analysis, when provided or supervised by a behavior analyst certified pursuant to the behavior analyst certification board, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.</p> <p>The policy shall include coverage for “applied behavior analysis” which means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and</p>	

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		<p>consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. Coverage for applied behavioral analysis shall be subject to a maximum benefit of \$45,000 per year per covered individual and such maximum annual benefit will increase by the amount calculated from the average ten year rolling average increase of the medical component of the consumer price index.</p> <p>The policy shall include a definition of “assistive communication devices” which at a minimum shall include dedicated devices which are specifically designed to aid in communication and are not generally useful to a person in the absence of a communication impairment and software applications that enable a non-covered device to function as a communication device.</p> <p>Such coverage may be subject to annual deductibles, copayments and coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy</p>	
<p>Direct Access to OB/GYN Services</p> <p>Explanation: Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p><a href="#">§ 3217-c</a></p> <p>42 USC § 300gg-19a 45 CFR § 147.138(a)</p> <p><a href="#">Model Language (PPACA Rider)</a></p>	<p>If this policy includes coverage for obstetric/gynecologic services, this policy may not 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 participating provider of such services of her choice or for any care related to pregnancy provided that:</p> <ul style="list-style-type: none"> <li>• such qualified provider discusses such services and treatment plan with the individual’s primary care practitioner in accordance with the insurer’s requirements; and</li> <li>• such qualified provider agrees to adhere to the insurer’s policies and procedures, including any 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 approved by the insurer.</li> </ul>	
<p>Designation of Primary Care Provider (PCP) &amp; Access to Pediatricians</p> <p>Explanation: Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>42 USC §300gg-19a 45 CFR §147.138(a)</p> <p><a href="#">Model Language (PPACA Rider)</a></p>	<p>If this policy requires or provides for designation of a PCP the policy must permit an insured to designate any participating PCP who is available to accept the insured.</p> <p>If designation of a PCP for a child is required, the 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.</p>	
<p>Out-of-Network Dialysis</p>	<p><a href="#">§ 3221(k)(16)</a></p>	<p>If this policy provides in-network only coverage for dialysis treatment the policy shall not deny out-of-network dialysis services provided the following conditions are met:</p> <ul style="list-style-type: none"> <li>• The out-of-network provider is duly licensed to practice and authorized to provide such treatment;</li> <li>• The out-of-network provider is located outside the service area of the insurer;</li> <li>• The in-network provider treating the insured for the condition issues a written order stating that the dialysis treatment is necessary;</li> <li>• The insured notifies the insurer in writing 30 days in advance of the proposed date(s) of the out-of-network dialysis treatment and attaches the written order of the in-network provider. If the insured must travel on sudden notice due to family or other emergency, shorter notice may be permitted, provided that the insurer has a reasonable opportunity to review the travel and treatment plans of the insured;</li> <li>• The insurer has the right to pre-approve the dialysis treatment schedule; and</li> </ul>	

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		Such coverage may be limited to 10 out-of-network treatments in a calendar year.	
<p>Limitations on Annual Dollar Limits</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p><a href="#">§ 3217-f</a></p> <p>42 USC §300gg-11 45 CFR §147.126</p> <p><a href="#">Model Language (PPACA Rider)</a></p>	<p>The policy may impose “restricted” annual dollar limits for essential health benefits for plan years prior to January 1, 2014 as follows:</p> <ul style="list-style-type: none"> <li>For a policy year beginning on or after 9/23/10 but before 9/23/11 the limit is \$750,000.</li> <li>For a policy year beginning on or after 9/23/11 but before 9/23/12 the limit is \$1,250,000.</li> <li>For a policy year beginning on or after 9/23/12 but before 9/23/14 the limit is \$2,000,000.</li> </ul> <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 and wellness services and chronic disease management; pediatric services, including oral and vision care.</p>	
<p>Prohibition on Lifetime Dollar Limits</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p><a href="#">§ 3217-f</a></p> <p>42 USC § 300gg-11 45 CFR § 147.126</p> <p><a href="#">Model Language (PPACA Rider)</a></p>	<p>The policy may not include a lifetime limit on essential health benefits. 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.</p>	
<p>Contraceptive Drugs and Devices</p>	<p><a href="#">§ 3221(l)(16)</a></p> <p>42 USC §300gg-13</p>	<p>If coverage for prescription drugs is provided under the policy, then coverage for contraceptive drugs and devices must be included. Coverage for contraceptive drugs and devices must be included in policies and certificates only through the addition of a rider, subject to provisions in statute regarding religious employers. Such coverage may be subject to annual deductibles and coinsurance deemed appropriate by the Superintendent and as are consistent with those established for other drugs or devices covered under the policy if the policy is “grandfathered” pursuant to 42 U.S.C. §18011(e).</p>	
<p><b>If prescription drugs are covered under this policy, the following mandates apply:</b></p>			
<p>Enteral Formulas</p>	<p><a href="#">§ 3221(k)(11)</a></p>	<p>If coverage for prescription drugs is provided under the policy, then coverage must be provided for enteral formulas for home use for which a physician or other licensed health care provider legally authorized to prescribe under Title 8 of the Education Law has issued a written order. The order must state that the formula is medically necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic physical disability, mental retardation or death. Specific diseases that enteral formulas are effective for include, but are not limited to: inherited amino-acid or organic acid metabolism; Crohn’s Disease; gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which if left untreated will cause malnutrition, chronic physical disability, mental retardation or death. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include coverage of modified solid food products, which is not required to exceed \$2,500 for any insured individual in any calendar year or continuous period of 12 months.</p>	
<p>Off-Label Cancer Drug Usage</p>	<p><a href="#">§ 3221(l)(12)</a></p>	<p>If coverage for prescription drugs is provided under the policy, then coverage may not be excluded because the drug is being prescribed to treat a type of cancer for which the FDA has not approved</p>	

