

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Review Standards for

Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for Group Commercial Insurers, Not for Profits, and HMOs

As of 6/23/15

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 or Contract – 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 New Product Rate Filings Only” in addition to completion of the applicable form sections identified above. For filing of rate changes to existing products (increases, decreases, or change in rate calculation rules or procedures), complete the “Actuarial Section for Existing Product Rate Filings Only” section. For filing of any other changes to rate or underwriting manuals (e.g., changes in commissions or underwriting), complete the “Actuarial Section for Existing Product Rate Filings Only” section.
- 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. All items with shaded boxes must be answered.
- E. Do not make any changes or revisions to this checklist.
- F. **Checklist Updates:** 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”.

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

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| LINE OF BUSINESS: | <u>Group Major Medical or Similar-Type Comprehensive Health Insurance</u> | LINE(S) OF INSURANCE | CODES |
| CODE: | H15G | Health – Hospital/Surgical/Medical Expense | H15G.001 H15G.002 H15G.003 |
| | H16G | Health – Major Medical | H16G.001A H16G.001B H16G.001C H16G.002A H16G.002C H16G.003A H16G.003D H16G.003G |

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

| REVIEW REQUIREMENT | REFERENCE | DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS | LOCATION OF STANDARD IN FILING |
|---|---|--|--------------------------------|
| GENERAL REQUIREMENTS FOR ALL FILINGS | <i>Note: Unless otherwise noted, all references are to Insurance Law, Insurance Regulations, and Insurance Department Circular Letters and OGC opinions</i> | <i>Note: This checklist is intended to provide guidance in the preparation of policy or contract 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 | § 3102(c) § 4306(d) § 4306(e) | <p>This submission contains a complete policy or contract form. Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>No statement by the individual in his application for a contract or policy shall avoid the contract or be used in legal proceedings thereunder, unless such application or an exact copy thereof is included in or attached to such contract.</p> <p>No agent or representative of such corporation and no broker, other than an officer or officers designated therein, is authorized to change the policy or contract or waive any of its provisions.</p> <p>If this submission contains insert pages, riders or endorsements, then the policy or contract 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> | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

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| | | This rider, insert pages, or endorsements are being attached to a policy or contract that was approved by the Department on _____, submission number _____. | |
| Form Requirements | 11 NYCRR 52.31(b), (c), (d), (e), (f), (l) | <p>Each form in the filing must meet the following requirements:</p> <ul style="list-style-type: none"> • This form contains no strikeouts. §52.31(b) • This form is submitted in duplicate. §52.31(c) • 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) • This form is submitted in the form intended for actual use. §52.31(e) • All blank spaces are filled in with hypothetical data. §52.31(f) • 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 the amount of insurance for each person. §52.31(l) • 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 or contractholder” to describe the variable material. §52.31(l) | |
| Flesch Score | § 3102(c) | 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. | |
| SERFF Filing Description or Letter of Submission | 11 NYCRR 52.33 Circular Letter No. 33 (1999) Supplement 1 to CL No. 33 (1999) | <p>The filing must include a SERFF filing description or a letter of submission that contains the following:</p> <ul style="list-style-type: none"> • The identifying form number of each form submitted. §52.33(a) • If the form is a policy or contract, the letter must indicate that the policy or contract is submitted pursuant to 11 NYCRR 52.7. §52.33(b) • Whether the form is new or supersedes an approved or filed form. § 52.33(c) • 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) • 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) • 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) • If the form is submitted in accordance with 11 NYCRR 52.32(c), the letter must identify the prefiled group coverage. § 52.33(f) • 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 or contract with which it may be used in lieu of the form number and approval date. §52.33(g) • If the form is a policy or contract, the letter must identify the form numbers and dates of approval of any applications previously approved to be used with the policy or contract unless | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

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| | | <p>the application is required to be attached to the policy or contract upon submission. §52.33(h)</p> <ul style="list-style-type: none"> • If the policy or contract 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 or contract and a list of all optional pages, together with an explanation of their use. § 52.33(i) <p><i>Note: Submission letters and or the SERFF filing description should advise as to whether the policy or contract 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 or contract.</i></p> | |
| Group Status and Recognition | <p>§ 4235 § 3201(b)(1) § 3231(a) § 4317(a)</p> <p>11 NYCRR 59</p> | <p>The SERFF filing description or 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). 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 or contract is issued to certain groups. In these cases, the group certificate is reviewed for compliance with New York Law. The group policy or contract that is delivered out-of-state is not reviewed.</p> | |
| Prefiled Group Coverage | <p>11 NYCRR 52.32</p> | <p>A copy of the letter of confirmation sent to the policyholder or contractholder 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"> • The effective date of coverage. § 52.32(a)(1) • The nature and extent of the benefits or change in benefits as then known. § 52.32(a)(2) • That the contractual forms may be executed and issued for delivery only after filing with or approval by the Department. §52.32(a)(3) • 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) <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 or contractholder 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> | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

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| Certificate | § 3221(a)(6) | The insurer shall issue either to the employer or person in whose name the policy or contract 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. | |
| Discrimination | § 2606 , § 2607 , & § 2608 | 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. | |
| Statement of ERISA Rights Is the insurer providing document as the plan administrator or for the plan administrator? Yes <input type="checkbox"/> No <input type="checkbox"/> | 29 CFR § 2520.104b-2 29 CFR § 2520.102-3(t) | Plan administrators of an employee benefit plan are required to furnish a copy of a Statement of ERISA rights as provided for in 29 CFR § 2520.102-3(t). If the insurer is providing this document as the plan administrator, or for the plan administrator, please indicate in the adjacent box. | |
| APPLICATION FORMS | | | Form/Page/Para Reference |
| Authorization | 11 NYCRR 420.18(b) | 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 allowable period is 24 months. | |
| Fraud Warning Statement | § 403(d) | The application contains the prescribed fraud warning statement. | |
| Prohibited Questions and Provisions | § 3221(q)(1) § 3204 11 NYCRR 52.51 | 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 or contract 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 or contract void. An agreement that acceptance of any policy or contract 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). | |
| POLICY FORM PROVISIONS | | | Form/Page/Para Reference |
| COVER PAGE (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | Model Language | <i>Use of the model language cover page is recommended.</i> | |
| Insurer name | | This policy or contract 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 or contract (such as on the cover). | |
| Table of Contents (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 3102(c)(1)(G) Model Language | <i>Use of the model language table of contents is recommended.</i> A table of contents is required for policies or contracts that are over 3,000 words or more than 3 pages regardless of the number of words. | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

| DEFINITIONS | § 3217 Model Language | <i>Definitions taken directly from N.Y. Insurance law that are included in the policy or contract form must comply with the Model Language (i.e. Emergency Condition, Emergency Services, and Hospital). For all additional definition, the use of model language is recommended to the extent it is appropriate and applicable for the terminology used in the policy or contract form.</i> | Form/Page/Para Reference |
|--|--|--|--------------------------|
| Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| HOW THIS COVERAGE WORKS | | <i>The following standards are required, as applicable. Use of the model language is recommended.</i> | |
| Selecting a Primary Care Provider | | | |
| Selecting, Accessing and Changing Participating Providers (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 3217-a(a)(9) § 3217-a(a)(10) § 4324(a)(9); (10) PHL § 4408(1)(i) Model Language | Where applicable, this policy or contract form 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. | |
| Designation of Primary Care Provider (PCP) & Access to Pediatricians Does this product require a PCP to be designated? Yes <input type="checkbox"/> No <input type="checkbox"/> (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 3217-e § 4306-d PHL § 4403(7) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language | If this policy or contract requires or provides for designation of a PCP the policy or contract must permit an insured to designate any participating PCP who is available to accept the insured. 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. | |
| Direct Access to OB/GYN Services Does this product require a PCP to be designated? Yes <input type="checkbox"/> No <input type="checkbox"/> (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 3217-c § 4306-b(a) § 4324(16-a) PHL § 4406-b PHL § 4408(1)(p-1) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language | If the policy or contract requires the designation of a PCP, it must provide a female insured 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: <ul style="list-style-type: none"> • Such qualified provider discusses such services and treatment plan with the individual's primary care practitioner in accordance with the insurer's requirements; and • 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. | |
| Direct Access to Maternal Depression Screenings | § 3217-g § 4306-f § 4406-f PHL § 2500-k | To the extent a policy or contract provides coverage for maternal depression screening, no insurer may limit a insured's direct access to screening and referral for maternal depression, as defined in subdivision one of section twenty-five hundred-l of the public health law, from a provider of obstetrical, gynecologic, or pediatric services of her choice; provided that the insured's access to such services, coverage and choice of provider is otherwise subject to the terms and conditions of the contract or policy under which the insured is covered. | |
| Preauthorization | | | |
| Preauthorization Requirements | § 3217-a(a)(2) | This policy or contract form includes a description of all preauthorization or other notification | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

