Large Group Major Medical and Other Similar-Type Comprehensive Health Insurance for Group Commercial Insurers, Article 43 Corporations, and HMOs

As of 12/5/2023

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: Complete all sections except the section entitled "Application Forms."
- Rider or Endorsement: Complete all items in the "Policy Forms" section relevant to the form being submitted.
- Application: Complete the section entitled "Application Forms."

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) and page number(s) where the requirement is met in the filing.

E. **Instructions for Citations:** All citations to Insurance regulations link to the Department of State's website and an unofficial copy of the NYCRR. 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, select the link labeled "ISC".

LINE OF BUSINESS: **Large Group Major Medical or Similar-Type Comprehensive Health Insurance**

CODES

TOI	LINE(S) OF INSURANCE	Sub-TOI
H15G	Health – Hospital/Surgical/Medical Expense	H15G.002 - Large Group Only
H16G	Health – Major Medical	H16G.002A - Large Group Only - PPO H16G.002C - Large Group Only - Other
HOrg02G	Group Health Organizations - (HMO)	HOrg02G.003B - Large Group Only - POS HOrg02G.003C - Large Group Only - HMO HOrg02G.003D - Large Group Only - Other

REVIEW REQUIREMENT	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD IN FILING
GENERAL REQUIREMENTS FOR ALL FILINGS	*Unless otherwise noted, all references are to Insurance Law, Insurance Regulations, and Department of Financial Services Circular Letters and OGC opinions*	*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.*	Form/Page/Para Reference
Model Language Required	§ 3217-i(d) § 4306-h(d) Model Language	The use of model language is required for group major medical or similar-type comprehensive health insurance and is required for all sections where model language is available.	
Certificate	§ 3221(a)(6) § 4305(a)	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 § 2612 § 3243 § 4330 11 NYCRR 52.72 11 NYCRR 52.75 Circular Letter No. 12 (2017) Circular Letter No. 9 (2018) Circular Letter No. 8 (2019) Circular Letter No. 13 (2020)	No insurer or entity shall refuse to issue any insurance policy, cancel or decline to renew the policy or otherwise unfairly discriminate because of race, color, creed, national origin, disability, sex, marital status, status as a victim of domestic violence, or engage in sexual stereotyping. "Sex" includes sexual orientation, gender identity or expression, and transgender status.	

Entire Contract	§ 3204	The policy form, including any endorsements or attached papers (if any), constitutes the entire contract of insurance. No change in the policy will be valid unless it is approved by an executive officer of the insurer and the approval is endorsed on or attached to the policy. No agent or broker has the authority to change the policy or waive any of its provisions. Incorporation by reference is not permitted.	
Filing Description in SERFF	11 NYCRR 52.33 Circular Letter No. 33 (1999) Supplement No. 1 to Circular Letter No. 33 (1999)	The filing must include a SERFF filing description that contains the following: • 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 or contract, the letter must identify the form number and approval date of the policy or contract 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 the application is required to be attached to the policy or contract upon submission. § 52.33(h) • If the policy or contract form 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 form and a list of all optional pages, together with an explanation of their use. § 52.33(i) *Note: The SERFF filing description should advise as to whether the policy or contract is intended for internet sales.*	
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.	
Form Requirements	§ 3201(c) § 3217(b) 11 NYCRR 52.1(c) 11 NYCRR 52.31	Each form in the filing must meet the following requirements: • The form provisions are NOT misleading or unreasonably confusing. § 3217(b)(2), § 52.1(c) • The form provisions provide substantial economic value to the insured. § 3217(b)(5), § 52.1(c) • The form provisions are NOT unjust, unfair, inequitable, misleading, or deceptive to the policyholder. §§ 3201(c)(3), 3217(b) • The form contains no strikeouts. § 52.31(b)	

		• The 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) • The 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. A full explanation of the nature and scope of the variable material, contained in an Explanation or Memorandum of Variable Material, should be uploaded to the Supporting Documentation tab in SERFF. § 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" to describe the variable material. § 52.31(l)	
Group Status and Recognition	§ 3201(b)(1) § 3231(a) § 4235(c)(1) § 4317(a) 11 NYCRR 59	The SERFF filing description should include a statement that this policy or contract form 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). The size of the group should be indicated (small, large or both). Requests for discretionary group recognition must be accompanied by written documentation that demonstrates that the proposed group meets 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) but for which the proposed discretionary group does not meet one or more of the requisites specifically required by § 4235. The request for allowance of a discretionary group must be granted before the policy may be issued to the discretionary group. Pursuant to Insurance Law § 3201(b)(1) and Insurance Regulation 123 (11 NYCRR Part 59), an accident and health certificate is deemed delivered in New York and subject to review and approval regardless of the actual place of delivery, if the policy is issued to one of the following groups: • § 4235(c)(1)(D), a group policy is issued to a trustee or trustees of a fund established or participated in by two or more employers not in the same industry with respect to an employer principally located within New York; • § 4235(c)(1)(K), a group policy issued to an association; • § 4235(c)(1)(L), a group policy issued to a bank, retailer or other issuer of a credit card to insure holders of the credit card; or a bank, savings and loan association, credit union, mutual fund, money market fund, stockbroker or other similar financial institution regulated by state or federal law to insure the depositors, account holders, or members of that financial institution; • § 4235(c)(1)(M), a group policy issued to a discretionary group approved by the Superintendent; • § 4237(a)(3)(F), a blanket policy issued to any other substantially similar group approved by the Superintendent as eligible for insurance under a blanket accident and health insurance policy or a discretionary group approved by the Superintendent; or	

		• Any groups not recognized in Insurance Law §§ 4235(c)(1) or 4237(a)(3). The group certificate is reviewed for compliance with New York Law. The group policy delivered out-of-state is not reviewed.	
Prefiled Group Coverage	11 NYCRR 52.32	A copy of the letter of confirmation sent to the group 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: • 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) *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 group 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.*	
Rider or Endorsement	11 NYCRR 52.18(g)(2) 11 NYCRR 52.31(a)	Except for riders by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all riders added to a policy after date of issue which reduce or eliminate coverage in the policy shall provide for signed acceptance by the policyholder. § 52.18(g)(2) New policy forms must comply with any statutory requirements without the use of amendatory riders or endorsements except for minor changes where the minor changes are necessitated by distinctive New York requirements. Previously approved policies may have riders attached to comply with changes in New York law, but only if the riders do not cause the policy in its entirety to mislead or confuse the policyholder. § 52.31(a)	
Statement of ERISA Rights Is the insurer providing document as the plan administrator or on behalf of the plan administrator? Yes ☐ No ☐	29 CFR § 2520.104b-2 29 CFR § 2520.102-3(t)	Plan administrators of an employee welfare 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 on behalf of the plan administrator, indicate in the adjacent box.	
APPLICATION FORMS			Form/Page/Para Reference
Authorization	11 NYCRR 420.18(b) Circular Letter No. 8 (2017) 42 USC § 290dd-2	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.	

	42 CFR § 2.31	A written authorization that consents to a disclosure of substance use disorder records must include: (1) the specific name or general designation of the program or person permitted to make the disclosure; (2) the name or title of the individual or the name of the organization to which disclosure is to be made; (3) the name of the patient; (4) the purpose of the disclosure; (5) how much and what kind of information is to be disclosed; (6) the signature of the patient and, when required for a patient who is a minor, the signature of a person authorized to give consent under 42 C.F.R. § 2.14 or, when required for a patient who is incompetent or deceased, the signature of a person authorized to sign under 42 C.F.R. § 2.15 on behalf of the patient; (7) the date on which the consent is signed; (8) a statement that the consent is subject to revocation at any time except to the extent that the program or person that is to make the disclosure has already acted in reliance on it, where acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer; and (9) the date, event or condition upon which the consent will expire if not revoked before that date, event or condition.	
Electronic Application	§ 3201(c)(3) 11 NYCRR 52.1(c) State Technology Law Article III 9 NYCRR Part 540 Accident and Health Insurance Electronic Application Guidance	If an insurer is seeking approval to use a previously approved paper application in electronic format, and the electronic application is identical to the previously approved paper application (e.g., a fillable PDF version of the paper application), then an extension of approval filing should be submitted under the filing type "Approval Extended." The screen shots of the electronic application process, including any drop downs, pop-ups, FAQs, or linked material that could appear in the application process should be uploaded to the Supporting Documentation tab in SERFF. If an insurer is seeking approval of an electronic application that is not identical to a previously approved paper application or a paper application currently pending approval, screenshots should be submitted for approval as the application policy form using the filing type "Normal Pre-Approval." The screenshots should contain a distinct form number in the lower left corner of the first screen shot and should comply with all applicable paper and electronic application requirements. Reflexive material, including drop down options, should be submitted for approval in a corresponding Explanation of Variable Material. Any pop-ups, FAQs, or linked material that could appear in the application process should be uploaded to the Supporting Documentation tab in SERFF. If an electronic signature is used, it must comply with the Electronic Signatures and Records Act (State Technology Law Article III). The filing should describe the procedures for the use of electronic signatures and certify that the signature complies with the Electronic Signatures and Records Act (State Technology Law Article III).	
Electronic Delivery of Documents	State Technology Law Article III OGC Opinion No. 09-01-01 OGC Opinion No. 05-11-28 9 NYCRR Part 540	Before an insurer transmits policy forms or any other documents to an insured electronically, it must obtain the insured's consent. If the insured refuses to consent to receiving documents electronically, the insurer must send a hard copy of the policy forms or other documents to that insured.	
Fraud Warning Statement	§ 403(d) 11 NYCRR 86.4	The application form contains the prescribed fraud warning statement listed below. The fraud warning statement must be placed directly above the signature line and printed in such a way that it is conspicuous to the insured such as by using bold font or larger font size. "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information,	