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		the drug. The drug must be recognized for treatment of the specific type of cancer for which it has been prescribed in one of the following reference compendia: the American Hospital Formulary Service Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.	
Usual and Customary Cost of Prescribed Drugs	<a href="#">§ 4325(h)</a>	If coverage for prescription drugs is provided under the policy, the co-payment shall not exceed the usual and customary cost of such prescribed drug.	
Prohibition for Tier IV Drugs	<a href="#">§ 3221(a)(16)</a>	If coverage for prescription drugs is provided under the policy, then the policy shall not impose cost-sharing (co-payment, coinsurance and deductible) for any prescription drug that exceeds the cost-sharing for non-preferred brand drugs or its equivalent (or brand drugs if there is no non-preferred brand drug category).	
Eye Drops	<a href="#">§ 3221(k)(17)</a>	If coverage for prescription drugs is provided under the policy, then the policy shall allow for the limited refilling of eye drop medication requiring a prescription prior to the last day of the approved dosage period. Any refill dispensed prior to the expiration of the approved coverage period shall, to the extent practicable, be limited in quantity so as not to exceed the remaining dosage initially approved for coverage. The limited refilling shall not limit or restrict coverage with respect to any previously or subsequently approved prescription for eye drop medication.	
Orally Administered Anticancer Medications	<a href="#">§ 3221(l)(12-a)</a>	If coverage for prescription drugs and cancer chemotherapy treatment is provided under the policy, then the policy shall provide coverage for a prescribed orally administered anticancer medication used to kill or slow the growth of cancerous cells. Such coverage may be subject to copayments, coinsurance or deductibles that apply to coverage for intravenous or injected anticancer medications.	
Mail Order Drugs for Policies With a Provider Network	<a href="#">§ 3221(l)(18)</a>	If coverage for prescription drugs is provided under the policy, then the policy shall permit an insured to fill any prescription that may be obtained at a network participating mail order or other non-retail pharmacy, at the insured's option, at a network participating non-mail order retail pharmacy provided that the network participating non-mail order retail pharmacy agrees in advance, through a contractual network agreement, to the same reimbursement amount and the same terms and conditions that the insurer has established for the network participating mail order or other non-retail pharmacy.	
<b>MAKE AVAILABLE BENEFITS</b>		<i>The following benefits must be made available to policyholders annually, in writing, and must be included in the policy if requested by the policyholder.</i>	
Licensed Clinical Social Worker	<a href="#">§ 3221(l)(4)</a>	If this policy provides reimbursement for psychiatric or psychological services or for the diagnosis and treatment of mental, nervous or emotional disorders and ailments by physicians, psychiatrists or psychologists, the policy must make available and if requested by the policyholder, provide the same coverage to insureds for the such services when performed by a licensed clinical social worker, within the lawful scope of his or her practice, who is licensed pursuant to Article 154 of the Education Law (Education Law § 7700 et seq.).	
Mental, Nervous and Emotional Disorders for Policies that are not subject to MHPAEA	<a href="#">§ 3221(l)(5)</a>	This policy must make available to policyholders in the small group market coverage of mental, nervous and emotional disorders comparable to other coverage provided under the policy for adults and children with biologically based mental illnesses as defined by 3221(l)(5)(B)(ii). This policy must also make available to policyholders in the small group market comparable coverage for children with serious emotional disturbances, as defined by 3221(l)(5)(C).  Such mental health coverage may be subject to the terms and conditions otherwise applicable under the policy, such as network limitations and variations, exclusions, co-pays, coinsurance, deductibles	

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		or other specific cost sharing mechanisms.	
Registered Professional Nurse	<a href="#">§ 3221(l)(9)</a>	If this policy provides coverage for any service within the lawful scope of practice of a duly licensed registered professional nurse, the policy must make available reimbursement when such service is performed by a duly licensed registered professional nurse.	
<b>MANDATORY STANDARD PROVISIONS</b>		<i>Note: These provisions MUST be included in each policy. The provision must be no less favorable to the insured than the statutory provision.</i>	
Cost of Service	<a href="#">§ 3201(c)(3)</a> <a href="#">11NYCRR52.1(c)</a>	If the cost of the service is less than the copayment for the service, the patient is responsible for the lesser amount.	
Renewal	<a href="#">§ 3221(p)</a> <a href="#">§ 3221(a)(5)</a> <a href="#">11NYCRR52.18(c)</a>	This policy provides that except as specified in § 3221(p), the insurer must renew or continue in force such coverage at the option of the policyholder.  The policy must specify the conditions under which the insurer may refuse to renew the policy.	
Right to New Policy After Termination (Conversion)	<a href="#">§ 3221(e)</a>	This policy provides that if the employee or member insured under the group policy ceases to be covered because of termination of: (1) employment or membership in the class or classes eligible for coverage under the policy or (2) the policy for any reason whatsoever, unless the policyholder has replaced the group coverage with similar and continuous coverage for the same group, such employee or member, who has been insured for at least 3 months under the group policy, shall be entitled to be issued, without evidence of insurability, upon application made within 45 days after the termination and payment of the quarterly, or at the option of the employee or member, a less frequent premium applicable to the class of risk to which the person belongs, an individual policy of insurance. The insurer is not required to issue a converted policy to any person who is eligible or covered for similar benefits by another insurance policy. The policy shall, at the option of employee or member, provide identical benefits to the employee's or member's dependents. The effective date of the converted policy shall be the date of the termination of the individual's insurance with the group policy.  Conversion must also be made available, upon the death of the employee or member, to the surviving spouse and dependents, if they were covered under the group policy, and the former spouse of the employee or member upon the divorce or annulment of the marriage to the employee or member. Conversion must also be made available to a child covered under the policy who reaches the age limiting coverage under the group policy.  The policy provides that the certificate holder be given written notice of its conversion privilege within 15 days before or after termination of the group coverage. However, if the notice is sent more than 15 days, but less than 90 days after termination of the group policy, the time allowed for conversion is extended for 45 days past the date on which notice was given. If the notice is not given within 90 days of termination of group coverage, the time allowed for the exercise of the conversion privilege shall expire at the end of the 90 days.	
Continuation Coverage	<a href="#">§ 3221(e)(11)</a> <a href="#">§ 3221(m)</a>  COBRA, Title X of Public Law 99-272	This policy contains a provision regarding continuation coverage. §3221(m) provides continuation coverage in circumstances when federal COBRA requirements do not apply, including for groups under 20 and upon application of the employee or member to continue hospital, surgical or medical expense insurance for himself or herself and his or her eligible dependents.  An employee or member who wishes continuation of coverage must request continuation in writing and remit the first premium payment within the 60-day period following the later of: the date of termination or the date the employee is sent notice by first class mail of the right to continuation by	