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| <p>(Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3238 § 4324(a)(1) PHL § 4408(1)(b) Model Language</p> | <p>requirements for treatments and services. If the policy or contract form requires a gatekeeper, the preauthorization requirements may not be imposed on the insured for in-network services. A preauthorization or notification penalty of either 50% of the allowable amount for services rendered or \$500.00, whichever is less, is permissible.</p> | |
| Medical Necessity | | | |
| <p>Definition of Medical Necessity (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3217-a(a)(1) § 4324(a)(1) Model Language</p> | <p>This policy or contract includes a definition of “medical necessity” used in determining whether benefits will be covered.</p> | |
| <p>Contact Information (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3217-a(a)(16) § 4324(a)(16) PHL § 4408(1)(q) Model Language</p> | <p>This policy or contract includes all appropriate mailing addresses and telephone numbers to be utilized by insureds seeking information or authorization.</p> | |
| Protection from Surprise Bills | | | |
| <p>Protection from Surprise Bills and IDR Process (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>Article 6 of the Financial Services Law (Chapter 60 of the Laws of 2014) Model Language</p> | <p>The policy or contract form shall provide that the insured will be held harmless for any non-participating physician charges for a surprise bill that exceeds an insured’s copayment, coinsurance or deductible if the insured assigns benefits in writing to the non-participating physician. The non-participating physician may only bill an insured for a copayment, coinsurance or deductible.</p> <p>The policy or contract form also includes a description of the independent dispute resolution process.</p> | |
| Delivery of Covered Services Using Telehealth | | | |
| <p>Delivery of Covered Services Using Telehealth Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3217-h § 4306-6 PHL § 4406-g Model Language</p> | <p>An insurer shall not exclude from coverage a service that is otherwise covered under a policy that provides comprehensive coverage for hospital, medical, or surgical care because the service is delivered via telehealth, however, an insurer may exclude from coverage a service by a health care provider where the provider is not otherwise covered under the policy. An insurer may subject the coverage of services delivered via telehealth to reasonable utilization review and quality assurance requirements that are at least as favorable as those requirements for the same service when not delivered using telehealth.</p> <p>An insurer may subject the coverage of services delivered via telehealth to copayments, coinsurance or deductibles provided that they are at least as favorable to the insured as those established for the same service when not delivered via telehealth.</p> <p>“Telehealth” means the use of electronic information and communication technologies by a provider to deliver health care services to an insured while the insured is located at a site that is different from the site where the provider is located.</p> | |
| Case Management | | | |
| <p>Case Management Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3201(c)(3) Model Language</p> | <p>Where applicable, this policy or contract form includes a description of the case management procedures for members with health care needs due to serious, complex, and/or chronic health conditions.</p> | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

| ACCESS TO CARE AND TRANSITIONAL CARE | | <i>The following standards are required, as applicable. Use of the model language is required.</i> | |
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| Referral or Authorization to Non-Participating Providers (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 4804(a) § 3217-a(a)(11) § 3217-d(d) § 4324(a)(12) § 4306-C(b) PHL § 4408(1)(l) Model Language | If a policy or contract form is a managed care product as defined in § 4801(c) or a HMO, or an EPO or a comprehensive insurance product that uses a network of providers it must describe how an insured may obtain a referral or authorization to a health care provider outside of the insurer's network when the insurer does not have a health care provider with appropriate training and experience in the network to meet the health care needs of the insured and the procedure by which the insured can obtain such referral or authorization. | |
| Specialty Care Provider as PCP (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 4804 (b) § 3217-a(a)(13) § 3217-d(b) § 4324(a)(13) § 4306-C(b) PHL § 4408(1)(m) Model Language | If this policy or contract form requires (i) the designation of a PCP, and (ii) that specialty care must be provided pursuant to a referral from a PCP, then it must include a notice that an insured 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, is permitted to request that a specialist be designated as their PCP to provide or coordinate the insured's medical care and describe the procedure for requesting and obtaining a specialist as a PCP. | |
| Standing Referrals (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 4804(c) § 3217-a(a)(12) § 3217-d(b) § 4324(a)(12) § 4306-C(b) PHL § 4408(1)(l) Model Language | If this policy or contract requires (i) the designation of a PCP, and (ii) that specialty care must be provided pursuant to a referral from a PCP, it must include a notice that an insured with a condition which requires on-going care from a specialist, may request a standing referral to such specialist and describe the procedure for requesting and obtaining such a standing referral. | |
| Specialty Care Center (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 4804 (d) § 3217-a(a)(14) § 3217-d(b) § 4324(a)(14) § 4306-C(b) PHL § 4408(1)(n) Model Language | If this policy or contract requires (i) the designation of a PCP, and (ii) that specialty care must be provided pursuant to a referral from a PCP, then it must include a notice that an insured 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 describe the procedure for requesting and obtaining such a referral to a specialty care center. | |
| Transitional Care When a Provider Leaves the Network (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 4804(e) § 3217-d(c) § 4306-C(c) PHL § 4403(6)(e) Model Language | If an insured is in an ongoing course of treatment when a provider leaves the network, then the policy or contract form must describe how an insured may to continue to receive treatment for the ongoing treatment from the former participating provider for up to 90 days from the date the provider's contractual obligation to provide services terminated. If the insured is pregnant and in the second or third trimester, the insured may be able to continue care with a former participating provider through delivery and any postpartum care directly related to the delivery. In order for the insured to continue to receive care for up to 90 days or through a pregnancy with a former participating provider, the provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of the insurer's contractual agreement with the provider and must also agree to provide the insurer with the necessary medical information related to the insured's care and adhere to the insurer's policies and procedures, including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider. | |
| Transitional Care For a New Member in a Course of Treatment | § 4804(f) § 3217-d(c) § 4306-C(c) | If an insured is in an ongoing course of treatment with a non-participating provider when the insured's coverage becomes effective for (i) a life-threatening disease or condition or a degenerative and disabling condition or disease, or (ii) care for pregnancy if the insured is in the second or third | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

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| <p>(Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>PHL § 4403(6)(f) Model Language</p> | <p>trimester, then this policy or contract form must describe how the insured may continue to receive care for the ongoing course of treatment from the non-participating provider for up to 60 days from the effective date of the insured's coverage. The insured may continue care through delivery and any post-partum services directly related to the delivery.</p> <p>In order for the insured to continue to receive care for up to 60 days or through pregnancy, the nonparticipating provider must agree to accept as payment the insurer's fees for such services. The provider must also agree to provide the insurer with necessary medical information related to the insured's care and to adhere to the insurer's policies and procedures including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.</p> | |
| <p>COST SHARING EXPENSES AND ALLOWED AMOUNT</p> | | <p><i>The following standards are required. Use of the model language is recommended.</i></p> | |
| <p>Cost of Service (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3201(c)(3) 11 NYCRR 52.1(c) Model Language</p> | <p>If the cost of the service is less than the copayment for the service, the patient is responsible for the lesser amount.</p> | |
| <p>Maximum Out-of-Pocket Limit (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>IRC § 223(c)(2)(A)(ii) 42 USC § 300gg-6 45 CFR § 155.20 45 CFR § 156.20 Model Language</p> | <p>The cost-sharing for in-network services may not exceed the dollar amounts in effect under § 223(c)(2)(A)(ii) of the Internal Revenue Code. For 2015, the amounts are \$6,600 for individual coverage and \$13,200 for other than individual coverage (e.g., individual/spouse, parent and child/children and family).</p> | |
| <p>Non-Participating Providers and Non-Authorized Services (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3217-a(a)(6) § 4324(a)(6) PHL § 4408(1)(f) Model Language</p> | <p>This policy or contract 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.</p> | |
| <p>Reimbursement of Providers (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3217-a(a)(4) § 4324(a)(4) PHL § 4408(1)(d) Model Language</p> | <p>This policy or contract includes a description of the types of methodologies the insurer uses to reimburse providers.</p> | |
| <p>WHO IS COVERED</p> | | <p><i>The following standards are required. Use of the model language is recommended except where noted as required.</i></p> | |
| <p>Spouse (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 4235(f)(1)(A) § 4305(c)(1) Circular Letter No. 27 (2008) Model Language</p> | <p>If dependent coverage is selected by the policyholder or contractholder, this policy or contract 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.</p> | |
| <p>Dependents</p> | <p>§ 4235(f)(1)(A)(i) § 3221(a)(7) § 4305(c)(1)</p> | <p>If dependent coverage is selected by the policyholder or contractholder, this policy or contract provides coverage of children until age 26.</p> | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

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| <p>(Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>42 USC §300gg-14 45 CFR § 147.120 Model Language</p> | <p><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></p> | |
| <p>Extended Dependent Coverage (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 4235(f)(1)(B) § 4305(c)(1) Model Language</p> | <p>If dependent coverage is selected by the policyholder or contractholder, this policy or contract must make available and if requested by the policyholder or contractholder, 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.</p> <p>The company must comply with the notice requirements set forth in 4235(f).</p> | |
| <p>Unmarried Students on Medical Leave of Absence</p> | <p>§ 3237 § 4306-a 42 USC §300gg-7</p> | <p>If this policy or contract 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.</p> | |
| <p>Unmarried Disabled Children (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 4235(f)(1)(A)(ii) § 4305(c)(1) Model Language</p> | <p>If dependent coverage is selected by the policyholder or contractholder, this policy or contract provides coverage for unmarried disabled children, regardless of age, who are incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap, and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate.</p> <p><i>Note: Such coverage shall not terminate while the policy or contract 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></p> | |
| <p>Newborn Infants (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 4235(f)(2) § 4305(c)(1) Model Language</p> | <p>If dependent coverage is selected by the policyholder or contractholder, this policy or contract 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.</p> <p><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></p> | |
| <p>Adopted Children and Step-Children</p> | <p>11NYCRR52.18(e)(2); (3)</p> | <p>If dependent coverage is selected by the policyholder or contractholder, this policy or contract provides that adopted children and stepchildren dependent upon the insured are eligible for coverage</p> | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

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| (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 4305(c)(1) Model Language | on the same basis as natural children. Further, a family policy or contract 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. | |
| (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 4235(f)(1)(A) § 4305(c)(1) OGC Opinion 01-11-23 Model Language | This policy or contract may cover domestic partners, who are financially interdependent on the employee or member, but such coverage is not required. If such coverage is provided, the policy or contract shall require the applicant to provide the following: <ul style="list-style-type: none"> • Registration as a domestic partner or an affidavit of domestic partnership. • Proof of cohabitation • 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. | |
| New Family Members (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | Model Language | The policy or contract describes the requirements to add new family members to the policy or contract. | |
| New Employees | § 3221(a)(3) | New employees or members of the class must be added to the class for which they are eligible. | |
| (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | 11NYCRR52.70(e)(3) § 3221(q)(5) Model Language | This policy or contract 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). <i>Note: If a certificate holder fails to timely enroll a newborn pursuant to the terms of the policy or contract, the insurer may deny enrollment of the newborn only for the period of time prior to the certificate holder's untimely request for enrollment of the newborn.</i> | |
| MANDATORY COVERED BENEFITS | | <i>The following standards are required. Use of Model language is required except where noted as recommended.</i> | |
| PREVENTIVE CARE | | <i>Use of Model language is required except where noted as recommended.</i> | |
| Primary and Preventive Health Services | § 3221(l)(8) § 3221(k)(18) § 4303(j) | This policy includes the following coverage for primary and preventive health services for a covered child from the date of birth through age 19: <ul style="list-style-type: none"> • An initial hospital check-up and well child visits scheduled in accordance with the American | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