		or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."	
Non-binary Gender Designation Option	Circular Letter No. 13 (2020)	If the application elicits the applicant's gender, the application should include a non-binary gender designation as a response option.	
Prohibited Questions and Provisions	§ 3204 § 3221(q)(1) § 4305(k)(1) 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), or disability. • Questions regarding 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).	
Representations not Warranties	§ 3105 § 3204(c), (d)	Statements made on the application by the applicant are representations and not warranties, and only material misrepresentations can avoid a contract of insurance. No representation is deemed material unless knowledge by the insurer of the facts misrepresented would have led to a refusal by the insurer to issue the policy. No misrepresentation shall avoid any contract of insurance or defeat recovery thereunder unless the misrepresentation was also intentional. No statement by the individual in his application for a policy or contract 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. *Note: The insurer may make insertions to the application only for administrative purposes if the insertions are clearly not ascribed to the applicant. No other insertions or alterations of a written application will be made by anyone other than the applicant without the applicant's written consent pursuant to Insurance Law § 3204(d).*	
POLICY OR CONTRACT FORM PROVISIONS			Form/Page/Para Reference
COVER PAGE Model Language Used? Yes ☐ No ☐	Model Language	*Use of the model language is required.*	
Insurer Name	11 NYCRR 52.1(c)	This policy or contract form contains the name and full address of the issuing insurer on the cover page.	
Signature of Company Officer		The signature of company officer(s) appears prominently on the policy or contract form (such as on the cover page).	
Table of Contents (Recommended) Model Language Used?	§ 3102(c)(1)(G) Model Language	A table of contents is required for policies or contracts that are over 3,000 words or more than three pages regardless of the number of words.	

Yes ☐ No ☐			
DEFINITIONS Model Language Used? Yes ☐ No ☐	§ 3217 Model Language	*Use of the model language is required.*	Form/Page/Para Reference
Hospital	11 NYCRR 52.2(m)	"Hospital" is defined as a short-term, acute, general hospital, that: a. is primarily engaged in providing, by or under the continuous supervision of physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons; b. has organized departments of medicine and major surgery; c. has a requirement that every patient must be under the care of a physician or dentist; d. provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.); e. if located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 USC § 1395x(k); f. is duly licensed by the agency responsible for licensing such hospitals; and g. is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational or rehabilitory care.	
Services Performed at Comprehensive Care Center for Eating Disorders	§ 3221(k)(14) § 4303(dd) Model Language	This policy or contract form may not exclude coverage for services covered under the policy or contract when provided by a comprehensive care center for eating disorders pursuant to Mental Hygiene Law Article 30. Reimbursement for services provided through such comprehensive care centers shall, to the extent possible and 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.	
HOW THIS COVERAGE WORKS Model Language Used? Yes ☐ No ☐		*Use of the model language is required.*	Form/Page/Para Reference
Selecting a Primary Care Provider and Access to Providers			
Selecting, Accessing, and Changing Participating Providers	§ 3217-a(a)(9) § 3217-a(a)(10) § 4324(a)(9) § 4324(a)(10) PHL § 4408(1)(i) PHL § 4408(1)(j) 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") and Access to Pediatricians Does this plan require a PCP to be designated?	§ 3217-e § 4306-d PHL § 4403(7) 42 USC §300gg-19a 45 CFR §147.138(a) Model Language	If this policy or contract requires the designation of a PCP, this policy or contract form permits 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 is permitted to designate a physician who specializes in pediatrics as the child's PCP if the provider is in-network and available to accept the child.	

Yes ☐ No ☐			
Direct Access to OB/GYN Services Does this plan require a PCP to be designated? Yes ☐ No ☐	§ 3217-a(a)(16-a) § 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 this policy or contract requires the designation of a PCP, it must not limit a female insured's direct access to primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions from a qualified participating provider of such services of her choice or for any care related to pregnancy provided that: • 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 PHL § 2500-k PHL § 4406-f 11 NYCRR 52.18(a)(11) Circular Letter No. 1 (2016) Model Language	To the extent this policy or contract provides coverage for maternal depression screening and requires the designation of a PCP, it must not limit an insured's direct access to screening and referral for maternal depression, as defined in § 2500-k 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. However, if the infant is covered under a different policy than the mother and the screening and referral are performed by a provider of pediatric services, coverage for the screening and referral shall also be provided under the policy in which the infant is covered.	
Network Adequacy	§ 3217-d(d) § 3217-h § 4306-g § 3241(a) § 4306-c(d) § 4804(a) PHL § 4403(6)(a) Model Language	If the policy or contract form uses a network of providers and is found inadequate in a specialty type in a particular county, the policy or contract form must permit the insured to see an out-of-network provider for the covered service at the in-network cost-sharing.	
Provider Directory	§ 3217-a(a)(17) § 4324(a)(17) § PHL § 4408(1)(r) 42 USC § 300gg–115 Model Language	The policy or contract form lists the information available in the provider directory and states that to find out if the provider is a preferred or participating provider, the insured may check the provider directory, call the insurer, or visit the insurer's website. The policy or contract form provides that the insured is only responsible for any in-network cost-sharing that would apply to covered services if received from a provider who is not a participating provider in the following situations: • The provider is listed as a participating provider in the insurer's online provider directory; • The insurer's paper provider directory listing the provider as a participating provider is incorrect as of the date of publication; • The insurer gives the insured written notice that the provider is a participating provider in response to the insured's telephone request for network status information about the provider; or • The insurer does not provide the insured with a written notice within one (1) business day of the insured's telephone request for network status information. If a provider bills the insured for more than the in-network cost-sharing and the insured pays the bill, the insured is entitled to a refund from the provider, plus interest.	

Preauthorization			
Preauthorization Requirements	§ 3217-a(a)(2) § 3238 § 4324(a)(2) PHL § 4408(1)(b) Model Language	This policy or contract form includes a description of all preauthorization or other notification 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.	
Medical Necessity			
Definition of Medical Necessity	§ 3217-a(a)(1) § 4324(a)(1) PHL § 4408(1)(a) Model Language	This policy or contract form includes a definition of "medical necessity" used in determining whether benefits will be covered.	
Contact Information	§ 3217-a(a)(16) § 4324(a)(16) PHL § 4408(1)(q) Model Language	This policy or contract form includes all appropriate mailing addresses and telephone numbers to be utilized by insureds seeking information or authorization.	
Protection from Surprise Bills			
Protection from Surprise Bills and IDR Process	Financial Services Law Article 6 (Chapter 60 of the Laws of 2014) 23 NYCRR 400 42 USC § 300gg–111 42 USC § 300gg–131 42 USC § 300gg–132 Model Language	This policy or contract form provides that the insured will be held harmless for any non-participating provider charges for a surprise bill that exceed an insured's in-network deductibles, copayments and/or coinsurance. The non-participating provider may only bill an insured for any in-network deductible, copayment and/or coinsurance. The policy or contract form also includes a description of the independent dispute resolution process.	
Delivery of Covered Services Using Telehealth			
Delivery of Covered Services Using Telehealth	§ 3217-h § 4306-g PHL § 4406-g 11 NYCRR 52.18(h) Model Language	This policy or contract form shall not exclude from coverage a service that is otherwise covered under the policy or contract form because the service is delivered via telehealth; however, it may exclude from coverage a service by a health care provider where the provider is not otherwise covered under the policy. Coverage of services delivered via telehealth may be subject 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. Services delivered via telehealth may be subject to deductibles, copayments and/or coinsurance provided that they are at least as favorable to the insured as those established for the same service when not delivered via telehealth. "Telehealth" means the use of electronic information and communication technologies, including telephone or video using smart phones or other devices, and audio-only visits, by a provider to deliver health care services to an insured individual while the individual is located at a site that is different from provider's location.	
Case Management		*The following language is optional. If the language is inserted in the policy form, use of the model language is required.*	

Case Management	Model Language	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.	
ACCESS TO CARE AND TRANSITIONAL CARE (Required) Model Language Used? Yes ☐ No ☐		*The following standards are required, as applicable. Use of the model language is required.*	Form/Page/Para Reference
Referral or Authorization to Non-Participating Providers	§ 3217-a(a)(11) § 3217-d(d) § 4306-c(d) § 4324(a)(11) § 4804(a) PHL § 4403(6)(a) PHL § 4408(1)(k) Model Language	If a policy or contract form is a managed care product as defined in Insurance Law § 4801(c), an 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	§ 3217-a(a)(13) § 3217-d(b) § 4306-c(b) § 4324(a)(13) § 4804(c) PHL § 4403(6)(c) 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 or Authorizations	§ 3217-a(a)(12) § 3217-d(b) § 4306-c(b) § 4324(a)(12) § 4804(b) PHL § 4403(6)(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 or authorization to such specialist and describe the procedure for requesting and obtaining such a standing referral or authorization.	
Specialty Care Center	§ 3217-a(a)(14) § 3217-d(b) § 4306-c(b) § 4324(a)(14) § 4804(d) PHL § 4403(6)(d) PHL § 4408(1)(n) 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, 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	§ 3217-d(c) § 4306-c(c) § 4804(e) PHL § 4403(6)(e) 42 USC § 300gg–113	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 continue to receive 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, the insured may continue care with a	

	Model Language	former participating provider through delivery and any postpartum care directly related to the delivery. The provider must 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 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, and obtaining preauthorization, referrals or authorizations, and a treatment plan approved by the insurer. The care is treated as if being received from a participating provider.	
Transitional Care For a New Member in a Course of Treatment	§ 3217-d(c) § 4306-c(c) § 4804(f) PHL § 4403(6)(f) Model Language	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 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. 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, and obtaining preauthorization, referrals or authorization, 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.	
COST SHARING EXPENSES AND ALLOWED AMOUNT Model Language Used? Yes ☐ No ☐		*The following standards are required. Use of the model language is required.*	Form/Page/Para Reference
Cost of Service	§ 3201(c)(3) 11 NYCRR 52.1(c) Model Language	If the cost of the service is less than the deductibles, copayments and/or coinsurance for the service, the patient is responsible for the lesser amount.	
Maximum Out-of-Pocket Limit	§ 3217-i(c) § 4306-h(c) IRC § 223(c)(2)(A)(ii) 42 USC § 300gg-6 45 CFR § 156.130 Model Language	The cost-sharing for in-network services may not exceed the dollar amounts in effect under Internal Revenue Code § 223(c)(2)(A)(ii). The individual maximum out-of-pocket permitted by federal law applies to each individual regardless of whether the individual is covered by a plan providing individual coverage or coverage other than individual coverage.	
Non-Participating Providers and Non-Authorized Services	§ 3217-a(a)(6) § 4324(a)(6) PHL § 4408(1)(f) Model Language	This policy or contract form 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 or by any provider without the required authorization or when a procedure, treatment or service is not a covered health care benefit.	
Reimbursement of Providers	§ 3217-a(a)(4) § 4324(a)(4) PHL § 4408(1)(d)	This policy or contract form includes a description of the types of methodologies the insurer uses to reimburse providers.	