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<p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p><a href="#">Model Language</a></p>	<p>the group policyholder. The Insurance Law permits the policyholder to charge an additional 2% administrative fee for continued coverage.</p> <p>The continuation benefits terminate:</p> <ul style="list-style-type: none"> <li>• 36 months after the date the employee or member’s benefits would otherwise have terminated because of termination of employment or membership.</li> <li>• In the case of an eligible dependent, 36 months after the date such person’s benefits would otherwise have terminated by reason of the death of the employee or member, divorce or legal separation of the employee or member from his or her spouse, the employee or member becoming eligible for Medicare, or a dependent child ceasing to be a dependent child under the generally applicable requirements of the policy.</li> <li>• On the date which the employee or member becomes entitled to coverage under Medicare.</li> <li>• On the date which the employee or member becomes covered by an insured or uninsured arrangement which provides hospital, surgical or medical coverage for individuals in a group which does not contain any exclusion or limitation with respect to any pre-existing condition.</li> <li>• The end of the period for which premiums were made if the employee or member fails to make timely payment.</li> </ul>	
<p>Young Adult Option</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p><a href="#">§3221(r)</a></p> <p><a href="#">Model Language</a></p>	<p>This policy provides 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). If a young adult or the young adult’s parent elects this coverage, the young adult is issued a separate individual policy.</p> <p>The company must comply with the notice requirements to each employee or member as set forth in 3221(r).</p>	
<p>Suspension of Coverage</p>	<p><a href="#">§ 3221(n)</a></p> <p><a href="#">11NYCRR52.17(a)(9)</a></p> <p><a href="#">Circular Letter No. 7 (2003)</a></p> <p>USERRA, 38 USC §4317</p>	<p>This policy provides that:</p> <ul style="list-style-type: none"> <li>• Any covered persons who are also members of a reserve component of the armed forces of the United States, including the National Guard, shall be entitled, upon request, to have their coverage suspended during a period of active duty.</li> <li>• The insurer will refund any unearned premiums for the period of the suspension.</li> <li>• Persons covered by this policy shall be entitled to resumption of coverage, upon written application and payment of the required premium within 60 days after the date of termination of the period of active duty.</li> <li>• Coverage shall be retroactive to the date of termination of the period of active duty.</li> <li>• No exclusion or waiting period may be imposed for any condition unless the condition arose during the period of active duty and the condition has been determined by the secretary of veterans affairs to be a condition incurred in the line of duty or a waiting period had been imposed and was not completed at the time of suspension.</li> </ul>	
<p>Supplementary Coverage for Employees or Members who are also members of the reserve components of the armed services or the National Guard</p>	<p><a href="#">§ 3221(n)</a></p> <p><a href="#">Circular Letter No. 7 (2003)</a></p>	<p>If the policyholder does not choose to voluntarily maintain coverage for any employee or member of when they enter active duty, then such member or employee shall be entitled to continuation or conversion coverage.</p>	
<p>Extension of Benefits</p>	<p><a href="#">11NYCRR52.18(b)(4) &amp; (6)</a></p>	<p>Upon termination of insurance, whether due to termination of employment, termination of eligibility or termination of the policy, an extension of benefits shall be provided during a period of total</p>	