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| <p>(Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>Circular Letter No. 3 (1994) Circular Letter No. 13 (2006) Required Immunizations</p> <p>42 USC § 300gg-13 45 CFR §147.130</p> <p>Model Language HRSA Guidelines</p> | <p>Academy of Pediatrics.</p> <ul style="list-style-type: none"> 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. <p>Such coverage shall not be subject to annual deductibles and/or coinsurance.</p> <p>If the policy or contract 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"> Evidence-based items or services for children and adults with a rating of A or B by the U.S. Preventive Services Task Force (“USPSTF”). Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Preventive care and screenings for infants, children and adolescents in guidelines supported by the Health Resources and Services Administration (“HRSA”). Preventive care and screenings for women in guidelines supported by HRSA. <p><i>Note: Every policy or contract that provides medical, major medical or similar comprehensive-type coverage that includes coverage for a physical or well care visit once in every 365 days shall be interpreted to mean that such physical or well care visit can be had once every calendar year, regardless of whether or not 365 days has passed since the previous physical or well care visit.</i></p> <p><i>Note: For new items or services added to the list of recommended preventive services receiving an A or B rating from the United States Preventive Services Task Force, or new recommendations from HRSA, insurers should provide the required coverage for such items or services no later than six months from when the recommendation is made.</i></p> | |
| <p>Federally Mandated Preventive Health Services</p> <p>(Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>42 USC § 300gg-13 45 CFR §147.130</p> <p>Model Language HRSA Guidelines</p> | <p>If the policy or contract is not “grandfathered” pursuant to 42 U.S.C. §18011(e), it must provide coverage for the following preventive care and screenings for children and adults with no cost-sharing:</p> <ul style="list-style-type: none"> Evidence-based items or services for children and adults with a rating of “A” or “B” by the U.S. Preventive Services Task Force (“USPSTF”). Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Preventive care and screenings for infants, children and adolescents in guidelines supported by the Health Resources and Services Administration (“HRSA”). Preventive care and screenings for women in guidelines supported by the HRSA. <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance.</p> <p><i>Note: For new items or services added to the list of recommended preventive services receiving an A or B rating from the United States Preventive Services Task Force, or new recommendations from HRSA, insurers should provide the required coverage for such items or services no later than six months from when the recommendation is made.</i></p> | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

| | | | |
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| <p>Cervical Cytology Screening</p> <p>(Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3221(l)(14) § 4303(t) 42 USC §300gg-13 45 CFR §147.130</p> <p>Model Language HRSA Guidelines</p> | <p>This policy or contract form includes coverage for annual cervical cytology screening for cervical cancer and its precursor states for women age 18 and older. Cervical cytology screening includes an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.</p> <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines if the policy or contract is not “grandfathered” pursuant to 42 U.S.C. §18011(e).</p> <p><i>Note: For new items or services added to the list of recommended preventive services receiving an A or B rating from the United States Preventive Services Task Force, or new recommendations from HRSA, insurers should provide the required coverage for such items or services no later than six months from when the recommendation is made.</i></p> | |
| <p>Mammography Screening</p> <p>(Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3221(l)(11) § 4303(p) 42 USC §300gg-13 45 CFR §147.130</p> <p>Model Language HRSA Guidelines</p> | <p>This policy or contract form includes the following coverage for mammography screening for occult breast cancer:</p> <ul style="list-style-type: none"> • 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. • A single, baseline mammogram for covered persons age 35-39, inclusive. • An annual mammogram for covered persons age 40 and older. <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines if the policy or contract is not “grandfathered” pursuant to 42 U.S.C. §18011(e).</p> <p><i>Note: For new items or services added to the list of recommended preventive services receiving an A or B rating from the United States Preventive Services Task Force, or new recommendations from HRSA, insurers should provide the required coverage for such items or services no later than six months from when the recommendation is made.</i></p> | |
| <p>Family Planning and Reproductive Health Services</p> <p>(Required, with changes permitted) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>45 CFR §147.130</p> <p>Model Language 42 USC § 300gg-13 HRSA Guidelines</p> | <p>This policy or contract form includes coverage for family planning services which consist of federal Food and Drug Administration (“FDA”) approved contraceptive methods prescribed by a provider (not covered under the prescription drug benefits), counseling on use of contraceptives, related topics and sterilization procedures for women. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF. See the Contraceptive Drugs and Devices section for information regarding the religious employer exemption.</p> <p><i>Note: For new items or services added to the list of recommended preventive services receiving an A or B rating from the United States Preventive Services Task Force, or new recommendations from HRSA, insurers should provide the required coverage for such items or services no later than six months from when the recommendation is made.</i></p> | |
| <p>Bone Mineral Density Measurements or Tests, Drugs and Devices</p> | <p>§ 3221(k)(13) § 4303(bb) 42 USC §300gg-13</p> | <p>This policy or contract form includes coverage for bone mineral density measurements or tests, prescription drugs, and devices approved by the FDA or generic equivalents as approved substitutes. Bone mineral density measurements or tests, drugs or devices include those covered for individuals</p> | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

| | | | |
|---|---|--|--|
| <p>(Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>45 CFR §147.130 Model Language</p> | <p>meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. Individuals qualifying for coverage, at a minimum, include individuals:</p> <ul style="list-style-type: none"> • Previously diagnosed as having osteoporosis or having a family history of osteoporosis; • With symptoms or conditions indicative of the presence or significant risk of osteoporosis; • On a prescribed drug regimen posing a significant risk of osteoporosis; • With lifestyle factors to a degree as posing a significant risk of osteoporosis; or, • With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis. <p>If the policy or contract is not “grandfathered” pursuant to 42 U.S.C. §18011(e), such coverage, when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF, shall not be subject to deductibles, copayments and/or coinsurance. Other such coverage provided may be subject to deductibles, copayments and/or coinsurance.</p> <p><i>Note: For new items or services added to the list of recommended preventive services receiving an A or B rating from the United States Preventive Services Task Force, or new recommendations from HRSA, insurers should provide the required coverage for such items or services no later than six months from when the recommendation is made.</i></p> | |
| <p>Prostate Cancer Screening</p> <p>(Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3221(l)(11-a) § 4303(z-1) Model Language</p> | <p>This policy or contract form includes coverage for the diagnostic screening for prostate cancer including:</p> <ul style="list-style-type: none"> • 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 • An annual standard diagnostic examination for men age 50 and over who are asymptomatic and for men age 40 or older with a family history of prostate cancer or other prostate cancer risk factors. <p>Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent of the New York State Department of Financial Services (“Superintendent”) and as are consistent with other benefits within the policy or contract form.</p> | |
| <p>PRE-HOSPITAL EMERGENCY MEDICAL SERVICES & EMERGENCY SERVICES</p> | | <p><i>The following standards are required. Use of Model language is required except where noted as recommended.</i></p> | |
| <p>Pre-Hospital Emergency Medical Services</p> <p>(Required for the first 3 paragraphs) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3221(l)(15) § 4303(aa) Model Language</p> | <p>This policy or contract includes coverage for pre-hospital emergency medical services for the treatment of an emergency condition when such services are provided by an ambulance service issued a certificate to operate pursuant to §3005 of the Public Health Law.</p> <p>“Pre-hospital emergency medical services” means the prompt evaluation and treatment of an emergency condition and/or non-airborne transportation to a hospital. The services must be provided by an ambulance service issued a certificate under the Public Health Law. Coverage will be provided for transportation to a hospital provided by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:</p> | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

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| | | <p>Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;</p> <ul style="list-style-type: none"> • Serious impairment to such person’s bodily functions; • Serious dysfunction of any bodily organ or part of such person; or • Serious disfigurement of such person. <p>An ambulance service may not charge or seek reimbursement from the insured for pre-hospital emergency medical services except for the collection of any applicable copayment, deductible or coinsurance.</p> | |
| <p>Emergency Services</p> <p>(Required for paragraph “A”) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3221(k)(4) § 3217-a(a)(8) § 4900(c) § 4303(a)(2) PHL § 4408(1)(h)</p> <p>Circular Letter No.1 (2002)</p> <p>42 USC §300gg-19a 45 CFR § 147.138(b)</p> <p>Model Language</p> | <p>This policy or contract includes coverage for the treatment of an emergency condition in hospital facilities:</p> <ul style="list-style-type: none"> • Without the need for any prior authorization; • Regardless of whether the provider is a participating provider; • Without imposing any administrative requirement or limitation on out-of-network coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers; • The cost-sharing (co-payment or coinsurance) shall be the same regardless of whether the services are provided by a participating or a non-participating provider; and • The benefits for out-of-network emergency services must at a minimum equal the greatest of the following amounts: (i) the amount negotiated with in-network providers for the emergency service; (ii) the amount for the emergency service calculated using the same method the insurer uses to determine payments for out-of-network services excluding any in-network co-payment or coinsurance; or the amount that would be paid under Medicare for the emergency service excluding any in-network co-payment or coinsurance. • The policy or contract form shall provide that the insured shall be held harmless for any non-participating provider charge for emergency services that exceeds the in-network copayment, coinsurance or deductible. • If a dispute involving a payment for emergency services provided by a physician is submitted to an independent dispute resolution entity (“IDRE”), the insurer must pay the amount, if any, determined by the IDRE for physician services. <p>Note the following definitions must be used: Emergency condition means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:</p> <ul style="list-style-type: none"> • Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; • Serious impairment to such person’s bodily functions; • Serious dysfunction of any bodily organ or part of such person; or • Serious disfigurement of such person. | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

| | | | |
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| | | Emergency services means a medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such emergency condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an emergency condition as may be necessary to assure that, within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a facility, or to deliver a newborn child (including the placenta). | |
| OUTPATIENT SERVICES, INPATIENT SERVICES, EQUIPMENT AND DEVICES | | <i>The following standards are required. Use of Model language is required except where noted as recommended.</i> | |
| Chiropractic Care (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 3221(k)(11) § 4303(y) Model Language | <p>This policy or contract 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 or contract 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 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 or contract 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 or contract. Additionally, a policy or contract 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 or contract 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> | |
| Clinical Trials (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | 42 U.S.C. § 300gg-8 Model Language | <p>This policy or contract provides coverage for the routine patient costs for participation in an "approved clinical trial" and such coverage shall not be subject to Utilization Review if the insured is: (i) eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition; and (2) is referred by a Participating Provider who has concluded that the insured's participation in the approved clinical trial would be appropriate.</p> <p>An "approved clinical trial" means a phase I, II, III, or IV clinical trial that is: (i) a federally funded or approved trial; (ii) conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or (iii) a drug trial that is exempt from having to make an investigational new drug application.</p> | |
| Dialysis Coverage | § 3221(k)(16) § 4303(gg) | If the policy or contract does not otherwise cover out-of-network services, dialysis treatment or services provided by a non-participating provider must be covered if the following conditions are | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