	Model Language		
WHO IS COVERED Model Language Used? Yes ☐ No ☐		*The following standards are required. Use of the model language is required.*	Form/Page/Para Reference
Spouse	§ 4235(f)(1)(A) § 4305(c)(1) Circular Letter No. 27 (2008) Model Language	If dependent coverage is selected by the group, this policy or contract form must provide coverage for the lawful spouse, unless there is a divorce or annulment of the marriage. This includes marriages between same-sex partners.	
Dependents	§ 3221(a)(7) § 4235(f)(1)(A)(i) § 4305(c)(1)(A)(i) § 4306(i) 42 USC §300gg-14 45 CFR § 147.120 Model Language	If dependent coverage is selected by the group, this policy or contract form provides coverage of children until the age of 26. *Note: Pursuant to § 2608-a of the Insurance Law, 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.*	
Extended Dependent Coverage	§ 4235(f)(1)(B) § 4305(c)(1)(B) Model Language	If dependent coverage is selected by the group, this policy or contract must make available and if requested by the group, provide coverage for unmarried children through the age of 29 (up to age 30); regardless of financial dependence; who are not insured by or eligible for coverage under an employer-sponsored health benefit plan covering them as an employee or member, whether insured or self-insured; and who live, work or reside in New York State or the service area of the insurer. The insurer must comply with the notice requirements set forth in § 4235(f).	
Unmarried Students on Medical Leave of Absence	§ 3237 § 4306-a 42 USC §300gg-28	If this policy or contract form provides coverage for dependent children who are full-time students to a higher age than other dependent children, then coverage shall continue when such dependent takes a medical leave of absence from school due to illness or injury for a period of 12 months from the last day of attendance at school, provided, however, that coverage of a dependent student is not required beyond the age at which coverage would otherwise terminate. To qualify for such coverage, the insurer may require that the medical necessity of the leave be certified to by the student's attending physician who is licensed to practice in the state of New York.	
Unmarried Disabled Children	§ 4235(f)(1)(A)(ii) § 4305(c)(1)(A)(ii) Model Language	If dependent coverage is selected by the group, this policy or contract form provides coverage for unmarried disabled children, regardless of age, who are incapable of self-sustaining employment by reason of mental illness, developmental disability, intellectual disability, as defined in the mental hygiene law, or physical disability, and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate. *Note: Such coverage shall not terminate while the coverage 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.*	
Newborn Infants	§ 4235(f)(2) § 4305(c)(1)(C) Model Language	If dependent coverage is selected by the group, this policy or contract form 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. *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. 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.*	
Adopted Children and Step-Children	11 NYCRR 52.18(e)(2), (3) Model Language	If dependent coverage is selected by the group, this policy or contract provides that adopted children and stepchildren dependent upon the insured are eligible for coverage on the same basis as natural children. Further, a family policy 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.	
Domestic Partners	§ 4235(f)(1)(A) § 4305(c)(1) OGC Opinion 01-11-23 OGC Op No. 01-09-11 Model Language	The policy form may provide coverage for domestic partners, but such coverage is not required. In order to qualify as domestic partners, the insured must demonstrate proof of mutual economic interdependence evidenced as follows: 1. Registration as a domestic partnership in jurisdictions that have such registration; or 2. If no registration is available, then: a. An alternative affidavit of domestic partnership. The affidavit must be notarized and must contain the following: i. The partners are both 18 years of age or older and are mentally competent to consent to contract; ii. The partners are not related by blood in a manner that would bar marriage under laws of the State of New York; iii. The partners have been living together on a continuous basis prior to the date of the application; and iv. Neither individual has been registered as a member of another domestic partnership within the last at least six (6) months; b. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and c. Proof that the partners are financially interdependent by submission of two (2) or more of the following: a joint bank account; joint credit card or charge card; joint obligation on a loan; status as an authorized signatory on the partner's bank account, credit card or charge card; joint ownership of holdings or investments; joint ownership of residence; joint ownership of real estate other than residence; listing of both partners as tenants on the lease of the shared residence; shared rental payments of residence (need not be shared 50/50); listing of both partners as tenants on a lease, or shared rental payments, for property other than residence; a common household and shared household expenses (need not be shared 50/50); shared household budget for purposes of receiving government benefits; status of one as representative payee for the other's 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 (need not be shared 50/50); execution of wills naming each other as executor and/or beneficiary; designation as beneficiary under the other's life insurance	

		policy; designation as beneficiary under the other's 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; or other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.	
New Employees	§ 3221(a)(3) 11 NYCRR 52.18(f)	New employees or members of the class must be added to the class for which they are eligible.	
Enrollment Periods	§ 3221(q)(5) § 4305(k)(5) 11 NYCRR 52.70(e)(3) 29 CFR 2590.701-6 Model Language	This policy or contract form 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 Insurance Law §§ 3221(q)(5) and 4305(k)(5).	
MANDATORY COVERED BENEFITS		*The following standards are required. Use of model language is required.*	Form/Page/Para Reference
PREVENTIVE CARE Model Language Used? Yes ☐ No ☐		*Use of model language is required.*	
Primary and Preventive Pediatric Health Services	§ 3221(k)(8) § 3221(l)(8) § 4303(j), (ii) 11 NYCRR 52.76 Circular Letter No. 3 (1994) Circular Letter No. 13 (2006) Circular Letter No. 13 (2020) Required Immunizations 42 USC § 300gg-13 45 CFR §147.130 11 NYCRR 52.76 Model Language	This policy or contract form provides the following coverage for primary and preventive health services for a covered child from the date of birth through age 19: • An initial hospital check-up and well child visits scheduled in accordance with the American Academy of Pediatrics. • 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. • For non-grandfathered health plans, additional preventive care and screenings for infants, children and adolescents with a rating of "A" or "B" by the USPSTF or in guidelines supported by Health Resources and Services Administration ("HRSA"). Such coverage shall not be subject to deductibles, copayments and/or coinsurance. *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 ("USPSTF"), or new recommendations from the HRSA, insurers should provide the required coverage for such items or services no later than six months from when the recommendation is made.* *Note: This policy or contract form must provide coverage for a physical or well care visit once every year even if 365 days have not passed since the previous physical or well care visit.*	
Preventive Adult Services	§ 3221(l)(8) § 4303(j) 11 NYCRR 52.76 42 USC § 300gg-13 45 CFR §147.130	If the policy or contract form is not "grandfathered" pursuant to 42 U.S.C. § 18011(e), it provides coverage for the following preventive care and screenings for adults with no cost-sharing: • Evidence-based items or services for adults with a rating of "A" or "B" by the USPSTF. • Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.	

	Circular Letter No. 21 (2017) Supplement No. 1 to Circular Letter No. 21 (2017) Supplement No. 2 to Circular Letter No. 21 (2017) Circular Letter No. 12 (2019) Circular Letter No. 13 (2020) Model Language HRSA Guidelines	• Preventive care and screenings for women in guidelines supported by the HRSA. Such coverage shall not be subject to deductibles, copayments and/or coinsurance. *Note: For new items or services added to the list of recommended preventive services receiving an A or B rating from the USPSTF, 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.*	
Cervical Cytology Screening and Well Woman Visits	§ 3221(l)(14) § 4303(t) 42 USC § 300gg-13 45 CFR § 147.130 Circular Letter No. 13 (2020) 11 NYCRR 52.76 Model Language HRSA Guidelines	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 cervical cancer screening tests, and laboratory and diagnostic services provided in connection with examining and evaluating the cervical cancer screening tests. 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). *Note: For new items or services added to the list of recommended preventive services receiving an A or B rating from the USPSTF, 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.* *Note: This policy or contract form must provide coverage for a well woman visit once every year even if 365 days have not passed since the previous well woman visit.*	
Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	§ 3221(l)(11) § 3221(l)(19) § 4303(p), (qq) Circular Letter No.2 (2016) Supplement No. 1 to Circular Letter No. 2 (2016) Circular Letter No. 13 (2020) 42 USC § 300gg-13 45 CFR § 147.130 11 NYCRR 52.76 Model Language HRSA Guidelines	This policy or contract form includes the following coverage for mammography screening for occult breast cancer: • 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. • Upon the recommendation of the insured's provider, an annual screening mammogram for insureds age 35 through 39 if medically necessary. • An annual mammogram for covered persons age 40 and older. • Screening and diagnostic imaging, including tomosynthesis (3D mammograms), diagnostic mammograms, breast ultrasounds and MRIs, for the detection of breast cancer. Such coverage shall not be subject to deductibles, copayments and/or coinsurance.	