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		disability for surgery performed during the next 31 days for the injury, sickness or pregnancy causing the total disability. This extension of benefits provision also includes a specific extension for conditions as a result of pregnancy, childbirth or related medical condition if the pregnancy commenced while coverage was in force.	
Misstatement	<a href="#">§ 3221(a)(1)</a>	The policy must provide that statements by the insured must be in writing and signed in order to be used to reduce benefits or avoid the insurance.	
Changes	<a href="#">§ 3221(a)(2)</a>	The policy must provide that no agent has the authority to change the policy or waive any provisions and that no change shall be valid unless approved by an officer of the insurer and evidenced by endorsement on the policy, or by amendment to the policy signed by the policyholder and insurer.	
Premiums	<a href="#">§ 3221(a)(4)</a>	The policy must provide that premiums are to be paid to the insurer by the employer or such other person designated, by the due date, with a grace period as specified.	
Certificate	<a href="#">§ 3221(a)(6)</a>	The insurer shall issue either to the employer or person in whose name the policy is issued, for delivery to each member of the insured group, a certificate setting forth in summary form a statement of the essential features of the insurance coverage.	
Notice of Claim	<a href="#">§ 3221(a)(8)</a>	The policy must provide that the insured has a minimum of 20 days to provide the insurer with written notice of claim. However, failure to give notice within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such notice and the notice was provided as soon as reasonably possible.	
Proof of Loss	<a href="#">§ 3221(a)(9)</a>	The policy must provide that the insured has a minimum of 120 days to provide the insurer with proof of loss after the date of such loss. However, failure to give proof within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such proof and the proof was provided as soon as reasonably possible.	
Filing Proof of Loss	<a href="#">§ 3221(a)(10)</a>	The policy must provide that the insurer will furnish the insured or the policyholder such forms as are usually furnished for filing proof of loss. If such forms are not furnished before the expiration of fifteen days after the insurer receives notice of the claim, the insured shall be deemed to have complied with the proof of loss requirements upon submitting within the time fixed written proof covering the occurrence, character and extent of the loss for which the claim is made.	
Examination	<a href="#">§ 3221(a)(11)</a>	The insurer shall have the right and opportunity to examine the insured making a claim as required during the pendency of the claim and the right and opportunity to conduct an autopsy in the case of death unless prohibited by law.	
Action in Law or Equity	<a href="#">§ 3221(a)(14)</a>	The policy must provide that no action in law or equity shall be brought to recover on the policy prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy and that no such action shall be brought after the expiration of two years following the time such proof of loss is required by the policy.	
Prompt Payment of Claims	<a href="#">§ 3224-a</a>	This policy must pay claims to the policyholder, covered person or health care provider according to §3224-a.	
<b>OPTIONAL STANDARD PROVISIONS</b>		<i>If optional standard provisions are included in the policy, they must comply with the following.</i>	
Pre-existing Condition Limitation	<a href="#">§ 3232</a> <a href="#">11NYCRR52.20</a>	This policy includes a pre-existing condition provision for insureds age 19 and above which: <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> </ul>	
Model Language Used?	42 USC § 300gg-1 42 USC § 300gg-3 42 USC § 300gg-4		

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Yes <input type="checkbox"/> No <input type="checkbox"/>	45 CFR §§ 144.103, 146.111(a)(1)(i) & 147.108  <a href="#">Model Language</a>	<ul style="list-style-type: none"> <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 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>Groups over 300 may not impose a pre-existing condition provision.</p>	
Wellness Programs	<a href="#">§ 3239</a>	<p>Wellness programs are permitted and are defined as programs designed to promote health and prevent disease that may contain rewards and incentives for participation. A wellness program may include but is not limited to: the use of a health risk assessment tool; a smoking cessation program; a weight management program; a stress management program; a worker injury prevention program; a nutrition education program; and a health or fitness incentive program. A wellness program may use rewards and incentives for participation provided that where the group health insurance policy or subscriber contract is required to be community-rated, the rewards and incentives shall not include a discounted premium rate or a rebate or refund of premium.</p> <p>Permissible rewards and incentives include: full or partial reimbursement of the cost of participating in smoking cessation or weight management programs; full or partial reimbursement of the cost of membership in a health club or fitness center; the waiver or reduction of copayments, coinsurance and deductibles for preventive services covered under the group policy or subscriber contract; and monetary rewards in the form of gift cards or gift certificates, so long as the recipient of the reward is encouraged to use the reward for a product or a service that <b><u>promotes good health</u></b>, such as healthy cook books, over the counter vitamins or exercise equipment.</p> <p>Participation in the wellness program must be available to similarly situated members of the group and must be voluntary on the part of the member. The terms of the wellness program must be set forth in the policy or contract.</p>	
Subrogation	<a href="#">General Obligations Law § 5-335</a> <a href="#">Civil Practice Law and Rules § 4545(a)</a>	If a subrogation provision is included in this policy or certificate, it must comply with NYS General Obligations Law § 5-335 and Civil Practice Law and Rules § 4545(a).	
Coordination of Benefits Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	<a href="#">11NYCRR52.23</a>  <a href="#">Model Language</a>	If this policy contains a coordination of benefits provision, then it must comply with 11 NYCRR 52.23.	
Unilateral Modification	<a href="#">11NYCRR52.18(a)(8)</a>	Unilateral modifications by an insurer to an existing policy must be made with at least 30 days prior written notice to the policyholder. Unilateral modification by the insurer may be made only at the time of renewal. If the policy requires the policy holder to provide written notice to terminate coverage, the notice of the unilateral modification by the insurer must be provided to such policy holder no less than 14 days prior to the date by which the policy holder is required to provide notice	