| | | | |
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| <p>(Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>Model Language</p> | <p>met:</p> <ul style="list-style-type: none"> • The out-of-network provider is duly licensed to practice and authorized to provide such treatment; • The out-of-network provider is located outside the service area of the insurer; • The in-network provider treating the insured for the condition issues a written order stating that the dialysis treatment is necessary; • 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; • The insurer has the right to pre-approve the dialysis treatment schedule; and • Such coverage may be limited to 10 out-of-network treatments in a calendar year. <p>Benefits for services of a non-participating provider are subject to any applicable cost-sharing that applies to dialysis treatments by a participating provider. However, the insured will also be responsible for paying any difference between the amount the insurer would have paid had the service been provided by a participating provider and the non-participating provider's charge.</p> | |
| <p>Home Health Services</p> <p>(Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3221(k)(1) § 4303(a)(3)</p> <p>Model Language</p> | <p>This policy or contract includes coverage of home care for not less than 40 visits in any calendar year or continuous twelve month period for each person covered under the policy or contract if hospitalization or confinement in a nursing facility would otherwise be required. Home care must be provided by an agency possessing a valid certificate of approval or license issued pursuant to Article 36 of the Public Health Law and shall consist of one or more of the following:</p> <ul style="list-style-type: none"> • Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse. • Part-time or intermittent home health aide services which consist primarily of caring for the patient. • Physical, occupational or speech therapy if provided by the home health service or agency. • Medical supplies, prescription drugs and medications prescribed by a physician and laboratory services by or on behalf of a certified or licensed home health agency. • Each visit by a member of a home care team shall be considered as one home care visit. • Four hours of home health aide service shall be considered as one home care visit | |
| <p>Treatment of Correctable Medical Conditions that Cause Infertility/Infertility Treatments</p> <p>(Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3221(k)(6) § 4303(s)</p> <p>11 NYCRR 52.18(a)(10)</p> <p>Definition of Infertility</p> <p>OGC Opinion 05-11-10 Model Language</p> | <p>This policy or contract shall not exclude coverage for hospital, surgical or medical care for the diagnosis and treatment of correctable medical conditions otherwise covered under the policy or contract solely because the medical condition results in infertility.</p> <ul style="list-style-type: none"> • Coverage shall not exclude surgical or medical procedures which would correct malformation, disease or dysfunction resulting in infertility. • Coverage shall not exclude diagnostic tests and procedures including hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysteroqram, 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 or contract. • 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 or contract. | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

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| | | <ul style="list-style-type: none"> 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 are the only infertility treatments that may be expressly excluded in the policy or contract. | |
| <p>Preadmission Testing</p> <p>(Required)</p> <p>Model Language Used?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3221(k)(2) § 4303(a)(1) Model Language</p> | <p>This policy or contract includes coverage for preadmission testing ordered by a physician performed in the out-patient facilities of a hospital as a planned preliminary to admission of the patient as an in-patient for surgery in the same hospital provided that: tests are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed; reservations for a hospital bed and for an operating room were made prior to the performance of the tests; the surgery actually takes place within seven days of the tests; and the patient is physically present at the hospital for the tests.</p> | |
| <p>Second Medical Opinion for Cancer Diagnosis</p> <p>(Required)</p> <p>Model Language Used?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3221(k)(9) § 4303(w) Model Language</p> | <p>This policy or contract 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"> 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. 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. <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 or contract.</p> | |
| <p>Second Surgical Opinion</p> <p>(Required)</p> <p>Model Language Used?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3221(k)(3) § 4303(b) Circular Letter No. 29 (1979) Model Language</p> | <p>This policy or contract form includes coverage for a second surgical opinion by a qualified physician on the need for surgery.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p> | |
| <p>Mandatory Second Surgical Opinion</p> <p>(Required)</p> <p>Model Language Used?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3221(k)(3) § 4303(b) Circular Letter No. 29 (1979) Model Language</p> | <p>The policy or contract form may contain a mandatory second surgical opinion provision only if such provision is consistent with Circular Letter No. 29 (1979).</p> <p>Such coverage may not be subject to deductibles, copayments and/or coinsurance.</p> | |
| <p>Surgical Services</p> <p>(Required)</p> <p>Model Language Used?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>11 NYCRR § 52.6 Model Language</p> | <p>This policy or contract includes coverage for physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or specialist, assistant (including a physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p> | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

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| <p>Oral Surgery</p> <p>(Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>11 NYCRR § 52.16(c)(9) Model Language</p> | <p>This policy or contract form provides coverage for the following limited dental and oral surgical procedures due to accidental injury to sound natural teeth within 12 months of the accident or dental care or treatment necessary due to congenital disease or anomaly.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p> | |
| <p>Post Mastectomy Reconstruction</p> <p>(Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3221(k)(10) § 4303(x) Model Language Women’s Health and Cancer Rights Act of 1999, 29 USC 1185b</p> | <p>This policy or contract 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 or contract.</p> | |
| <p>Autism Spectrum Disorder</p> <p>(Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3221(l)(17) § 4303(ee) Model Language 11 NYCRR 440</p> | <p>This policy or contract 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"> • Behavioral health treatment; • Psychiatric care; • Psychological care; • Medical care provided by a licensed health care provider; • Therapeutic care, including therapeutic care which is deemed habilitative or nonrestorative, in the event that the policy or contract provides coverage for therapeutic care; and • Pharmacy care in the event that the policy or contract provides coverage for prescription drugs. <p>This policy or contract 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.</p> <p>The policy or contract 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 analysis provider as defined and described in 11 NYCRR 440, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.</p> <p>The policy or contract shall include coverage for “applied behavior analysis” which means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and 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.</p> <p>The policy or contract 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> | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

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| | | Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form. | |
| Diabetes Equipment, Supplies and Self-Management Education (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 3221(k)(7) § 4303(u) Model Language | This policy or contract 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 or contract. Note: This benefit must appear in the base policy or contract 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 or contract (i.e. lower cost sharing). <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 or contract may not limit coverage to care prescribed by a physician.</i> | |
| Hospital Services (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | 11 NYCRR 52.5 Model Language | This policy or contract provides coverage for inpatient hospital services for acute care, for an illness, injury or disease of a severity that must be treated on an inpatient basis, including: <ul style="list-style-type: none"> • Semiprivate room and board; • General, special, and critical nursing care; • Meals and special diets; • The use of operating, recovery, and cystoscopic rooms and equipment; • The use of intensive care, special care, or cardiac care units and equipment; • Diagnostic and therapeutic items, such as drugs and medications, sera, biological and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the hospital; • Dressings and plaster casts; • Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, x-ray examinations and radiation therapy, laboratory and pathological examinations; • Blood and blood products except when participation in a volunteer blood replacement program is available; • Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation; • Short-term physical, speech and occupational therapy; and • Any additional medical services and supplies which are customarily provided by hospitals. <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p> | |
| Maternity Care (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 3221(k)(5) § 4303(c) Model Language 29 USC § 1185 | This policy or contract includes coverage for maternity care, to the same extent as coverage provided for illness or disease under the policy or contract. <ul style="list-style-type: none"> • 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. • 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. | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

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| | | <ul style="list-style-type: none"> • 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 • Maternity coverage also includes parent education, training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments. | |
| Mastectomy Care (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 3221(k)(8) § 4303(v) Model Language Women’s Health and Cancer Rights Act of 1999, 29 USC 1185b | This policy or contract includes coverage for a period of inpatient hospital care as is determined by the attending physician in consultation with the patient to be medically appropriate for a person undergoing a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered under the policy or contract, and any physical complications arising from the mastectomy, including lymphedema. 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 or contract. | |
| End of Life Care (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 4805 PHL § 4406-e Model Language | This policy or contract form provides coverage for acute care provided in a licensed Article 28 facility or acute care facility that specializes in the care of terminally ill patients if the subscriber is diagnosed with advanced cancer and has fewer 60 days to live. | |
| Ostomy Equipment and Supplies | § 3221(k)(19) § 4303(u-1) | This policy or contract provides coverage for equipment and supplies used for the treatment of ostomies, if prescribed by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law. Such coverage shall be subject to annual deductibles and coinsurance as deemed appropriate by the superintendent. | |
| MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES | | <i>The following standards are required. Use of Model language is required except where noted as recommended.</i> | |
| Inpatient Mental Health Care Services (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> Confirm that the cost-sharing for mental health services complies with all requirements under MHPAEA. Yes <input type="checkbox"/> No <input type="checkbox"/> | § 3221(l)(5) § 4303(g) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 Model Language | This policy or contract form provides coverage for inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders at least equal to the coverage provided for other health conditions under this policy or contract. Coverage for inpatient services for mental health care is limited to facilities as defined in Mental Hygiene Law § 1.03(10), and, in other states, to similarly licensed or certified facilities. Coverage for inpatient mental health care also includes services received at residential treatment facilities, including room and board charges. Coverage for residential treatment services is limited to facilities defined in Mental Hygiene Law § 1.03(33) and, in other states, to similarly licensed or certified facilities. Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with the federal Mental Health Parity Addiction Equity Act (“MHPAEA”). <i>Note: Under MHPAEA, group health policies or contracts 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 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 or contract form. The MHPAEA also prohibits such policy or contract forms from imposing</i> | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