		Note: For new items or services added to the list of recommended preventive services receiving an A or B rating from the USPSTF, 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.	
Family Planning and Reproductive Health Services	§ 3221(l)(16) § 4303(cc) Supplement No. 1 to Circular Letter No. 1 (2003) Circular Letter No. 13 (2020) 42 USC § 300gg-13 45 CFR § 147.130 11 NYCRR 52.76 Model Language HRSA Guidelines	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, Devices, and Products section below for information regarding the religious employer exemption. *Note: For new items or services added to the list of recommended preventive services receiving an A or B rating from the USPSTF, 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.*	
Bone Mineral Density Measurements or Tests, Drugs and Devices	§ 3221(k)(13) § 4303(bb) 42 USC § 300gg-13 45 CFR § 147.130 Circular Letter No. 13 (2020) 11 NYCRR 52.76 Model Language	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 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: • 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. 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. *Note: For new items or services added to the list of recommended preventive services receiving an A or B rating from the USPSTF, 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.*	
Prostate Cancer Screening	§ 3221(l)(11-a) § 4303(z-1) Model Language	This policy or contract form includes coverage for the diagnostic screening for prostate cancer including: • 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. Such coverage shall not be subject to deductibles, copayments and/or coinsurance.	
Colon Cancer Screening	§ 3221(l)(11-b) § 4303(uu) Circular Letter No. 4 (2022) Supplement No. 1 to Circular Letter No. 4 (2022)	This policy or contract form provides coverage for colon cancer screenings for insureds age 45 to 75 including: • All colon cancer examinations and laboratory tests in accordance with the USPSTF and any additional screenings recommended by the American Cancer Society Guidelines for average risk individuals; and • Initial colonoscopy or other medical test for colon cancer screening and a follow-up colonoscopy performed because of a positive result from a non-colonoscopy preventive screening test. Such coverage shall not be subject to deductibles, copayments, and/or coinsurance when provided in accordance with USPSTF recommendations, but may be subject to deductibles, copayments, and/or coinsurance for additional screenings provided in accordance with the American Cancer Society Guidelines.	
AMBULANCE, PRE-HOSPITAL EMERGENCY MEDICAL SERVICES & EMERGENCY SERVICES Model Language Used? Yes ☐ No ☐		*The following standards are required. Use of model language is required.*	
Ambulance and Pre-Hospital Emergency Medical Services	§ 3221(l)(15) § 4303(aa) 42 USC § 300gg–112 42 USC § 300gg–135 Model Language	This policy or contract form provides 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 Public Health Law § 3005. "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: • 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. **Emergency Ground Ambulance Transportation.** An insurer shall provide reimbursement for pre-hospital emergency medical services at rates negotiated between the insurer and the provider of such services. In the absence of agreed upon rates, an insurer shall pay for such services at the usual and customary charge, which shall not be	

		excessive or unreasonable. An ambulance service must hold the insured harmless and may not charge or seek reimbursement from the insured for pre-hospital emergency medical services except for the collection of any applicable deductibles, copayments, and/or coinsurance. **Emergency Air Ambulance Transportation:** The policy or contract form provides that the insurer will pay a participating provider the amount the insurer has negotiated with the participating provider for the air ambulance service. The policy or contract form provides that the insurer will pay a non-participating provider: • The amount the insurer has negotiated with the non-participating provider for air ambulance services; • An amount the insurer has determined is reasonable for air ambulance services; or • The non-participating provider's charge for air ambulance services. The negotiated amount or the amount that is determined to be reasonable will not exceed the non-participating provider's charge for air ambulance services. If the insurer uses a negotiated amount or an amount that is determined to be reasonable for air ambulance services, the policy or contract form must provide that, if a dispute for air ambulance services is submitted to an independent dispute resolution entity (IDRE), then the insurer will pay the amount, if any, determined by the IDRE for air ambulance services. The insured is responsible for any in-network cost-sharing for air ambulance services. Non-participating providers may not bill the insured for more than the in-network cost-sharing.	
Emergency Services	§ 3217-a(a)(8) § 3221(k)(4) § 3221(l)(20) § 3241(c) § 4303(a)(2) § 4303(rr) § 4324(a)(8) § 4900(c) PHL § 2805-i PHL § 4408(1)(h) Financial Services Law Article 6 (Chapter 60 of the Laws of 2014) 10 NYCRR 98-1.13 23 NYCRR 400 Circular Letter No.1 (2002) 42 USC § 300gg–111 42 USC § 300gg-19a(b) 45 CFR § 147.138(b) Model Language	This policy or contract form provides coverage for the treatment of an emergency condition in a hospital: • 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; and • The cost-sharing (deductibles, copayment and/or coinsurance) shall be the same regardless of whether the services are provided by a participating or a non-participating provider; and The policy or contract form provides that the insurer will pay a participating provider the amount the insurer has negotiated with the participating provider for the emergency services. The policy or contract form provides that the insurer will pay a non-participating provider: • The amount the insurer has negotiated with the non-participating provider for emergency services; • An amount the insurer has determined is reasonable for emergency services; or • The non-participating provider's charge for emergency services. The negotiated amount or the amount that is determined to be reasonable will not exceed the non-participating provider's charge for emergency services.	

		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 deductibles, copayments and/or coinsurance. Health care forensic examinations performed under Public Health Law § 2805-i are not subject to cost-sharing. If a dispute involving a payment for emergency services provided by a hospital or provider is submitted to an independent dispute resolution entity ("IDRE"), the insurer must pay the amount, if any, determined by the IDRE for hospital or provider services. *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: (i) 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; (ii) serious impairment to such person's bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person; or a condition described in Social Security Act § 1867(e)(1)(A)(i), (ii) or (iii).* *"Emergency services" means: (i) a medical screening examination as required under 42 USC § 1395dd, 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 medical condition; and (ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under 42 USC § 1395dd to stabilize the patient. For purposes of this paragraph, "to stabilize" means, with respect to an emergency condition, to provide such medical treatment of an emergency condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a facility, or to deliver a newborn child (including the placenta).*	
OUTPATIENT SERVICES, INPATIENT SERVICES, EQUIPMENT AND DEVICES Model Language Used? Yes ☐ No ☐		*The following benefits are required. Use of model language is required.*	
Chiropractic Care	§ 3221(k)(11) § 4303(y) Model Language	This policy or contract form 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.	

		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 coverage 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. *Note: A policy or contract form 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 form. Additionally, a policy or contract form 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 or contract form. This means, for example, that a policy or contract form 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.*	
Clinical Trials	42 USC § 300gg-8 Model Language	This policy or contract form 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 (ii) referred by a participating provider who has concluded that the insured's participation in the approved clinical trial would be appropriate. 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 FDA; or (iii) a drug trial that is exempt from having to make an investigational new drug application.	
Dialysis Coverage	§ 3221(k)(16) § 4303(gg) Model Language	If the policy or contract form 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 met: • 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. 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.	

End of Life Care	§ 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 than 60 days to live.	
Home Health Services	§ 3221(k)(1) § 4303(a)(3) Model Language	This policy or contract form provides coverage of home care for not less than 40 visits in a plan year for each person covered under this policy or contract form 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 Public Health Law Article 36 and shall consist of one or more of the following: • 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 (1) home care visit. • Four hours of home health aide service shall be considered as one (1) home care visit *Note: Plans may increase the number of covered home health care visits or remove the visit limit.*	
Hospital Services	11 NYCRR 52.5 Model Language	This policy or contract form 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: • Semiprivate room and board; • General, special, and critical nursing care; • Meals and special diets; • The use of operating, recovery, and cystocopic 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. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Infertility Treatments & Treatment of Correctable Medical Conditions that Cause Infertility	§ 3221(k)(6) § 4303(s) 11 NYCRR 52.18(a)(10) OGC Opinion 05-11-10	This policy or contract form provides services for the diagnosis and treatment (surgical and medical) of infertility.	

	Circular Letter No. 7 (2017) Model Language IVF and Fertility Preservation Law Q&A Guidance	"Infertility" is a disease or condition characterized by the incapacity to impregnate another person or to conceive, defined by the failure to establish a clinical pregnancy after 12 months of regular, unprotected sexual intercourse or therapeutic donor insemination, or after six (6) months of regular, unprotected sexual intercourse or therapeutic donor insemination for a female 35 years of age or older. Earlier evaluation and treatment may be warranted based on an insured's medical history or physical findings. **Basic Infertility Services.** This policy or contract form provides basic infertility services, which must be provided to an insured who is an appropriate candidate for infertility treatment. In order to determine eligibility, the insurer must use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of New York. Basic fertility services include: • Initial evaluation; • Semen analysis; • Laboratory evaluation; • Evaluation of ovulatory function; • Postcoital test; • Endometrial biopsy; • Pelvic ultrasound; • Hysterosalpingogram; • Sono-hystogram; • Testis biopsy; • Blood tests; and • Medically appropriate treatment of ovulatory dysfunction. **Comprehensive Infertility Services.** If the basic infertility services do not result in increased fertility, this policy or contract form provides comprehensive infertility services. Comprehensive infertility services include: • Ovulation induction and monitoring; • Pelvic ultrasound; • Artificial insemination; • Hysteroscopy; • Laparoscopy; and • Laparotomy. **In Vitro Fertilization (IVF).** Coverage is provided for three (3) IVF cycles per lifetime. This includes the cryopreservation and storage of sperm, ova, and embryos in connection with in vitro fertilization. A "cycle" is all treatment that starts when: preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of undergoing in vitro fertilization using a fresh embryo transfer, or medications are administered for endometrial preparation with the intent of undergoing in vitro fertilization using a frozen embryo transfer. **Fertility Preservation Services.**	