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		to terminate coverage.	
<b>TERMINATION PROVISIONS</b>		<i>The following are the only termination provisions permissible under the Insurance Law and the policy may, but is not required to, include these termination provisions.</i>	
Notice of Termination	<a href="#">11NYCRR52.18(c)</a>	Unless otherwise specified under the Insurance Law, notices of nonrenewal or termination shall provide at least 30 days prior written notice.	
Termination for Failure to Pay Premiums	<a href="#">§ 3221(p)(2)(A)</a>	This policy includes a provision permitting the insurer to terminate the policy if the policyholder or a participating entity has failed to pay premiums or contributions in accordance with the terms of the policy or the insurer has not received timely premium payments.	
Termination for Fraud	<a href="#">§ 3221(p)(2)(B)</a>	This policy includes a provision permitting the insurer to terminate the policy if the policyholder or a participating entity has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the policy.	
Termination for Failure to Comply With a Material Plan Provision	<a href="#">§ 3221(p)(2)(C)</a>	This policy includes a provision permitting the insurer to terminate the policy if the policyholder has failed to comply with a material plan provision relating to employer contribution or group participation rules, as permitted in §4235.	
Discontinuation of a Class of Policy	<a href="#">§ 3221(p)(2)(D);</a> <a href="#">§ 3221(p)(3)(A)</a>	This policy includes a provision permitting the insurer to discontinue this class of policy upon written notice to each policyholder, participant, and beneficiary not less than 90 days prior to the date of discontinuance. The insurer must offer policyholders the option to purchase all (or with respect to the large group market, any) other hospital, surgical, and medical expense coverage currently being offered by the insurer to a group in such market and in exercising the option to discontinue coverage of this class, the insurer must act uniformly without regard to the claims experience of those policyholders or any health status-related factor relating to any insureds covered or new insureds who may become eligible for such coverage.	
Discontinuation of all Policies in the Small or Large Group Market	<a href="#">§ 3221(p)(2)(D);</a> <a href="#">§ 3221(p)(3)(B)</a>	This policy includes a provision permitting the insurer to discontinue all hospital, surgical and medical expense coverage in the small or large group market upon written notice to the superintendent and to each policyholder, participant, and beneficiary at least 180 days prior to the date of discontinuance.	
Termination for Failure to Meet Requirements of Group	<a href="#">§ 3221(p)(2)(E);</a> <a href="#">§ 4235(c)(1)</a>	This policy includes a provision permitting the insurer to terminate the policy if the policyholder ceases to meet the requirements of a group under §4235, or a participating employer, labor union, association or entity ceases membership in the group to which the policy was issued. Coverage terminated pursuant to this provision shall be done uniformly without regard to any health status factor relating to any individual.	
Termination if there are No Longer Insureds in the Insurer's Service Area	<a href="#">§ 3221(p)(2)(F)</a>	This policy includes a provision permitting the insurer, in regard to a network plan, to terminate the policy if there is no longer any insured who lives, resides, or works in the service area of the insurer, or in the area for which the insurer is authorized to do business.	
Rescission	<a href="#">§ 3105</a> <a href="#">§ 3204</a>	No misrepresentation shall avoid the policy or defeat any recovery thereunder unless the insured makes a misrepresentation that is material and intentional. Notification must be given to the insured 30 calendar days prior to cancellation.	
Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	42 USC § 300gg-12 45 CFR § 147.128  <a href="#">Model Language (PPACA Rider)</a>		
<b>PERMISSIBLE EXCLUSIONS AND</b>		<i>No policy shall limit or exclude coverage by type of illness, accident, treatment or medical condition, except for the following exclusions which may, but are not required to be included in the</i>	

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LIMITATIONS		<i>policy.</i>	
War or Act of War, Participation in Felony, Riot or Insurrection, Service in the Armed Forces	<a href="#">11NYCRR52.16(c)(4)(i)</a>	This policy excludes coverage for illness, accident, treatment or medical condition arising out of war or act of war (whether declared or undeclared), participation in a felony, riot or insurrection and service in the Armed Forces or units auxiliary thereto.  Exclusions for terrorism are not included in this permissible exclusion.	
Suicide, Attempted Suicide, Intentionally Self-Inflicted Injury	<a href="#">11NYCRR52.16(c)(4)(ii)</a>	This policy excludes coverage for illness, accident, treatment or medical condition arising out of suicide, attempted suicide or intentionally self-inflicted injury.	
Aviation	<a href="#">11NYCRR52.16(c)(4)(iii)</a>	This policy excludes coverage for illness, accident, treatment or medical condition arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.	
Cosmetic Surgery	<a href="#">11NYCRR52.16(c)(5)</a> <a href="#">11NYCRR56</a>	This policy excludes coverage for cosmetic surgery, except that cosmetic surgery does not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.  <i>Note: All exclusions for cosmetic surgery must be based on medical necessity, with the insured receiving all utilization review and external appeal rights under Article 49, except as otherwise provided in 11NYCRR56.</i>	
Foot Care	<a href="#">11NYCRR52.16(c)(6)</a>	This policy excludes coverage for foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet.	
Mandatory No-Fault Recovered or Recoverable	<a href="#">11NYCRR52.16(c)(8)</a>	This policy excludes benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable.	
Medicare, Other Governmental Programs and Workers' Compensation	<a href="#">11NYCRR52.16(c)(8)</a>	This policy excludes coverage for treatment provided in a government hospital; benefits provided under Medicare or other governmental programs (except Medicaid); any state or federal workers' compensation, employers' liability or occupational disease law, unless where otherwise provided in State or Federal statute.	
Hospital Employees	<a href="#">11NYCRR52.16(c)(8)</a>	This policy excludes coverage for services rendered and separately billed by employees of hospitals, laboratories or other institutions.	
Immediate Family	<a href="#">11NYCRR52.16(c)(8)</a>	This policy excludes coverage for services performed by a member of the insured's immediate family.	
Services For Which No Charge Normally Made	<a href="#">11NYCRR52.16(c)(8)</a>	This policy excludes coverage for services for which no charge is normally made.	
Dental Care or Treatment	<a href="#">11NYCRR52.16(c)(9)</a>	This policy excludes coverage of dental care or treatment, except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly.  <i>Note: It is impermissible to exclude treatment of temporomandibular joint dysfunction where the treatment is medical in nature, unless a medical necessity determination is made and the insured receives all utilization review and external appeal rights under Article 49.</i>	
Eyeglasses and Hearing Aids	<a href="#">11NYCRR52.16(c)(10)</a>	This policy excludes coverage for eyeglasses, hearing aids and examination for the prescription or fitting thereof.  <i>Note: It is impermissible to exclude lasik and other surgeries or treatments to the eyes, unless a</i>	