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| | | <p><i>separate cost-sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract 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> | |
| <p>Outpatient Mental Health Care Services</p> <p>(Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Confirm that the cost-sharing for mental health services complies with all requirements under MHPAEA. Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3221(1)(5) § 4303(g) § 4303(h) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 Model Language</p> | <p>This policy or contract form provides coverage for outpatient mental health care services including, but not limited to, partial hospitalization program and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Such coverage is limited to facilities that have been issued an operating certificate pursuant to Article 31 of the Mental Hygiene Law or are operated by the New York State Office of Mental Health and, in other states, to similarly licensed or certified facilities; and services provided by a psychiatrist or psychologist licensed to practice in this state; a licensed clinical social worker who meets the requirements of Insurance Law §§ 3221(1)(4)(D) and 4303(h)(1); or a professional corporation or a university faculty practice corporation thereof.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA.</p> <p><i>Note: Under MHPAEA, group health policy or contract forms 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 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 or contract form. The MHPAEA also prohibits such policy or contract forms from imposing separate cost-sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract 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> | |
| <p>Inpatient Substance Use Services</p> <p>(Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Confirm that the cost-sharing for substance use services complies with all requirements under MHPAEA. Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3221(1)(6) § 4303(k) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 Model Language</p> | <p>This policy or contract form provides coverage for inpatient substance use services relating to the diagnosis and treatment of substance use disorder, including detoxification and rehabilitation services. Inpatient substance use services are limited to facilities in New York which are certified by the Office of Alcoholism and Substance Abuse Services (“OASAS”), and in other states, to those facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.</p> <p>Coverage for inpatient substance use services also includes services received at residential treatment facilities, including room and board charges. Coverage for residential treatment services is limited to Facilities certified by OASAS; and, in other states, to those facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with the federal Mental Health Parity Addiction Equity Act (“MHPAEA”).</p> <p><i>Note: Under MHPAEA, group health policy or contract forms 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 applicable to such mental health or substance</i></p> | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

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| | | <p><i>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 or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost-sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract 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> | |
| <p>Outpatient Substance Use Services</p> <p>(Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Confirm that the cost-sharing for substance use services complies with all requirements under MHPAEA. Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3221(1)(7) § 4303(1) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136 Model Language</p> | <p>This policy or contract form provides coverage for outpatient substance use services relating to the diagnosis and treatment of substance use disorder, including detoxification and rehabilitation services. Such coverage is limited to facilities in New York State, certified by the OASAS or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs or by physicians who have been granted a waiver pursuant to the Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the acute detoxification stage of treatment or during stages of rehabilitation, and, in other states, to those facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use disorder services related to the diagnosis and treatment of alcoholism and/or substance use and/or dependency.</p> <p>Coverage must also be provided for up to 20 outpatient visits for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member: (i) identifies himself or herself as a family member of a person suffering from substance use disorder; and (ii) is covered under the same family policy or contract that covers the person receiving, or in need of, treatment for substance use, and/or dependency. Payment for a family member should be the same amount regardless of the number of family members who attend the family therapy session.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with the federal Mental Health Parity Addiction Equity Act (“MHPAEA”).</p> <p><i>Note: The insurer may not deny coverage to a family member who identifies himself or herself as a family member of a person suffering from substance abuse or dependency and who seeks treatment as a family member who is otherwise covered by the policy or contract. The coverage provided under this statute includes treatment as a family member pursuant to such family member’s own policy or contract provided such family member does not exceed the allowable number of family visits and is otherwise entitled to the coverage pursuant to this mandate.</i></p> <p><i>Note: Under MHPAEA, group health policy or contract forms 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 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 or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost-sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such</i></p> | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

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| | | <i>policy or contract 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> | |
| Services Performed at Comprehensive Care Center for Eating Disorders (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 3221(k)(14) § 4303(dd) Model Language | This policy or contract may not exclude coverage for services covered under the policy or contract 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. | |
| PRESCRIPTION DRUG COVERAGE | | <i>If prescription drugs are covered under this policy or contract, the following mandates apply. Use of Model language for the following mandates is recommended.</i> | |
| Enteral Formulas (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 3221(k)(11) § 4303(y) OGC Opinion 10-12-03 Model Language | If coverage for prescription drugs is provided under the policy or contract, then coverage must be provided for enteral formulas for home use, whether administered orally or via feeding tube, 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. | |
| Off-Label Cancer Drug Usage (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 3221(l)(12) § 4303(q) Model Language | If coverage for prescription drugs is provided under the policy or contract, 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 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 (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 4325(h) PHL § 4406-c(6) Model Language | If coverage for prescription drugs is provided under the policy or contract, the copayment shall not exceed the usual and customary cost of such prescribed drug. | |
| Prohibition for Tier IV Drugs (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 3221(a)(16) § 4303(gg) PHL § 4406-c(7) Model Language | If coverage for prescription drugs is provided under the policy or contract, then the policy or contract 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 | § 3221(k)(17) § 4303(hh) | If coverage for prescription drugs is provided under the policy or contract, then the policy or contract shall allow for the limited refilling of eye drop medication requiring a prescription prior to | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

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| <p>(Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>Model Language</p> | <p>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.</p> | |
| <p>Orally Administered Anticancer Medications (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3221(1)(12-a) § 4303(q-1) Model Language</p> | <p>If coverage for prescription drugs and cancer chemotherapy treatment is provided under the policy or contract, then the policy or contract 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</p> | |
| <p>Mail Order Drugs for Policies With a Provider Network (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3221(1)(18) § 4303(hh) Model Language</p> | <p>If coverage for prescription drugs is provided under the policy or contract, then the policy or contract 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.</p> | |
| <p>Contraceptive Drugs and Devices (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3221(1)(16) § 4303(cc) Model Language</p> | <p>If coverage for prescription drugs is provided under the policy or contract, then coverage for contraceptive drugs and devices must be included except for groups that meet the definition of a religious employer in §§ 3221(1)(16)(A) and 4303(cc)(1)(A) of the Insurance Law. In such cases, the subscriber has option to purchase the coverage of contraceptive drugs and devices by rider. 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 or contract if the policy or contract is "grandfathered" pursuant to 42 U.S.C. §18011(e).</p> <p><i>Note: Since the statute refers to contraceptive drugs and devices prescribed by a physician "or other licensed health care provider legally authorized to prescribe under title eight of the education law...", the policy or contract may not limit coverage to contraceptive drug and devices prescribed by a physician.</i></p> <p>Policies or contracts that are not "grandfathered" must cover contraceptive drugs and devices regardless of whether the policy or contract covers prescription drugs. All FDA approved contraceptive methods, sterilization procedures and patient education and counseling for women with reproductive capacity must be covered. Contraceptive coverage must be provided with no cost sharing.</p> <p><i>Note: For new items or services added to the list of recommended preventive services receiving an A or B rating from the United States Preventive Services Task Force, or new recommendations from HRSA, insurers should provide the required coverage for such items or services no later than six months from when the recommendation is made.</i></p> | |
| <p>ADDITIONAL OPTIONAL BENEFITS</p> | | <p><i>Use of the model language is recommended if including these optional benefits.</i></p> | |
| <p>Acupuncture (Recommended)</p> | <p>Model Language</p> | <p>This policy or contract form may provide coverage for acupuncture.</p> | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

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| Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| Advanced Infertility Services (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | Model Language | This policy or contract form covers advanced infertility services. | |
| Dental Care (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | Model Language | This policy or contract form may provide coverage for dental care. | |
| Durable Medical Equipment and Braces (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | Model Language | This policy or contract may form provide coverage for the rental or purchase of durable medical equipment and braces, including orthotic braces. | |
| Habilitative Services (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | Model Language | This policy or contract form may include coverage for habilitation services. | |
| Laboratory Procedures, Diagnostic Testing and Radiology Services (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | Model Language | This policy or contract form may provide coverage for x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services. | |
| Prosthetics (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | Model Language | This policy or contract form provides coverage for prosthetic devices. | |
| Rehabilitative Services (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | Model Language | This policy or contract form may include coverage for rehabilitation services. | |
| Shoe Inserts (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | Model Language | This policy or contract form may cover shoe inserts that are necessary to: support, restore or protect body function; redirect, eliminate or restrict motion of an impaired body part; or relieve or correct a condition caused by an injury or illness. | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

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| <p>Telemedicine Program (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>Model Language</p> | <p>This policy or contract form covers online internet consultations between the insured and providers who participate in the telemedicine program for medical conditions that are not an emergency condition.</p> | |
| <p>Vision Care (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>Model Language</p> | <p>This policy or contract form may provide coverage for vision care.</p> | |
| <p>Wellness Programs (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3239 Model Language</p> | <p>This policy or contract form should provide a detailed description of the wellness program and/or reward being offered as part of the wellness program. The description should include how the insured accesses and participates in the wellness program, a description of the wellness activities, and the rewards. All wellness programs and any rewards must have a nexus to accident and health insurance.</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.</p> | |
| <p>Additional Benefits Provided in Policy or Contract, or By Rider Additional benefits provided? Yes <input type="checkbox"/> No <input type="checkbox"/> If additional benefits are provided, please explain below:</p> | <p>11 NYCRR 52.1(c)</p> | <p>The policy or contract form, or by rider, may provide new forms of coverage and new ways of reducing health care costs. Innovations should provide health care benefits of real economic value. Innovations should not be designed merely to produce superficial differences or play upon people's fears of particular diseases, be unduly complex and serve to confuse and make intelligent choice more difficult. Benefits which are contrary to the health care needs of the public and only serve to confuse or obfuscate and provide no economic value are prohibited.</p> | |
| <p><u>Benefit Explanation:</u></p> | | | |
| <p>MAKE AVAILABLE BENEFITS</p> | | <p><i>The following benefits must be made available to policyholders or contractholders annually, in writing, and must be included in the policy or contract if requested by the policyholder or contractholder. Use of Model Language is recommended.</i></p> | |
| <p>Care in a Nursing Home or Skilled Nursing Facility (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3221(1)(2) § 4303(d) Model Language</p> | <p>This policy or contract must make available coverage for care in a nursing home, as defined by Public Health Law §2801, or a skilled nursing facility as defined in 42 USC §§1395, when such services are preceded by a hospital stay of at least three days and further hospitalization would otherwise be necessary. In determining the total days of coverage for nursing home care that must be made available, two days of nursing home care is equivalent to one day of hospital care.</p> | |
| <p>Ambulatory Care (Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3221(1)(3)</p> | <p>This policy or contract must make available coverage for ambulatory care in hospital out-patient facilities, as a hospital is defined in Public Health Law §2801 or 42 U.S.C. §1395 and physicians' offices.</p> <p>Ambulatory care in hospital out-patient facilities includes services for diagnostic X-rays, laboratory and pathological examinations, physical, occupational and radiation therapy, and services and medications for nonexperimental cancer chemotherapy and cancer hormone therapy. However, physical therapy services are to be provided in connection for the same illness for which the insured</p> | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