		This policy or contract form provides standard fertility preservation services when a medical treatment will directly or indirectly lead to iatrogenic infertility. Standard fertility preservation services include the collecting, preserving, and storing of ova or sperm. "Iatrogenic infertility" means an impairment of the insured's fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form. **Exclusions and Limitations.** This mandate does not require coverage of the following treatments in connection with infertility: • Gamete intrafallopian tube transfers (GIFT) or zygote intrafallopian tube transfers (ZIFT); • Reversal of elective sterilizations; • Costs associated with an ovum or sperm donor, including the donor's medical expenses • Ovulation predictor kits; • Reversal of tubal ligations; • Costs for services relating to surrogate motherhood that are not otherwise covered services under the policy or contract; • Cloning; or • Medical or surgical services or procedures determined to be experimental or investigational. When determining coverage under this benefit, the insurer may not discriminate based on the insured's expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, other health conditions, or based on personal characteristics including age, sex, sexual orientation, marital status or gender identity. *Note: These are the only infertility treatments that may be expressly excluded in the policy or contract form. The exclusions listed above may be removed.*	
Interruption of Pregnancy	§ 3221(k)(22) § 4303(ss) 11 NYCRR 52.16(o) Model Language	This policy or contract form provides coverage for abortion services including any prescription drug prescribed for an abortion, including both generic and brand-name drugs, and prescription drugs that have not been approved by the FDA for abortions if the prescription drug is a recognized medication for abortions in one of the following reference compendia: • The WHO Model Lists of Essential Medicines; • The WHO Abortion Care Guidelines; or • The National Academies of Science, Engineering and Medicine Consensus Study Report. In-network abortion services must be provided with no cost-sharing, unless the plan is a high deductible health plan as defined in Internal Revenue Code § 223(c)(2) in which case coverage for abortion services may be subject to the deductible. For groups that meet the definition of a religious employer in §§ 3221(l)(16)(E) and 4303(cc)(5)(A), the insurer may exclude coverage for abortion services only if the insurer (1) receives an annual certification from the group policyholder that it is a religious employer requesting removal of such coverage and (2) issues a rider to each certificate holder at no premium cost that provides coverage for abortion services without cost-sharing.	

Maternity Care	§ 3221(k)(5) § 3221(l)(20) § 4303(c), (oo) 29 USC § 1185 Circular Letter No. 5 (2018) Model Language	This policy or contract form provides coverage for maternity care, to the same extent as coverage is provided for illness or disease under the policy or contract form. 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. Such coverage may be subject to deductibles, copayments and/or coinsurance. The mother has the option to be discharged earlier than the time periods listed above, and, in such cases, is entitled to one (1) home care visit in addition to any home care provided under §3221(k)(1) or § 4303(a)(3). Such home care is not subject to deductibles, copayments and/or coinsurance. Maternity coverage also includes coverage of the services of a midwife licensed pursuant to Education Law Article 140, practicing consistent with a collaborative relationship with a physician or a hospital licensed pursuant to Public Health Law Article 28, consistent with the requirements of Education Law § 6951. Maternity coverage also includes parent education, training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments. Comprehensive lactation support services, including breastfeeding equipment and supplies, must be provided without cost-sharing through the duration of breast feeding. This coverage includes the cost of renting or purchasing one (1) breast pump per pregnancy in conjunction with childbirth. This policy or contract form also provides coverage for the inpatient use of pasteurized donor human milk, which may include fortifiers as medically necessary, for which a health care professional has issued an order for an infant who is medically or physically unable to receive maternal breast milk, participate in breast feeding, or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breast feeding despite optimal lactation support. Such infant must have a documented birth weight of less than 1,500 grams, or a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis. 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.	
Mastectomy Care	§ 3221(k)(8) § 4303(v) Model Language Women's Health and Cancer Rights Act of 1998, 29 USC 1185b	This policy or contract form provides 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 deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
Outpatient Hospital Services	11 NYCRR 52.5 Model Language	This policy or contract form provides coverage for hospital services and supplies described in the inpatient hospital section of this policy or contract form that can be provided while being treated in an outpatient facility.	

		Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Post Mastectomy Reconstruction	§ 3221(k)(10) § 4303(x) Women's Health and Cancer Rights Act of 1998, 29 USC 1185b Model Language	This policy or contract form provides coverage for breast or chest wall 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 or chest wall 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. Chest wall reconstruction surgery includes aesthetic flat closure as defined by the National Cancer Institute. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
Preadmission Testing	§ 3221(k)(2) § 4303(a)(1) Model Language	This policy or contract form provides 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 (7) days of the tests; and the patient is physically present at the hospital for the tests. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Second Medical Opinion for Cancer Diagnosis	§ 3221(k)(9) § 4303(w) Model Language	This policy or contract form provides 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. • 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. 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.	
Second Surgical Opinion	§ 3221(k)(3) § 4303(b) Circular Letter No. 29 (1979) Model Language	This policy or contract form provides coverage for a second surgical opinion by a qualified physician on the need for surgery. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Mandatory Second Surgical Opinion	§ 3221(k)(3) § 4303(b) Circular Letter No. 29 (1979)	This policy or contract form may contain a mandatory second surgical opinion provision only if such provision is consistent with Circular Letter No. 29 (1979). Such coverage may not be subject to deductibles, copayments and/or coinsurance.	

	Model Language		
Surgical Services	11 NYCRR 52.6 Model Language	This policy or contract form provides 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. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Diabetes Equipment, Supplies and Self-Management Education	§ 3221(k)(7) § 4303(u) 10 NYCRR 60-3.1 Model Language	This policy or contract form provides coverage for equipment, supplies and self-management education described in §§ 3221(k)(7) or 4303(u) for the treatment of diabetes. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits. The total amount that an insured is required to pay out-of-pocket for covered prescription insulin drugs shall not exceed $100 per 30-day supply, regardless of the amount or type of insulin needed to fill such insured's prescription. *Note: Plans may apply the prescription drug cost-sharing to the benefit if the cost-sharing is more favorable to the insured than when treated as a medical benefit. Since the statute refers to equipment, supplies, and self-management education that are prescribed by a physician "or other licensed health care provider legally authorized to prescribe under title eight of the education law…," this policy or contract form may not limit coverage to care prescribed by a physician.*	
Ostomy Equipment and Supplies	§ 3221(k)(19) § 4303(u-1)	This policy or contract form 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 Education Law Title 8. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent.	
MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES Model Language Used? Yes ☐ No ☐		*The following standards are required. Use of model language is required.*	
Inpatient Mental Health Care Services Confirm that the cost-sharing for Mental Health services complies with all requirements under MHPAEA. Yes ☐ No ☐	§ 3221(l)(5) § 4303(g) Circular Letter No. 5 (2014) Circular Letter No. 4 (2016) Circular Letter No. 13 (2019) Federal Mental Health Parity and Addiction Equity Act of 2008	This policy or contract form provides coverage for inpatient mental health care services relating to the diagnosis and treatment of mental health conditions. 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 hospitals or 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 and, in other states, to similarly licensed or certified facilities.	

	(MHPAEA), 29 USC 1185a 45 CFR 146.136 Model Language	For purposes of this benefit, "mental health condition" means any mental health condition as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders or another source which must be a generally recognized independent standard of current medical practice, such as the International Classification of Diseases. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent, that are consistent with other benefits within the policy or contract form, and in accordance with MHPAEA. *Note: Under MHPAEA, a group health policy or contract form that provides both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (e.g., 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 form 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.*	
Outpatient Mental Health Care Services Confirm that the cost-sharing for Mental Health services complies with all requirements under MHPAEA. Yes ☐ No ☐	§ 3221(l)(5) § 4303(g), (n) Mental Hygiene Law § 36.01 Circular Letter No. 5 (2014) Circular Letter No. 4 (2016) Circular Letter No. 13 (2019) Federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), 29 USC 1185a 45 CFR § 146.136 Model Language	This policy or contract form provides coverage for outpatient mental health care services relating to the diagnosis and treatment of mental health conditions, including, but not limited to, partial hospitalization program and intensive outpatient program services. Such coverage is limited to facilities that have been issued an operating certificate pursuant to Mental Hygiene Law Article 31 or are operated by the New York State Office of Mental Health ("OMH"), and crisis stabilization centers licensed pursuant to Mental Hygiene Law § 36.01; and, in other states, to similarly licensed or certified facilities; services provided by a psychiatrist or psychologist licensed to practice in this state; a mental health counselor, marriage and family therapist, or psychoanalyst licensed pursuant to Education Law Article 163; a licensed clinical social worker within the lawful scope of his or her practice who is licensed pursuant to Education Law Article 154; a nurse practitioner licensed to practice in this state; or a professional corporation or a university faculty practice corporation thereof. This policy or contract form also provides coverage for outpatient mental health care provided at a preschool, elementary, or secondary school by a school-based mental health clinic licensed pursuant to Mental Hygiene Law Article 31 regardless of whether the school-based mental health clinic is a participating provider. The policy or contract form provides that the insurer will pay a non-participating provider the amount negotiated with the non-participating provider. In the absence of a negotiated rate, the insurer will pay an amount no less than the rate that would be paid under the Medicaid program. The school-based mental health clinic shall not seek reimbursement from the insured for outpatient services except for the in-network cost-sharing. For purposes of this benefit, "mental health condition" means any mental health condition as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders or another source which must be a generally recognized independent standard of current medical practice, such as the International Classification of Diseases.	