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		<i>medical necessity determination is made and the insured receives all utilization review and external appeal rights under Article 49.</i>	
Custodial Care and Transportation	<a href="#">11NYCRR52.16(c)(11)</a>	This policy excludes coverage for custodial care as defined in 11NYCRR52.16(l) and for transportation.  <i>Note: All exclusions for custodial care that exceed the definition contained in 11NYCRR52.16(l) must be based on medical necessity, with the insured receiving all utilization review and external appeal rights.</i>	
Rest Cures	<a href="#">11NYCRR52.16(c)(11)</a>	This policy excludes coverage for rest cures.	
Outside the U.S.	<a href="#">11NYCRR52.16(c)(12)</a>	This policy excludes coverage while the insured is outside the United States, its possessions or the countries of Canada or Mexico.	
Illegal Occupation	<a href="#">§ 3221(c)</a> <a href="#">§ 3216(d)(2)(J)</a>	The policy excludes losses to which a contributing cause was the insured’s participation in a felony or attempted felony. If included, the exclusion can be no more restrictive than to provide that the insurer shall not be liable for any loss to which a contributing cause was the insured’s commission of or attempt to commit a felony or to which a contributing cause was the insured’s being engaged in an illegal occupation.	
Intoxicants and Narcotics	<a href="#">§ 3221(c)</a> <a href="#">§ 3216(d)(2)(K)</a>	The policy excludes losses in consequence of the insured’s being intoxicated or under the influence of a narcotic. If included, the exclusion can be no more restrictive than to provide that the insurer shall not be liable for any loss sustained or contracted in consequence of the insured’s being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.	
<b>PROVISIONS THAT MUST BE INCLUDED IN THE POLICY OR WRITTEN DISCLOSURE STATEMENT</b>		<i>Insurers shall provide insureds and upon request prospective insureds the following written disclosure information, which may be incorporated into the policy. In the event of any inconsistency between any separate written disclosure statement and the policy, the terms of the policy shall be controlling.</i>	
Benefits and Exclusions	<a href="#">§ 3217-a(a)(1)</a>	This policy includes a description of coverage provisions; health care benefits; benefit maximums, including benefit limitations; and exclusions of coverage.	
Definition of Medical Necessity	<a href="#">§ 3217-a(a)(1)</a>	This policy includes a definition of “medical necessity” used in determining whether benefits will be covered.	
Prior Authorization Requirements	<a href="#">§ 3217-a(a)(2)</a> <a href="#">§ 3238</a>	This policy includes a description of all prior authorization or other requirements for treatments and services. If the policy requires pre-authorization for health care services, it will do so in compliance with Section 3238 of the Insurance Law. The Department will not approve a penalty greater than 50% for failure to obtain pre-authorization of health care services.	
Utilization Review Policies and Procedures	<a href="#">§ 3217-a(a)(3)</a> <a href="#">Article 49</a>  42 USC § 300gg-19	This policy includes a description, consistent with Article 49, of the utilization review policies and procedures including: <ul style="list-style-type: none"> <li>• The circumstances under which utilization review will be undertaken;</li> <li>• the toll-free telephone number of the utilization review agent;</li> <li>• the timeframes under which utilization review decisions must be made for prospective, retrospective and concurrent decisions;</li> <li>• the right to reconsideration;</li> <li>• the right to appeal, including the expedited and standard appeals processes and the timeframes for such appeals;</li> <li>• the right to designate a representative;</li> <li>• a notice that all denials of claims will be made by qualified clinical personnel and that all</li> </ul>	
Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	29 CFR 2560.503-1 45 CFR § 147.136  <a href="#">Model Language</a>		

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		<p>notices of denials will include information about the basis of the decision;</p> <ul style="list-style-type: none"> <li>• a notice of the right to an external appeal, together with a description, jointly promulgated by the commissioner of health and superintendent of insurance, of the external appeal process and the timeframes for such appeals; and</li> <li>• further appeal rights, if any.</li> </ul>	
<p>External Appeal Procedures</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p><a href="#">Article 49</a></p> <p>45 CFR § 147.136 42 USC § 300gg-19</p> <p><a href="#">Model Language</a></p>	<p>This policy includes a description of the external appeal procedures, including:</p> <ul style="list-style-type: none"> <li>• Instructions on how to request an external appeal;</li> <li>• The circumstances under which an external appeal may be pursued (service denied as not medically necessary or experimental/investigational, including clinical trials and treatment for rare diseases; and for managed care health insurance contracts as defined as §4801(c), out-of-network denials when the service is not available in-network and the insurer recommends an alternate treatment) and</li> <li>• The timeframe for submitting an external appeal.</li> </ul>	
Reimbursement of Providers	<a href="#">§ 3217-a(a)(4)</a>	This policy includes a description of the types of methodologies the insurer uses to reimburse providers.	
Insured's Financial Responsibility for Payment	<a href="#">§ 3217-a(a)(5)</a>	This policy includes a description of the insured's financial responsibility for payment of premiums, coinsurance, co-payments, deductibles, and any other charges, annual limits on an insured's financial responsibility, caps on payments for covered services and financial responsibility for non-covered health care procedures, treatment or services.	
Non-Participating Providers and Non-Authorized Services	<a href="#">§ 3217-a(a)(6)</a>	This policy includes a description of the insured's financial responsibility for payment when services are provided by a health care provider who is not part of the insurer's network of providers or by any provider without the required authorization or when a procedure, treatment or service is not a covered health care benefit.	
Grievance Procedures	<p><a href="#">§ 3217-a(a)(7)</a> <a href="#">§ 3217-d(a)</a> <a href="#">§ 4802</a></p> <p>42 USC § 300gg-19 29 CFR 2560.503-1 45 CFR § 147.136</p>	<p>A policy that is a managed care product as defined in §4801(c) or a comprehensive policy that utilizes a network of providers shall include a description of the grievance procedure to be used to resolve disputes between the insurer and the insured, including:</p> <ul style="list-style-type: none"> <li>• the right to file a grievance regarding any dispute between an insured and the insurer;</li> <li>• the right to file a grievance orally when the dispute is about referrals or covered benefits;</li> <li>• the toll-free telephone number which insureds may use to file an oral grievance;</li> <li>• the timeframes and circumstances for expedited and standard grievances;</li> <li>• the right to appeal a grievance determination and the procedures for filing such an appeal;</li> <li>• the timeframes and circumstances for expedited and standard appeals;</li> <li>• the right to designate a representative;</li> <li>• a notice that all disputes involving clinical decisions will be made by qualified clinical personnel; and,</li> <li>• that all notices of determination will include information about the basis of the decision and further appeal rights, if any.</li> </ul>	
Selecting, Accessing and Changing Participating Providers	<p><a href="#">§ 3217-a(a)(9)</a> <a href="#">§ 3217-a(a)(10)</a></p>	Where applicable, this policy includes a description of the procedures for insureds to select, access and change primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients.	
Referral to Non-Participating Providers	<a href="#">§ 3217-a(a)(11)</a>	Where applicable, this policy includes notice that an insured enrolled in a managed care product as defined in §4801(c) may obtain a referral to a health care provider outside of the insurer's network or panel when the insurer does not have a health care provider with appropriate training and experience in the network or panel to meet the health care needs of the insured and the procedure by which the insured can obtain such referral.	