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| | | <p>had been hospitalized or in connection with surgical care, but do not need to be provided if commenced more than six months after discharge from a hospital or the date surgical care was rendered or after 365 days from the date of hospital discharge or the date surgical care was rendered.</p> <p>Ambulatory care in physician's offices includes diagnostic X-rays, radiation therapy, laboratory and pathological examinations, and services and medications used for nonexperimental cancer chemotherapy and cancer hormone therapy.</p> <p><i>Note: It is a violation of section 52.16(c) of Insurance Regulation 62 (11 NYCRR 52) to subject certain services within a class of service to a higher level of cost sharing. For example, it is impermissible to subject high cost radiologic services such as PET scans or CAT scans or other similar services to an increased level of cost sharing as compared to less expensive radiologic services, such as x-rays.</i></p> | |
| <p>Licensed Clinical Social Worker</p> <p>(Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3221(l)(4) § 4303(i) Model Language</p> | <p>If this policy or contract 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 or contract must make available and if requested by the policyholder or contractholder, 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.).</p> | |
| <p>Registered Professional Nurse</p> | <p>§ 3221(l)(9)</p> | <p>If this policy or contract provides coverage for any service within the lawful scope of practice of a duly licensed registered professional nurse, the policy or contract must make available reimbursement when such service is performed by a duly licensed registered professional nurse.</p> | |
| <p>Hospice Care</p> <p>(Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3221(l)(10) § 4303(o) Model Language</p> | <p>This policy or contract must make available at least 210 days of inpatient hospice care in a hospice or in a hospital and home care and outpatient services provided by the hospice, including drugs and medical supplies, and 5 visits for bereavement counseling. Such coverage may be subject to annual deductibles and coinsurance deemed appropriate by the Superintendent and as are consistent with those imposed on other benefits within the policy or contract.</p> <p><i>Note: Hospice care is defined as the care and treatment of an insured who has been certified by the insured's primary attending physician as having a life expectancy of six months or less which is provided by a hospice organization certified pursuant to Article 40 of the Public Health Law or under a similar certification process required by the state in which the hospice is located.</i></p> | |
| <p>Out-of-Network Benefits</p> <p>(Recommended) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3241(b)</p> | <p>For a policy or contract issued or renewed on or after April 1, 2015, if the insurer offers a policy or contract that provides coverage for out-of-network health care services, the policy or contract must make available and, if requested by the policyholder or contractholder, provide at least one option for coverage for at least eighty percent (20% coinsurance for the insured) of the usual and customary cost of each out-of-network health services after imposition of a deductible or any permissible benefit maximum.</p> <p><i>Usual and customary cost is defined as the 80th percentile of all charges for the particular health care service performed by a provider in the same or specialty and provided in the same geographical areas as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent.</i></p> <p><i>Note: This coinsurance listed above shall not apply to emergency care services in hospital facilities or pre-hospital emergency medical services, as defined by §3216(i)(24)(E)(i); (i); 3221(l)(15)(E)(i);</i></p> | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

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| | | <i>4303(aa)(5)(A). The cost-sharing for out-of-network emergency services must be the same as in-network emergency services.</i> | |
| PERMISSIBLE EXCLUSIONS AND LIMITATIONS | 11 NYCRR 52.16(c) | <i>No policy or contract form shall limit or exclude coverage by type of illness, accident, treatment or medical condition, with an exception for the following exclusions.</i> <i>The following exclusions are permissible and all the exclusions need not be included. However, if an exclusion is included, the model language must be used.</i> | |
| Aviation Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | 11 NYCRR 52.16(c)(4)(iii) Model Language | This policy or contract form excludes coverage for services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline. | |
| Convalescent and Custodial Care Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | 11 NYCRR 52.16(c)(11) Model Language | This policy or contract form excludes coverage for services related to rest cures, custodial care or transportation. Custodial care means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include covered services determined to be medically necessary. | |
| Cosmetic Services Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | 11 NYCRR 52.16(c)(5) 11 NYCRR 56 Model Language | This policy or contract form excludes coverage for cosmetic services, prescription drugs, or 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. Cosmetic surgery does not include surgery determined to be medically necessary. If a claim for a procedure listed in 11 NYCRR 56 is submitted retrospectively and without medical information, any denial will not be subject to utilization review unless medical information is submitted. | |
| Coverage Outside of the United States, Canada or Mexico Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | 11 NYCRR 52.16(c)(12) Model Language | This policy or contract form excludes coverage for care or treatment provided outside of the United States, its possessions, Canada or Mexico. | |
| Dental Services Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | 11 NYCRR 52.16(c)(9) Model Language | This policy or contract form excludes coverage for dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or except as required in the oral surgery or pediatric dental benefits, as applicable. | |
| Experimental or Investigational Treatment Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 3221(k)(12) Article 49 Model Language | This policy or contract form excludes coverage for any health care service, procedure, treatment, device, or prescription drug that is experimental or investigational. However, coverage will be provided for experimental or investigational treatments, including, treatment of rare diseases, or patient costs for the insured's participation in a clinical trial, when the denial of services is overturned by an external appeal agent certified by the State. However, for clinical trials, no coverage will be provided for the costs of any investigational drugs or devices, non-health services required for the insured to receive the treatment, the costs of managing the research, or costs that would not be covered under the policy or contract form for non-investigational treatments. | |
| Felony Participation Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | 11 NYCRR 52.16(c)(4)(i) Model Language | This policy or contract form excludes coverage for any illness, treatment or medical condition due to participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of a medical condition, including both physical and mental health conditions. | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

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| Foot Care Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | 11 NYCRR52.16(c)(6) Model Language | This policy or contract form excludes coverage for routine foot care. | |
| Government Facility Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | 11 NYCRR52.16(c)(8) Model Language | This policy or contract form excludes coverage for care or treatment provided in a hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law. | |
| Medically Necessary Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 3201(c)(3) Article 49 Model Language | This policy or contract form generally excludes coverage for any health care service, procedure, treatment, test, device, or prescription drug that is determined to not be medically necessary; however, coverage will be provided when the denial of services is overturned by an external appeal agent certified by the State. | |
| Medicare or Other Governmental Program Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | 11 NYCRR 52.16(c)(8) 52.26(c) Model Language | This policy or contract form excludes coverage for services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid). This policy or contract form may exclude Medicare benefits when coverage continues beyond the insured's eligibility for Medicare, provided appropriate adjustment is made to the premium. | |
| Military Service Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | 11 NYCRR52.16(c)(4) (i) Model Language | This policy or contract form excludes coverage for an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units. | |
| No-Fault Automobile Insurance Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | 11 NYCRR52.16(c)(8) Model Language | This policy or contract form excludes coverage for any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if the insured does not make a proper or timely claim for the benefits available under a mandatory no-fault policy. | |
| Services Separately Billed by Hospital Employees Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | 11 NYCRR52.16(c)(8) Model Language | This policy or contract form excludes coverage for services rendered and separately billed by employees of hospitals, laboratories or other institutions. | |
| Services With No Charge Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | 11 NYCRR52.16(c)(8) Model Language | This policy or contract form excludes coverage for services for which no charge is normally made. | |
| Services not Listed Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 3201(c)(3) Model Language | This policy or contract form excludes coverage for services that are not listed in the policy or contract form as being covered. | |
| Vision Services Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | 11 NYCRR52.16(c)(10) Model Language | This policy or contract form excludes coverage for the examination or fitting of eyeglasses or contact lenses. | |
| War | 11 NYCRR52.16(c)(4) (i) | This policy or contract form excludes coverage for an illness, treatment or medical condition due to war, declared or undeclared. | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

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| Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | Model Language | | |
| Workers' Compensation Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | 11 NYCRR52.16(c)(8) Model Language | This policy or contract form excludes coverage for services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law. | |
| CLAIM DETERMINATIONS | | <i>Use of the model language is required.</i> | |
| Notice of Claim (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 3221(a)(8) § 3224-a Model Language | The policy must provide that the insured has a minimum of 20 days to provide the insurer with written notice of claim. A claim may be submitted electronically. 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. | |
| Submission of Claim (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 3221(a)(9) § 4305(m) Model Language | The policy or contract 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. | |
| GRIEVANCE, UTILIZATION REVIEW AND EXTERNAL APPEAL | | <i>Use of the model language is required.</i> | |
| Grievance Procedures (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 3217-a(a)(7) § 3217-d(a) § 4802 § 4324(a)(7) § 4306-C(a) PHL § 4408(1)(p) PHL § 4408-a Model Language 42 USC §300gg-19 29 CFR §2560.503-1 45 CFR §147.136 | A policy or contract that is a managed care product as defined in §4801(c) or a comprehensive policy or contract 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: <ul style="list-style-type: none"> • The right to file a grievance regarding any dispute between an insured and the insurer; • The right to file a grievance orally when the dispute is about referrals or covered benefits; • The toll-free telephone number which insureds may use to file an oral grievance; • The timeframes and circumstances for expedited and standard grievances; • The right to appeal a grievance determination and the procedures for filing such an appeal; • The timeframes and circumstances for expedited and standard appeals; • The right to designate a representative; • A notice that all disputes involving clinical decisions will be made by qualified clinical personnel; and, • That all notices of determination will include information about the basis of the decision and further appeal rights, if any. | |
| Utilization Review Policies and Procedures (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 3217-a(a)(3) Article 49 § 3217-d(d) § 4306-c(d) § 4324(a)(3) PHL § 4408(1)(c) 42 USC §300gg-19 29 CFR §2560.503-1 45 CFR §147.136 | This policy or contract includes a description of the utilization review policies and procedures, including: <ul style="list-style-type: none"> • The circumstances under which utilization review will be undertaken; • The toll-free telephone number of the utilization review agent; • The timeframes under which utilization review decisions must be made for prospective, retrospective and concurrent decisions; • The right to reconsideration; • The right to appeal, including the expedited and standard appeals processes and the timeframes for such appeals; • The right to designate a representative; • A notice that all denials of claims will be made by qualified clinical personnel and that all | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