		This policy or contract form also provides coverage for nutritional counseling. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent, that are consistent with other benefits within the policy or contract form, and in accordance with MHPAEA. An insurer shall not impose a copayment or coinsurance for outpatient mental health services provided in a facility licensed, certified, or otherwise authorized by OMH that exceeds the copayment or coinsurance imposed for a primary care office visit under the policy or contract. *Note: Under MHPAEA, a group health policy or contract form that provides both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (e.g., 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 form 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.*	
Inpatient Substance Use Services Confirm that the cost-sharing for Substance Use services complies with all requirements under MHPAEA. Yes ☐ No ☐	§ 3221(l)(6) § 4303(k) Circular Letter No. 5 (2014) Circular Letter No. 4 (2016) Circular Letter No. 6 (2016) Circular Letter No. 14 (2017) Circular Letter No. 13 (2019) Federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), 29 USC 1185a 45 CFR § 146.136 Model Language	This policy or contract form provides coverage for inpatient substance use services relating to the diagnosis and treatment of substance use disorders, including detoxification and rehabilitation services. Inpatient substance use services are limited to facilities in New York which are licensed, certified, or otherwise authorized by the Office of Addiction Services and Supports ("OASAS"), and in other states, to those facilities that are licensed, certified, or otherwise authorized by a similar state agency and accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. 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 that are licensed, certified, or otherwise authorized by OASAS; and, in other states, to those facilities that are licensed, certified, or otherwise authorized by a similar state agency and accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. For purposes of this benefit, "substance use disorder" means any substance use disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders or another source which must be a generally recognized independent standard of current medical practice, such as the International Classification of Diseases. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent, that are consistent with other benefits within the policy or contract form, and in accordance with MHPAEA.	

		Note: Under MHPAEA, a group health policy or contract form that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (e.g., 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 form 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.	
Outpatient Substance Use Services Confirm that the cost-sharing for Substance Use services complies with all requirements under MHPAEA. Yes ☐ No ☐	§ 3221(l)(7) § 4303(l) Mental Hygiene Law § 36.01 Circular Letter No. 5 (2014) Circular Letter No. 4 (2016) Circular Letter No. 6 (2016) Circular Letter No. 14 (2017) Circular Letter No. 13 (2019) Circular Letter No. 14 (2019) Federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), 29 USC 1185a 45 CFR § 146.136 Model Language	This policy or contract form provides coverage for outpatient substance use services relating to the diagnosis and treatment of substance use disorder, including but not limited to partial hospitalization program services, intensive outpatient program services, counseling, and medication-assisted treatment. Such coverage is limited to facilities in New York State that are licensed, certified or otherwise authorized by OASAS to provide outpatient substance use disorder services; crisis stabilization centers licensed pursuant to Mental Hygiene Law § 36.01 and, in other states, to those facilities that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use disorder services relating to the diagnosis and treatment of alcoholism, substance use, and dependency or by physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe schedule III, IV and V narcotic medication for the treatment of opioid addition during the acute detoxification stage of treatment or during stages of rehabilitation. 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 dependence. Payment for a family member should be the same amount regardless of the number of family members who attend the family therapy session. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent, that are consistent with other benefits within the policy or contract form, and in accordance with MHPAEA. An insurer shall not impose a copayment or coinsurance for outpatient substance use services that exceeds the copayment or coinsurance imposed for a primary care office visit under the policy or contract. An insurer shall impose no greater than one copayment for all services provided in a single day by a facility licensed, certified, or otherwise authorized by OASAS to provide outpatient substance use services. *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. *Note: Under MHPAEA, a group health policy or contract form 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 form 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.*	
Autism Spectrum Disorder Confirm that the cost-sharing for autism spectrum disorder services complies with all requirements under MHPAEA. Yes ☐ No ☐	§ 3221(l)(17) § 4303(ee) Model Language	This policy or contract form provides 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: • 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 form provides coverage for therapeutic care; and • Pharmacy care in the event that the policy or contract form provides coverage for prescription drugs. This policy or contract form includes 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. This policy or contract form includes 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 licensed or certified behavior analysis provider, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. This policy or contract form includes 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. This policy or contract form includes a definition of "assistive communication devices" which at a minimum includes 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. 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, and in accordance with the federal Mental Health Parity Addiction Equity Act ("MHPAEA"). *Note: Under MHPAEA, a group health policy or contract form that provides both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (e.g., 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 form 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. These requirements apply to behavioral health treatment.*	
PRESCRIPTION DRUG COVERAGE (Required if Rx Benefit Provided) Model Language Used? Yes ☐ No ☐		*If prescription drugs are covered under this policy or contract, the following mandates apply. Use of model language is required if the policy or contract form provides a prescription drug benefit. Some benefits (noted below) are required even if prescription drugs are not otherwise covered under the policy or contract form.*	
Contraceptive Drugs, Devices, and Products *Note: Coverage for contraceptive drugs, devices, and products is required even when prescription drugs are not otherwise covered under the policy or contract.*	§ 3221(l)(16) § 4303(cc) Supplement No. 1 to Circular Letter No. 1 (2003) Supplement No. 2 to Circular Letter No. 1 (2003) Supplement No. 3 to Insurance Circular Letter No. 1 (2003) 42 USC § 300gg-13 45 CFR § 147.130 Model Language HRSA Guidelines	This policy or contract form provides coverage for contraceptive drugs, devices, and other products, including over-the-counter contraceptive drugs, devices, and other products, approved by the FDA and as prescribed or otherwise authorized under State or Federal law. "Over-the-counter contraceptive products" means those products provided for in comprehensive guidelines supported by HRSA. Coverage also includes emergency contraception when provided pursuant to a prescription or order or when lawfully provided over-the-counter. The insured may request coverage for an alternative version of a contraceptive drug, device and other product if the covered contraceptive drug, device and other product is not available or is deemed medically inadvisable, as determined by the insured's attending health care provider. For groups that meet the definition of a religious employer in §§ 3221(l)(16)(E) and 4303(cc)(5)(A), the subscriber will have the option to purchase the stand-alone contraceptive coverage rider. Such coverage shall not be subject to deductibles, copayments and/or coinsurance.	
Enteral Formulas	§ 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 the policy or contract form shall provide coverage for enteral formulas for home use, whether administered orally or via feeding tube, for which a physician or other licensed health care provider 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. Specific diseases and disorders include but are not limited to: inherited amino-acid or organic acid metabolism; Crohn's Disease; gastroesophageal reflux; gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies. Multiple food allergies include but are not limited to: immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract. This policy or contract form provides coverage for modified solid food products that are low in protein, contain modified protein, or are amino acid based to treat certain inherited diseases of amino acid and organic acid metabolism and severe protein allergic conditions. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Eye Drops	§ 3221(k)(17) § 4303(hh) Model Language	If coverage for prescription drugs is provided under the policy or contract, then the policy or contract form shall allow for the limited refilling of eye drop medication requiring a prescription prior to the last day of the approved dosage period. Any refill dispensed prior to the expiration of the approved coverage period shall, to the extent practicable, be limited in quantity so as not to exceed the remaining dosage initially approved for coverage. The limited refilling shall not limit or restrict coverage with respect to any previously or subsequently approved prescription for eye drop medication.	
Formulary Changes	§ 4909(a)-(b), (d)	The policy or contract form states that a prescription drug will not be removed from the formulary during the plan year, except when the FDA determines that the prescription drug should be removed from the market. Before the insurer removes a prescription from its formulary, the insurer must provide at least 90 days' notice prior to the start of plan year and post such notice on the insurer's website. The insurer will not add utilization management restrictions (e.g., step therapy or preauthorization requirements) to prescription drugs on the formulary unless the requirements are added due to FDA safety concerns.	
Formulary Disclosure	§ 3242(a) § 4329(a)	Every insurer that provides coverage for prescription drugs shall, with respect to the prescription drug coverage, publish an up-to-date, accurate, and complete list of all covered prescription drugs on its formulary drug list, including any tiering structure that it has adopted and any restrictions on the manner in which a prescription drug may be obtained, in a manner that is easily accessible to insureds and prospective insureds. The formulary drug list shall clearly identify the preventive prescription drugs that are available without annual deductibles or coinsurance, including co-payments.	
Formulary Exceptions	§ 3242(b) § 4329(b) Model Language	This policy or contract form provides for a standard and expedited formulary exception process for prescription drugs not on the insurer's formulary. The insured, the insured's designee or their prescribing health care professional may request a formulary exception for a clinically-appropriate prescription drug in writing, electronically or telephonically. For standard formulary exception requests, the insurer must make a decision and notify the insured or the insured's designee and the prescribing health care professional by telephone no later than 72 hours after receipt of the request. The insurer must notify the insured in writing of a denial within three (3) business days of receipt of the insured's request. If the insurer approves the request, the insurer must cover the prescription drug while the insured is taking the prescription drug, including any refills.	

		An expedited formulary exception may be requested if the insured is suffering from a health condition that may seriously jeopardize the insured's health, life or ability to regain maximum function or if the insured is undergoing a current course of treatment using a non-formulary prescription drug. The insurer must make a decision and notify the insured or the insured's designee and the prescribing health care professional by telephone no later than 24 hours after receipt of the request. The insurer must notify the insured in writing of a denial within three (3) business days of receipt of the insured's request. If the insurer approves the request, the insurer must cover the prescription drug while the insured suffers from the health condition that may seriously jeopardize the insured's health, life or ability to regain maximum function or for the duration of the insured's current course of treatment using the non-formulary prescription drug. If an insurer denies the formulary exception request, the denial is considered a final adverse determination for purposes of Insurance Law and Public Health Law Articles 49 and the insured, insured's designee or the insured's prescribing health care provider shall have the right to request that such denial be reviewed by an external appeal agent certified pursuant to Insurance Law § 4911.	
Initial Limited Supply of Prescription Opioid Drugs	§ 3221(k)(21) § 4303(qq) Circular Letter No. 6 (2016) Model Language	If this policy or contract form provides coverage for prescription drugs subject to a copayment, coverage shall be provided for an initial limited prescription for a seven (7) day supply or less of any schedule II, III, or IV opioid prescribed for acute pain with a copayment that is either proportional between the copayment for a 30 day supply and the amount of drugs the patient was prescribed or equivalent to the copayment for a full 30 day supply, provided that no additional copayments may be charged for any additional prescriptions for the remainder of the 30 day supply.	
Mail Order Drugs for Policies With a Provider Network	§ 3221(l)(18) § 4303(kk) Model Language	If this policy or contract form provides coverage for mail order drugs, then this 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 to the same reimbursement amount as a participating mail order or other non-retail pharmacy.	
Off-Label Cancer Drug Usage	§ 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, or denied, 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.	
Orally Administered Anticancer Medications	§ 3221(l)(12-a) § 4303(q-1) Model Language	If coverage for prescription drugs and cancer chemotherapy treatment is provided under the policy or contract, then the policy or contract form provides coverage for a prescribed orally administered anticancer medication used to kill or slow the growth of cancerous cells. Such coverage may be subject to deductibles, copayments and/or coinsurance that are at least as favorable as those that apply to coverage for intravenous or injected anticancer medications. Insurers shall not achieve compliance with the law by imposing an increase in cost-sharing for IV anti-cancer medications. Therefore, an increase in cost-sharing for IV anti-cancer medications may not be applied to oral anti-cancer medications.	