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Standing Referrals	<a href="#">§ 3217-a(a)(12)</a> <a href="#">§ 3217-d(b)</a>	Where applicable, this policy includes notice that an insured enrolled in a managed care product as defined in §4801(c) ) or covered under a comprehensive policy that utilizes a network of providers and requires that specialty care be provided pursuant referral from a primary care provider, with a condition which requires on-going care from a specialist may request a standing referral to such specialist and the procedure for requesting and obtaining such standing referral.	
Specialty Care Provider as PCP	<a href="#">§ 3217-a(a)(13)</a> <a href="#">§ 3217-d(b)</a>	Where applicable, this policy includes notice that an insured enrolled in a managed care product as defined in §4801(c) ) or covered under a comprehensive policy that utilizes a network of providers and requires that specialty care be provided pursuant referral from a primary care provider, with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request a specialist responsible for providing or coordinating the insured's medical care and the procedure for requesting and obtaining such a specialist.	
Specialty Care Center	<a href="#">§ 3217-a(a)(14)</a> <a href="#">§ 3217-d(b)</a>	Where applicable, this policy includes notice that an insured enrolled in a managed care product as defined in §4801(c) ) or covered under a comprehensive policy that utilizes a network of providers and requires that specialty care be provided pursuant referral from a primary care provider, with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request access to a specialty care center and the procedure by which such access may be obtained.	
Non-English Speaking Insureds	<a href="#">§3217-a(a)(15)</a>	This policy includes a description of how the insurer addresses the needs of non-English speaking insureds.	
Contact Information	<a href="#">§3217-a(a)(16)</a>	This policy includes all appropriate mailing addresses and telephone numbers to be utilized by insureds seeking information or authorization.	
<b>PROVIDER NETWORKS</b>	<a href="#">§3201(c)</a>	<p>If the policy will be used in conjunction with a provider network, then the following items or information must be submitted:</p> <ul style="list-style-type: none"> <li>• Participating provider directory;</li> <li>• Whether the provider network is capitated;</li> <li>• Provider selection criteria;</li> <li>• Quality assurance procedures;</li> <li>• Breakdown of geographic service area by county;</li> <li>• The underlying assumptions for the network regarding ratios of providers to insureds, the travel times and distances to participating providers;</li> <li>• Sample participating provider agreement; and,</li> <li>• Listing of providers by specialty type.</li> </ul> <p>The Department will not approve more than a 30% differential between in-network and out-of-network coverage unless supported by scholarly literature or actual claims experience of the insurer.</p>	
<b>FOR POLICIES ISSUED TO SMALL GROUPS (Groups of 2-50)</b>	<a href="#">11NYCRR360</a>	Special rules apply to small groups that limit the way insurers may restrict or limit coverage. These rules are found in 11NYCRR360, and if this policy is being issued in the small group market, they must be followed.	
<b>ACTUARIAL SECTION FOR NEW PRODUCT RATE FILINGS ONLY</b>		<p><i>Complete this section for all new product forms filings except those filings where a rate filing is unnecessary because: (select one)</i></p> <p><input type="checkbox"/> <i>The submission contains only application forms, disclosure statements, and/or advertising, OR</i></p> <p><input type="checkbox"/> <i>The submission is an out-of-state filing pursuant to Section 3201(b)(2), OR</i></p> <p><input type="checkbox"/> <i>The form submission has no premium rate implications and a letter or actuarial memorandum is enclosed that states and justifies this as appropriate.</i></p>	Form/Page/Para Reference