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| | Model Language | <p>notices of denials will include information about the basis of the decision;</p> <ul style="list-style-type: none"> • 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 • Further appeal rights, if any. | |
| <p>External Appeal Procedures</p> <p>(Required)</p> <p>Model Language Used?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>Article 49 PHL Article 49 45 CFR §147.136 42 USC § 300gg-19</p> <p>Model Language</p> | <p>This policy or contract form includes a description of the external appeal procedures, including:</p> <ul style="list-style-type: none"> • Instructions on how to request an external appeal; • The circumstances under which an external appeal may be pursued, including a service denied as: <ul style="list-style-type: none"> ○ not medically necessary; ○ experimental/investigational, including clinical trials and treatment for rare diseases; ○ out-of-network denials when the service is not available in-network and the insurer recommends an alternate treatment; ○ out-of-network referral denials on the basis that the insurer has a health care provider in-network with appropriate training and experience to meet the particular health care needs of the insured, and who is able to provide the service; and ○ The timeframe for submitting an external appeal. | |
| COORDINATION OF BENEFITS | | <i>Use of the model language is required.</i> | |
| <p>Coordination of Benefits</p> <p>(Required)</p> <p>Model Language Used?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>11 NYCRR 52.23</p> <p>Model Language</p> | <p>If this policy or contract contains a coordination of benefits provision, then it must comply with 11 NYCRR 52.23.</p> | |
| TERMINATION OF COVERAGE | | <i>The following are the only termination provisions permissible under the Insurance Law. Use of the model language is required.</i> | |
| <p>Termination for Failure to Pay Premiums</p> <p>(Required)</p> <p>Model Language Used?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3221(p)(2)(A) § 4305(j)(2)(A)</p> <p>Model Language</p> | <p>This policy or contract includes a provision permitting the insurer to terminate the policy or contract if the policyholder or contractholder or a participating entity has failed to pay premiums or contributions in accordance with the terms of the policy or contract or the insurer has not received timely premium payments.</p> | |
| <p>Termination for Fraud</p> <p>(Required)</p> <p>Model Language Used?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3221(p)(2)(B) § 4305(j)(2)(B) § 3105</p> <p>Model Language</p> | <p>This policy or contract includes a provision permitting the insurer to terminate the policy or contract if the policyholder or contractholder 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.</p> | |
| <p>Termination for Failure to Comply With a Material Plan Provision</p> <p>(Required)</p> <p>Model Language Used?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3221(p)(2)(C) § 4305(j)(2)(C)</p> <p>Model Language</p> | <p>This policy or contract includes a provision permitting the insurer to terminate the policy or contract if the policyholder or contractholder has failed to comply with a material plan provision relating to employer contribution or group participation rules, as permitted in §4235.</p> | |
| <p>Discontinuation of a Class of Policy</p> | <p>§ 3221(p)(2)(D); § 3221(p)(3)(A)</p> | <p>This policy or contract includes a provision permitting the insurer to discontinue this class of policy or contract upon written notice to each policyholder or contract holder, participant, and beneficiary</p> | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

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| (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 4305(j)(2)(D) § 4305(j)(3)(A) Model Language | not less than 90 days prior to the date of discontinuance. The insurer must offer policyholders or contractholders 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 contractholders 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 (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 3221(p)(2)(D) ; § 3221(p)(3)(B) § 4305(j)(2)(D) § 4305(j)(3)(B) Model Language | This policy or contract 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 or contractholder, participant, and beneficiary at least 180 days prior to the date of discontinuance. | |
| Termination for Failure to Meet Requirements of Group (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 3221(p)(2)(E) § 4235(c)(1) § 4305(j)(2)(E) Model Language | This policy or contract includes a provision permitting the insurer to terminate the policy or contract if the policyholder or contractholder 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 or contract 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 (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 3221(p)(2)(F) § 4305(j)(2)(F) Model Language | This policy or contract includes a provision permitting the insurer, in regard to a network plan, to terminate the policy or contract 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. | |
| Termination by Subscriber (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | Model Language | This policy or contract form describes how the subscriber may terminate the policy and the effective date of such termination. | |
| Rescission (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 3105 § 3204 42 USC § 300gg-12 45 CFR § 147.128 Model Language | No misrepresentation shall avoid coverage or defeat any recovery there under unless the insured makes a misrepresentation that is material and intentional. This policy or contract form may include a provision that in the event a subscriber makes an intentional misrepresentation of material fact in writing upon his/her enrollment application, coverage may be rescinded if the facts misrepresented would have lead the insurer to refuse to issue the coverage. | |
| Notice of Termination (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | 11 NYCRR 52.18(c) Model Language | Unless otherwise specified under the Insurance Law, notices of nonrenewal or termination shall provide at least 30 days prior written notice. | |
| Renewal (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 3221(p) § 3221(a)(5) § 4305(j) 11 NYCRR 52.18(c) Model Language | This policy or contract provides that except as specified in §§ 3221(p) and 4305(j), the insurer must renew or continue in force such coverage at the option of the group. The policy or contract must specify the conditions under which the insurer may refuse to renew the policy or contract. | |
| Premiums Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 3221(a)(4) Model Language | The policy or contract form 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. | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

| LOSS OF COVERAGE | | <i>Use of the model language is required.</i> | |
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| Extension of Benefits (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | 11 NYCRR 52.18(b)(5) and (6) Model Language | If the insured's coverage terminates by reason of termination of active employment, an extended benefit shall be provided during total disability, with respect to the sickness, injury or pregnancy which caused the disability, of at least 12 months subsequent to termination of insurance unless coverage is afforded for the total disability under another group health plan. 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. | |
| Continuation Coverage (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 3221(e)(11) § 3221(m) § 4305(e) COBRA, Title X of Public Law 99-272 Model Language | This policy or contract 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 the group policyholder or contractholder. The Insurance Law permits the policyholder or contractholder to charge an additional 2% administrative fee for continued coverage. The continuation benefits terminate: <ul style="list-style-type: none"> • 36 months after the date the employee or member's benefits would otherwise have terminated because of termination of employment or membership. • 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 or contract. • On the date which the employee or member becomes entitled to coverage under Medicare. • 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. • The end of the period for which premiums were made if the employee or member fails to make timely payment. | |
| Young Adult Option (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> | § 3221(r) § 4305(l) Model Language | This policy or contract 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 or contract, 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 or contract. The company must comply with the notice requirements to each employee or member as set forth in 3221(r). | |
| Suspension of Coverage (Required) | §3221(n) 11NYCRR52.17(a)(9) §§ 4305(g); (h) | This policy or contract provides that: <ul style="list-style-type: none"> • 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. | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

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| <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>Circular Letter No. 7 (2003) USERRA, 38 USC § 4317 Model Language</p> | <ul style="list-style-type: none"> • The insurer will refund any unearned premiums for the period of the suspension. • Persons covered by this policy or contract 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. • Coverage shall be retroactive to the date of termination of the period of active duty. • 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. | |
| <p>Supplementary Coverage for Employees or Members who are also members of the reserve components of the armed services or the National Guard (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3221(n) § 4305(g); (h) Circular Letter No. 7 (2003) Model Language</p> | <p>If the policyholder or contractholder 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>Right to New Policy After Termination (Conversion) (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3221(e), (f), (g) § 4303(d) Model Language</p> | <p>This policy or contract form provides that if the employee under the group policy or contract ceases to be covered because of termination of coverage because of: (i) termination for any reason of his employment; or (ii) termination for any reason whatsoever of the group policy or contract itself, unless the group policy holder has replaced the group policy or contract with similar and continuous coverage for the same group, such employee shall be entitled to a new policy as a direct pay member, covering such member and his eligible dependents.</p> <p>Conversion must also be made available, upon the death of the employee, to the surviving spouse and dependents, and the former spouse of the employee 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 or contract who reaches the age limiting coverage under the group policy or contract or whose young adult coverage terminates.</p> <p>The policy or contract form provides that the employee or his eligible dependents must request conversion within 60 days of the termination of the group coverage at which time they will be offered an individual direct pay contract at each level of coverage (i.e., bronze, silver, gold or platinum) that covers all benefits required by state and federal law. The employee or his eligible dependents must also pay the first premium of the new contract at the time they apply for coverage.</p> | |
| <p>GENERAL PROVISIONS</p> | | <p><i>Use of model language is recommended as applicable. Provisions that are required by the Insurance Law are indicated below.</i></p> | |
| <p>Assignment (Required) Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>Article 6 of the Financial Services Law; Chapter 60 of the Laws of 2014 Model Language</p> | <p>The policy or contract form must state whether or not assignment is permitted. This policy or contract or contract must allow assignment of monies due to the insured's health care provider resulting from a surprise bill for Covered Services.</p> | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

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| <p>Incontestability</p> <p>(Required)</p> <p>Model Language Used?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3221(a)(1) § 4306(e)</p> <p>Model Language</p> | <p>The policy or contract 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.</p> | |
| <p>Who May Change This Policy</p> <p>(Required)</p> <p>Model Language Used?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3221(a)(2) § 4306(e)</p> <p>Model Language</p> | <p>The policy or contract must provide that no agent has the authority to change the policy or contract 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 contract, or by amendment to the policy or contract signed by the policyholder or contractholder and insurer.</p> | |
| <p>Action in Law or Equity</p> <p>(Required)</p> <p>Model Language Used?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3221(a)(14)</p> <p>Model Language</p> | <p>The policy or contract must provide that no action in law or equity shall be brought to recover on the policy or contract prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy or contract 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.</p> | |
| <p>Subrogation</p> <p>(Required if Used)</p> <p>Model Language Used?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>General Obligations Law § 5-335 Civil Practice Law and Rules § 4545(a)</p> <p>Model Language</p> | <p>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).</p> | |
| <p>Unilateral Modification</p> <p>(Required)</p> <p>Model Language Used?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>11NYCRR52.18(a)(8)</p> <p>Model Language</p> | <p>Unilateral modifications by an insurer to an existing policy or contract must be made with at least 30 days prior written notice to the policyholder or contractholder. Unilateral modification by the insurer may be made only at the time of renewal. A contractual requirement to provide prior written termination requires at least 14 days notice. If the policy or contract requires the policyholder or contractholder 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 policyholder or contractholder is required to provide notice to terminate coverage.</p> | |
| <p>HMO Member Handbook Requirements</p> | | <p>If the Company plans to use the policy or contract to satisfy HMO member handbook requirements then the following provisions must be used.</p> | |
| <p>Input in Developing Our Policies</p> <p>Model Language Used?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>Model Language</p> | <p>This policy or contract includes a description of how the insurer may participate in the development of the Company's policies.</p> | |
| <p>Translation Services</p> <p>Model Language Used?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3217-a(a)(15) § 4324(a)(15) PHL § 4408(1)(p)</p> <p>Model Language</p> | <p>This policy or contract includes a description of how the insurer addresses the needs of non-English speaking insureds.</p> | |
| <p>More Information about Your Health Plan</p> <p>Model Language Used?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>PHL § 4408(2)</p> <p>Model Language</p> | <p>The insured can request additional information about his/her coverage. Upon the insured's request, the insurer must provide the following information:</p> <ul style="list-style-type: none"> • A list of the names, business addresses and official positions of the insurer's board of directors, officers and members; and the insurer's most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