Prohibition for Tier IV Drugs	§ 3221(a)(16) § 4303(jj) PHL § 4406-c(7) Circular Letter No. 12 (2018) Model Language	If coverage for prescription drugs is provided under the policy or contract, then the policy or contract form shall not impose cost-sharing (copayment, 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). Tier placement should be determined using an evidence-based process that analyzes the safety and effectiveness of a drug or device in addition to its economic value relative to alternative therapies. Determinations on tier placement may not be based on the cost of the drug alone.	
Tier Status	§ 4909(c)-(d)	The policy or contract form states that a prescription drug will not be moved to a tier with higher cost-sharing during the plan year, except that a brand name prescription drug may be moved to a tier with higher cost-sharing if an AB-rated generic equivalent or interchangeable biological product for the prescription drug is added to the formulary at the same time. Additionally, a prescription drug may be moved to a tier with a higher copayment during the plan year, provided the change does not apply to an insured who is already taking the prescription drug or has been diagnosed or presented with a condition on or prior to the start of the plan year, which condition is treated by such prescription drug or for which condition the prescription drug is or would be part of the insured's treatment regimen. Before a prescription drug is moved to a different tier, the insurer must provide at least 90 days' prior notice to the start of the plan year and such notice must be posted on the insurer's website. If a prescription drug is moved to a different tier during a plan year for one of the reasons above, the insurer must provide at least 30 days' prior notice before the change is effective. The insured will pay the cost-sharing applicable to the tier to which the prescription drug is assigned.	
Coverage for All Buprenorphine Products, Methadone or Long-Acting Injectable Naltrexone *Note: Coverage for all buprenorphine products, methadone or long-acting injectable naltrexone are required even when prescription drugs are not otherwise covered under the policy or contract form.*	§ 3221(l)(7-a) § 4303(l-1) Circular Letter No. 6 (2016) Circular Letter No. 14 (2017) Circular Letter No. 16 (2017)	This policy or contract form shall provide immediate coverage for all buprenorphine products, methadone or long-acting injectable naltrexone without prior authorization for the detoxification or maintenance treatment of a substance use disorder. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent, that are consistent with other benefits within the policy or contract form, and in accordance with MHPAEA.	
Usual and Customary Cost of Prescribed Drugs	§ 4325(h) PHL § 4406-c(6) Circular Letter No. 7 (2019) Model Language	If coverage for prescription drugs is provided under the policy or contract, copayments relating to prescription drugs shall not exceed the usual and customary cost of such prescribed drug.	
ADDITIONAL OPTIONAL BENEFITS (Required if benefits are included in policy form)		*Use of the model language is required if including these optional benefits. Limits in the model language on the following benefits may be revised or removed.*	

Model Language Used? Yes ☐ No ☐			
Acupuncture Is benefit included? Yes ☐ No ☐	Model Language	This policy or contract form provides coverage for acupuncture.	
Advanced Imaging Is benefit included? Yes ☐ No ☐	Model Language	This policy or contract form provides coverage for PET scans, MRI, nuclear medicine, and CAT scans.	
Allergy Testing and Treatment Is benefit included? Yes ☐ No ☐	Model Language	This policy or contract form provides coverage for testing and evaluations including: injections, and scratch and prick tests to determine the existence of an allergy. This policy or contract form also provides coverage for allergy treatment, including desensitization treatments, routine allergy injections, and serums.	
Ambulatory Surgery Center Is benefit included? Yes ☐ No ☐	Model Language	This policy or contract form provides coverage for surgical procedures performed at an ambulatory surgical center including services and supplies provided by the center the day the surgery is performed. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Autologous Blood Banking Services Is benefit included? Yes ☐ No ☐	Model Language	This policy or contract form provides coverage for autologous blood banking services when they are being provided in connection with a scheduled, covered inpatient procedure for the treatment of a disease or injury. In such instances, this policy or contract form will cover storage fees for what are determined to be a reasonable storage period that is appropriate for having the blood available when it is needed.	
Chemotherapy and Immunotherapy Is benefit included? Yes ☐ No ☐	Model Language	This policy or contract form provides coverage for chemotherapy and immunotherapy in an outpatient facility or in a professional provider office. Chemotherapy and immunotherapy may be administered by injection or infusion.	
Cochlear Implants Is benefit included? Yes ☐ No ☐	Model Language	This policy or contract form provides coverage for bone anchored hearing aids (i.e., cochlear implants) when they are medically necessary to correct a hearing impairment. Examples of when bone anchored hearing aids are medically necessary include the following: • Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or • Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.	
Dental Care Is benefit included? Yes ☐ No ☐	Model Language	This policy or contract form provides coverage for dental care.	
Durable Medical Equipment and Braces Is benefit included?	Model Language	This policy or contract form provides coverage for the rental or purchase of durable medical equipment and braces, including orthotic braces.	

Yes ☐ No ☐			
Emergency Ambulance Transportation Is benefit included? Yes ☐ No ☐	Model Language	In addition to pre-hospital emergency medical services, this policy or contract form provides coverage for emergency ambulance transportation by a licensed ambulance service (either ground, water or air ambulance) to the nearest hospital where emergency services can be performed. This coverage includes emergency ambulance transportation to a hospital when the originating facility does not have the ability to treat the insured's emergency condition.	
External Hearing Aids Is benefit included? Yes ☐ No ☐	Model Language	This policy or contract form provides coverage for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier, and receiver.	
Habilitation Services Is benefit included? Yes ☐ No ☐	Model Language	This policy or contract form provides coverage for habilitation services.	
Infusion Therapy Is benefit included? Yes ☐ No ☐	Model Language	This policy or contract form provides coverage for infusion therapy which is the administration of drugs using specialized delivery systems. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Laboratory Procedures, Diagnostic Testing, and Radiology Services Is benefit included? Yes ☐ No ☐	Model Language	This policy or contract form provides 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.	
Medical Supplies Is benefit included? Yes ☐ No ☐	Model Language	This policy or contract form provides coverage for medical supplies required for the treatment of a disease or injury, including maintenance supplies.	
Non-Emergency Ambulance Transportation Is benefit included? Yes ☐ No ☐	Model Language	This policy or contract form provides coverage for non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between facilities when the transport is any of the following: • From a non-participating hospital to a participating hospital. • To a hospital that provides a higher level of care that was not available at the original hospital. • To a more cost-effective acute care facility. • From an acute facility to a sub-acute setting.	
Prosthetics and Orthotics Is benefit included? Yes ☐ No ☐	Model Language	This policy or contract form provides coverage for prosthetic devices.	
Rehabilitation Services Is benefit included? Yes ☐ No ☐	Model Language	This policy or contract form provides coverage for rehabilitation services.	

Retail Health Clinics Is benefit included? Yes ☐ No ☐	Model Language	This policy or contract form provides coverage for basic health care services provided on a "walk-in" basis at retail health clinics, normally found in major pharmacies or retail stores. Covered services are typically provided by a physician's assistant or nurse practitioner. Covered services available at retail health clinics are limited to routine care and treatment of common illnesses.	
Shoe Inserts Is benefit included? Yes ☐ No ☐	Model Language	This policy or contract form provides coverage for 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.	
Telemedicine Program Is benefit included? Yes ☐ No ☐	Model Language	In addition to providing covered services via telehealth, this policy or contract form provides coverage for online internet consultations between the insured and providers who participate in the telemedicine program for medical conditions that are not an emergency condition.	
Urgent Care Services Is benefit included? Yes ☐ No ☐	Model Language	This policy or contract form provides coverage for urgent care. Urgent care is medical care for an illness, injury or condition that is serious enough for a reasonable person to seek care right away, but not so severe as to require emergency care.	
Vision Care Is benefit included? Yes ☐ No ☐	Model Language	This policy or contract form provides coverage for vision care.	
Wellness Programs Is benefit included? Yes ☐ No ☐	§ 3239 § 4224 45 CFR § 146.121 Model Language	This policy or contract form partially reimburses the subscriber and the subscriber's covered spouse or each covered dependent for certain exercise facility fees or membership fees. All wellness benefits must comply with Insurance Law § 3239. The policy or contract should provide a detailed description of the wellness program and/or reward being offered as part of the wellness program. All wellness programs and any rewards must have a nexus to accident and health insurance. 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.	
Additional Benefits Provided in Policy or Contract, or By Rider Additional benefits provided? Yes ☐ No ☐ If additional benefits are provided, please explain below:	11 NYCRR 52.1(c)	This policy or contract form, or 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 or 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.	
Benefit Explanation:			
MAKE AVAILABLE BENEFITS		*The following benefits must be made available to groups annually, in writing, and must be included in the policy or contract form if requested by the group. Use of model language is required.*	

(Required) Model Language Used? Yes ☐ No ☐			
Ambulatory Care	§ 3221(l)(3) § 4303(e), (f)	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. 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 non-experimental cancer chemotherapy and cancer hormone therapy. However, physical therapy services are to be provided in connection for the same illness for which the insured 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. Ambulatory care in physician's offices includes diagnostic X-rays, radiation therapy, laboratory and pathological examinations, and services and medications used for non-experimental cancer chemotherapy and cancer hormone therapy.	
Hospice Care	§ 3221(l)(10) § 4303(o) Model Language	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 at least 5 visits for bereavement counseling. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with those imposed on other benefits within this policy or contract form. *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 (6) months or less which is provided by a hospice organization certified pursuant to Public Health Law Article 40 or under a similar certification process required by the state in which the hospice organization is located. Insurers may remove the visit limit for bereavement counseling.*	
Nursing Home Care or Skilled Nursing Facility	§ 3221(l)(2) § 4303(d) Model Language	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 (2) days of nursing home care is equivalent to one day of hospital care.	
Out-of-Network Benefits	§ 3241(b)	If an insurer offers a policy or contract form that provides coverage for out-of-network health care services, the policy or contract form must make available and, if requested by the group, provide at least one option for coverage for at least 80% of the usual and customary cost, as defined by § 3241(b)(2) with 20% coinsurance for the insured, of each out-of-network health service after imposition of a deductible or any permissible benefit maximum. 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 similar specialty and provided in the same geographical areas as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent.	