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		<i>For rate changes to existing products, do NOT complete this section – complete the Existing Products-Rate Requirements section below.</i>	
<b>ACTUARIAL MEMORANDUM</b>	<a href="#">11NYCRR52.40(a)(1)</a>	Actuarial qualifications: a. Member of the Society of Actuaries; and b. Meet the “Qualification Standards of Actuarial Opinion” as adopted by the American Academy of Actuaries.	
Justification of Rates	<a href="#">§3103 &amp; §3221</a> <a href="#">11NYCRR52.40(e)</a> <a href="#">11NYCRR52.40(f)</a> <a href="#">11NYCRR360.10</a> <a href="#">11NYCRR360.11</a> <a href="#">11NYCRR52.45(f)</a> <a href="#">11NYCRR59.5(b)</a>	Small Group: a. Provide community rated rating methodology and assumptions used in calculating rates. b. Provide rating methodology and assumptions used in rate calculation for mental health coverage provided pursuant to §3221(1)(5). c. Actuarial justification for the use of claim costs and other assumptions. d. Non-claim expense components as a percentage of gross premium. e. Expected loss ratio(s).  Large Group: a. Development of manual rates including actuarial assumptions used and justification thereof. b. Provide rating methodology including experience rating formula. c. Provide all elements of the formula, such as claims run-off, credibility and trend factors. d. Provide actuarial justification of all assumptions used. e. Provide rating methodology and assumptions used in rate calculation for mental health coverage provided pursuant to §3221(1)(5). f. Non-claim expense components as a percentage of gross premium. g. Expected loss ratio(s).	
Loss Ratios	<a href="#">11NYCRR52.45(f)</a> <a href="#">11NYCRR59.5(b)</a>	Expected loss ratio(s) – with actuarial justification	
Reserve Basis	<a href="#">11NYCRR94</a>	Description of bases for unpaid claim liabilities and extra reserves (if any).	
Actuarial Certification	<a href="#">11NYCRR52.40(a)(1)</a>	a. The filing is in compliance with all applicable laws and regulations of the State of New York. 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. c. The expected loss ratio meets the minimum requirements of the State of New York. d. The benefits are reasonable in relation to the premiums charged. e. The rates are not unfairly discriminatory.	
Expected Loss Ratio Certification		The expected loss ratio is: <input type="text"/>	
<b>GROUP RATE MANUAL</b>	<a href="#">11NYCRR52.40(e)(2)</a> <a href="#">11NYCRR52.40(e)(3)</a> <a href="#">11NYCRR52.45(f)</a> <a href="#">11NYCRR59.5(b)</a>	a. Table of contents. b. Rate pages. c. Insurer name on each consecutively numbered rate page. d. Identification by form number of each policy, rider, or endorsement to which the rates apply. e. Brief description of benefits, types of coverage, limitations, exclusions, and issue limits. f. Description of rating classes, factors and premium discounts. g. Examples of rate calculations. h. Commission schedule(s) and fees. i. Underwriting guidelines and/or underwriting manual. j. Expected loss ratio(s).	

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Group Commercial Insurers Subject to Article 32

<p><b>ACTUARIAL SECTION FOR EXISTING PRODUCT RATE FILINGS ONLY</b></p>		<p><i>Complete this section for all filings of changes in rates (e.g., rate increases/decreases or changes in rate calculation rules or procedures), commissions or underwriting to existing products.</i></p> <p><i>(For new products, do NOT complete this section – complete the New Products-Rate Requirements section above instead.)</i></p>	
<p><b>ACTUARIAL MEMORANDUM</b></p>	<p><a href="#">11NYCRR52.40(a)(1)</a></p>	<p>Actuarial qualifications:</p> <ol style="list-style-type: none"> <li>a. Member of the Society of Actuaries; and</li> <li>b. Meet the “Qualification Standards of Actuarial Opinion” as adopted by the American Academy of Actuaries.</li> </ol>	
<p>Justification of Rates</p>	<p><a href="#">11NYCRR52.40(e)</a> <a href="#">11NYCRR52.40(g)(3)</a> <a href="#">11NYCRR52.45</a> <a href="#">11NYCRR59.5(b)</a></p>	<ol style="list-style-type: none"> <li>a. Description of proposed changes in coverage, rates, commissions, underwriting rules, etc.</li> <li>b. History of previous New York rate revisions.</li> <li>c. Provide New York and nationwide claims experience respectively, including:             <ol style="list-style-type: none"> <li>(i) Earned premium;</li> <li>(ii) Paid and incurred claims; and</li> <li>(iii) Incurred loss ratios.</li> </ol> </li> <li>d. Actuarial justification of proposed rates revision (increase/decrease).</li> <li>e. Non-claim expense components as a percentage of gross premium.</li> <li>f. Impact on rates as a result of each of the changes with actuarial justification.</li> <li>g. Expected loss ratio(s) after the proposed changes.</li> </ol>	
<p>Actuarial Certification</p>	<p><a href="#">11NYCRR52.40(a)(1)</a></p>	<ol style="list-style-type: none"> <li>a. The filing is in compliance with all applicable laws and regulations of the State of New York.</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”.</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> </ol>	
<p>Expected Loss Ratio Certification</p>		<p>The expected loss ratio is: <span style="background-color: gray; color: gray;">                    </span></p>	
<p><b>REVISED RATE MANUAL PAGES</b></p>	<p><a href="#">11NYCRR52.40(e)(2)</a> <a href="#">11NYCRR52.45(f)</a> <a href="#">11NYCRR59.5(b)</a></p>	<ol style="list-style-type: none"> <li>a. Table of contents.</li> <li>b. Rate pages.</li> <li>c. Insurer name on each consecutively numbered rate page.</li> <li>d. Identification by form number of each policy, rider, or endorsement to which the rates apply.</li> <li>e. Brief description of benefits, types of coverage, limitations, exclusions, and issue limits.</li> <li>f. Description of revised rating classes, factors and discounts.</li> <li>g. Examples of rate calculations.</li> <li>h. Commission schedule(s) and fees.</li> <li>i. Underwriting guidelines and/or underwriting manual.</li> <li>j. Expected loss ratio(s).</li> </ol>	