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| | | <p>disbursements.</p> <ul style="list-style-type: none"> • The information that the insurer provides the State regarding the insurer’s consumer complaints. • A copy of the insurer’s procedures for maintaining confidentiality of Member information. • A copy of the insurer’s drug formulary. The insured may also inquire if a specific drug is covered. • A written description of the insurer’s quality assurance program. • A copy of the insurer’s medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials. • Provider affiliations with participating hospitals. • A copy of the insurer’s clinical review criteria, and where appropriate, other clinical information the insurer may consider regarding a specific disease, course of treatment or utilization review guidelines. • Written application procedures and minimum qualification requirements for providers. | |
| <p>Your Medical Records and Reports</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>Model Language</p> | <p>This policy or contract includes a description of the mandatory release of insured’s medical information for the purpose of managing the insured’s health care.</p> | |
| <p>Your Rights</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>10 NYCRR 98-1.14(b)(1)</p> <p>Model Language</p> | <p>This policy or contract contains a provision which outlines the insured’s right to access and utilize his/her medical information under this policy or contract.</p> | |
| SCHEDULE OF BENEFITS | | <i>Use of model language is recommended.</i> | |
| <p>Prohibition on Lifetime Dollar Limits on Essential Health Benefits</p> | <p>§ 3217-f 42 USC § 300gg-11 45 CFR § 147.126 Model Language</p> | <p>The policy or contract form 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>Limitations on Annual Dollar Limits on Essential Health Benefits</p> | <p>§ 3217-f § 4306-e 42 USC § 300gg-11 45 CFR § 147.126 Model Language</p> | <p>The policy or contract form may not impose annual dollar limits for essential health benefits.</p> | |
| <p>Insured’s Financial Responsibility for Payment Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p>§ 3217-a(a)(5) § 4324(a)(5) PHL § 4408(1)(e)</p> | <p>This policy or contract 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.</p> | |
| PROVIDER NETWORKS | <p>§ 3201(c) § 3241</p> | <p>Insurers with a network of health care providers must submit the network to DFS for network adequacy review. Insurers shall ensure that the network is adequate to meet the health care needs of insureds and provide an appropriate choice of providers sufficient to render the services covered under the policy or contract. Please refer to the “Network Adequacy Standards and Guidance” document available on the Department’s website, http://www.dfs.ny.gov/insurance/ihealth.htm, for</p> | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

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| | | <p>general instructions regarding the review of networks. The standards for review are the same as those used by the New York State Department of Health. In general, these standards include the following:</p> <ul style="list-style-type: none"> o At least one hospital in each county; however, for Erie, Monroe, Nassau, Suffolk, Westchester, Bronx, Kings, New York and Queens the network will need to include at least 3 hospitals; o A choice of 3 primary care physicians (PCPs) in each county, and potentially more based on enrollment and geographic accessibility; and o At least 2 of each specialist provider type, and potentially more based on enrollment and geographic accessibility. <p>Provide the state tracking number of the filing containing the information described above: _____.</p> <p><i>Note: The Department will not permit 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.</i></p> | |
| MAJOR MEDICAL INSURANCE | 11NYCRR52.7 | <i>If the policy being issued is major medical insurance as defined by 11NYCRR52.7, the following benefits must be included.</i> | |
| Copayments | 11NYCRR52.7 | Copayments may not exceed 25%. | |
| Deductible | 11NYCRR52.7 | <p>A deductible stated on a per-person, per-family, per-illness, per-benefit period, or per-year basis, or a combination of such bases, not to exceed five percent of the lowest overall maximum limit under the policy, unless the policy is written to complement underlying hospital and medical insurance, in which case the deductible may be increased by the amount of the benefits provided by such underlying insurance for at least:</p> <ul style="list-style-type: none"> • Daily room and board as defined in 52.5(a). • Miscellaneous hospital services as defined in 52.5(b) provided that the maximum limitation shall not apply. • Surgical services as defined in 52.6(a). • Anesthetic services as defined in 52.6(b). • In-hospital medical services as defined in 52.6(c). • Mental health care consisting of 30 outpatient visits per year at no less than \$30 per visit and a yearly maximum of no less than \$1,500 and outpatient crisis intervention services consisting of at least three psychiatric emergency visits per year for which benefits shall be no less than \$60 per visit. <i>Note: Mental health care must also comply with §3221(l)(5), and may also be subject to the Federal Mental Health Parity Addiction Equity Act of 2008. Please see the Mandatory Covered Benefits Section for more information.</i> | |
| Out-of-Hospital Care | 11NYCRR52.7(g) | The policy includes coverage for out-of-hospital care consisting of physicians' services rendered on an ambulatory basis for diagnosis and treatment of sickness or injury, including the cost of drugs and medications available only on the prescription of a physician, and diagnostic X-ray, laboratory services, radiation therapy, chemotherapy and hemodialysis ordered by a physician. | |
| Prosthetic Appliances and Durable Medical Equipment | 11NYCRR52.7(h) | The policy includes coverage for prosthetic appliances meaning artificial limbs or other prosthetic appliances (including replacements thereof which are functionally necessary) and the rental or purchase of durable medical equipment required for therapeutic use, including repairs and necessary maintenance of the purchased equipment, not otherwise provided for under a manufacturer's | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

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| | | warranty. | |
| ACTUARIAL SECTION FOR NEW PRODUCT RATE FILINGS ONLY | | <p>Complete this section for all new product forms filings except those filings where a rate filing is unnecessary because: (select one)</p> <ul style="list-style-type: none"> <input type="checkbox"/> The submission contains only application forms, disclosure statements, and/or advertising, OR <input type="checkbox"/> The submission is an out-of-state filing pursuant to Section 3201(b)(2), OR <input type="checkbox"/> The form submission has no premium rate implications and a letter or actuarial memorandum is enclosed that states and justifies this as appropriate. <p>For rate changes to existing products, do NOT complete this section – complete the Existing Products-Rate Requirements section below.</p> | Form/Page/Para Reference |
| ACTUARIAL MEMORANDUM | 11NYCRR52.40(a)(1) | Actuarial qualifications: <ul style="list-style-type: none"> 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 | §3221 §4303 10NYCRR98-1.5(b)(18) 10NYCRR98-1.6(j) 10NYCRR98-1.8 11NYCRR52.40(e) 11NYCRR52.40(f) 11NYCRR52.45(f) 11NYCRR59.5(b) | <ul style="list-style-type: none"> 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); 4303(g); (h). f. Non-claim expense components as a percentage of gross premium. g. Expected loss ratio(s) <input type="text"/> %. | |
| Loss Ratios | 11NYCRR52.45(f) 11NYCRR59.5(b) | Expected loss ratio(s) – with actuarial justification | |
| Reserve Basis | 11NYCRR94 | Description of bases for unpaid claim liabilities and extra reserves (if any). | |
| Actuarial Certification | 11NYCRR52.40(a)(1) | <ul style="list-style-type: none"> 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"/> %. | |
| GROUP RATE MANUAL | 11NYCRR52.40(e)(2) 11NYCRR52.40(e)(3) 11NYCRR52.42(e) 11NYCRR52.45(f) 11NYCRR59.5(b) | <ul style="list-style-type: none"> 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. | |

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Review Standards for Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for
Group Commercial Insurers Subject to Article 32, 43, and HMOs

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| | | <ul style="list-style-type: none"> i. Underwriting guidelines and/or underwriting manual. j. Expected loss ratio(s). | |
| ACTUARIAL SECTION FOR EXISTING PRODUCT RATE FILINGS ONLY | | <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. (For new products, do NOT complete this section – complete the New Products-Rate Requirements section above instead.)</i> | |
| ACTUARIAL MEMORANDUM | 11NYCRR52.40(a)(1) | Actuarial qualifications: <ul style="list-style-type: none"> 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 | 11NYCRR52.40(e) 11NYCRR42.40(f) 11NYCRR52.40(g) 11NYCRR52.45(f) 11NYCRR59.5(b) | <ul style="list-style-type: none"> a. Description of proposed changes in coverage, rates, commissions, underwriting rules, etc. b. History of previous New York rate revisions. c. Provide New York and nationwide claims experience respectively, including: <ul style="list-style-type: none"> (i) Earned premium; (ii) Paid and incurred claims; and (iii) Incurred loss ratios. d. Actuarial justification of proposed rates revision (increase/decrease). e. Non-claim expense components as a percentage of gross premium. f. Impact on rates as a result of each of the changes with actuarial justification. g. Expected loss ratio(s) after the proposed changes. | |
| Loss Ratios | 11NYCRR52.45(f) 11NYCRR59.5(b) | Expected loss ratio(s) – with actuarial justification | |
| Reserve Basis | 11NYCRR94 | Description of bases for unpaid claim liabilities and extra reserves (if any). | |
| Actuarial Certification | 11NYCRR52.40(a)(1) | <ul style="list-style-type: none"> 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”. 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"/> %. | |
| REVISED RATE MANUAL PAGES | 11NYCRR52.40(e)(2) 11NYCRR52.42(e) 11NYCRR52.45(f) 11NYCRR59.5(b) | <ul style="list-style-type: none"> 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 revised rating classes, factors and discounts. g. Examples of rate calculations. h. Commission schedule(s) and fees. i. Underwriting guidelines and/or underwriting manual. j. Expected loss ratio(s). | |