		Note: The coinsurance listed above shall not apply to emergency services in hospital facilities or pre-hospital emergency medical services, as defined in §§ 3216(i)(24)(E)(i), 3221(l)(15)(E)(i), and 4303(aa)(5)(A). The cost-sharing for out-of-network emergency services must be the same as in-network emergency services.	
Registered Professional Nurse	§ 3221(l)(9) § 4303(m)	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.	
PERMISSIBLE EXCLUSIONS AND LIMITATIONS Model Language Used? Yes ☐ No ☐		*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.* *The following exclusions are permissible, except Conversion Therapy, which must be included. A plan does not need to include all of the exclusions. However, if an exclusion is included, use of the model language is required.*	Form/Page/Para Reference
Aviation	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	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.	
Conversion Therapy	11 NYCRR 52.16(n) Model Language	This policy or contract form excludes coverage for conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of an insured under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity. *Note: This exclusion is required.*	
Cosmetic Services	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	11 NYCRR 52.16(c)(12) Model Language	This policy or contract form excludes coverage for care or treatment while the insured is outside the United States, its possessions, Canada or Mexico.	

Dental Services	11 NYCRR 52.16(c)(9) Model Language	This policy or contract form excludes coverage for dental care or treatment 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. *(Note: Plans may, however, remove or extend the 12-month limitation.)*	
Experimental or Investigational Treatment	§ 3221(k)(12) § 4303(z) 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	§ 3221(c) 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.	
Foot Care	11 NYCRR 52.16(c)(6) Model Language	This policy or contract form excludes coverage for routine foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, this policy or contract form includes coverage for foot care for a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in a covered person's legs or feet.	
Government Facility	11 NYCRR 52.16(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	§ 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. Any denial of coverage should be treated as a medical necessity denial unless the denial is based on a benefit limit that is described in the contract or policy form.	
Medicare or Other Governmental Program	11 NYCRR 52.16(c)(8) 11 NYCRR 52.26(c) Model Language	This policy or contract form excludes coverage for benefits provided 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	11 NYCRR 52.16(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	11 NYCRR 52.16(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	11 NYCRR 52.16(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 Provided by a Family Member	11 NYCRR 52.16(c)(8) Model Language	This policy or contract form excludes coverage for services performed by a covered person's immediate family member. "Immediate family member" means a child, stepchild, spouse, parent, stepparent, sibling, stepsibling, parent-in-law, child-in-law, sibling-in-law, grandparent, grandparent's spouse, grandchild, or grandchild's spouse.	
Services With No Charge	11 NYCRR 52.16(c)(8) Model Language	This policy or contract form excludes coverage for services for which no charge is normally made.	
Services not Listed	§ 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. *Note: If out-of-network coverage is offered, all state mandated benefits (other than benefits that are solely essential health benefits) must be covered out-of-network.*	
Vision Services	11 NYCRR 52.16(c)(10) Model Language	This policy or contract form excludes coverage for the examination or fitting of eyeglasses or contact lenses.	
War	11 NYCRR 52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for an illness, treatment or medical condition due to war, declared or undeclared. *Note: Exclusions for terrorism are not permitted.*	
Workers' Compensation	11 NYCRR 52.16(c)(8) Model Language	This policy or contract form excludes coverage for benefits provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.	
CLAIM DETERMINATIONS Model Language Used? Yes ☐ No ☐		*Use of the model language is required.*	Form/Page/Para Reference
Notice of Claim	§ 3221(a)(8) § 3224-a Model Language	This policy or contract form provides that the insured must provide the insurer with written notice of claim as applicable. 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	§ 3221(a)(9) § 4305(m) Model Language	This policy or contract form provides 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.	
Payment of Claim	§ 3224-a(a), (b) Circular Letter No. 4 (2021)	Where the insurer's obligation to pay a claim is reasonably clear, the insurer shall pay the claim within 30 days of receipt of the claim (when transmitted via the internet or e-mail) or 45 days of receipt of the claim (when submitted by other means, such as paper or fax). If the insurer requests additional information, the insurer shall pay the claim within 15 days of the insurer's determination that payment is due but no later than 30 days (if the claim was transmitted via the internet or electronic mail) or 45 calendar days (if the claim was submitted by other means such as paper or facsimile) of receipt of the information.	
GRIEVANCE, UTILIZATION REVIEW AND EXTERNAL APPEAL		*Use of the model language is required.*	Form/Page/Para Reference

Model Language Used? Yes ☐ No ☐			
Grievance Procedures	§ 3217-a(a)(7) § 3217-d(a) § 4306-c(a) § 4324(a)(7) § 4802 PHL § 4408(1)(g) PHL § 4408-a 10 NYCRR 98-1.14 42 USC §300gg-19 29 CFR §2560.503-1 45 CFR §147.136 Model Language	A policy or contract form that is a managed care product as defined in § 4801(c), a comprehensive policy or contract that utilizes a network of providers, or an HMO, includes a description of the grievance procedure to be used to resolve disputes between the insurer and the insured, including: • 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	§ 3217-a(a)(3) § 3217-d(d) § 4306-c(d) § 4324(a)(3) Article 49 PHL § 4408(1)(c) 42 USC §300gg-19 29 CFR §2560.503-1 45 CFR §147.136 Model Language	This policy or contract form includes a description of the utilization review policies and procedures, including: • 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 notices of denials will include information about the basis of the decision; • A notice of the right to an external appeal, together with a description, jointly promulgated by the Commissioner of Health and Superintendent, of the external appeal process and the timeframes for such appeals; and • Further appeal rights, if any.	
Step Therapy Override Determinations	§ 4903(c-1), (c-2), (c-3) Model Language	If the insurer uses step therapy protocols for prescription drugs, the insured, the insured's designee or health care professional may request a step therapy protocol override determination for coverage of a prescription drug selected by the insured's health care professional. A step therapy protocol override determination request must include supporting rationale and documentation from a health care professional, demonstrating that: • The required prescription drug(s) is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured; • The required prescription drug(s) is expected to be ineffective based on the insured's known clinical history, condition, and prescription drug regimen; • The insured has tried the required prescription drug(s) while covered by the insurer or under a previous health insurance coverage, or another prescription drug in the same pharmacologic	

		class or with the same mechanism of action, and that prescription drug(s) was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event; • The insured is stable on a prescription drug(s) selected by their health care professional, provided this does not prevent the insurer from requiring the insured to try an AB-rated generic equivalent; or • The required prescription drug(s) is not in the insured's best interest because it will likely cause a significant barrier to the insured's adherence to or compliance with the insured's plan of care, will likely worsen a comorbid condition, or will likely decrease the insured's ability to achieve or maintain reasonable functional ability in performing daily activities. Standard Review. The insurer will make a step therapy protocol override determination and provide notification to the insured or the insured's designee and, where appropriate, the insured's health care professional, within 72 hours of receipt of the supporting rationale and documentation. Expedited Review. If the insured has a medical condition that places the insured's health in serious jeopardy without the prescription drug, the insurer will make a step therapy protocol override determination and provide notification to the insured or the insured's designee and the insured's health care professional, within 24 hours of receipt of the supporting rationale and documentation. If an insurer does not make a determination within 72 hours (or 24 hours for expedited reviews) of receipt of the supporting rationale and documentation, the step therapy protocol override request will be approved. If the insurer determines that the step therapy protocol should be overridden, the insurer will authorize immediate coverage for the prescription drug. An adverse step therapy override determination is eligible for an internal and external appeal pursuant to Insurance Law Article 49. *Note: A "step therapy protocol" means a policy, protocol or program that establishes the sequence in which the insurer will approve prescription drugs for a medical condition. When establishing a step therapy protocol, the insurer will use recognized evidence-based and peer reviewed clinical review criteria that also takes into account the needs of atypical patient populations and diagnoses.*	

External Appeal Procedures	Article 49
	PHL Article 49
	42 USC §300gg-19
	45 CFR §147.136
	Model Language
		This policy or contract form includes a description of the external appeal procedures, including:
		• Instructions on how to request an external appeal;
		• The circumstances under which an external appeal may be pursued, including a service denied as:
		  ○ 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;
		  ○ Formulary exception denials;
		  ○ Not an emergency service (including whether the correct cost-sharing was applied); and
		  ○ Not a service that resulted in a surprise bill (including whether the correct cost-sharing was applied); and	

		• The timeframe for submitting an external appeal.	
COORDINATION OF BENEFITS Model Language Used? Yes ☐ No ☐		*Use of the model language is required.*	Form/Page/Para Reference
Coordination of Benefits	11 NYCRR 52.23 Model Language	If this policy or contract contains a coordination of benefits provision, it must comply with 11 NYCRR 52.23.	
TERMINATION OF COVERAGE Model Language Used? Yes ☐ No ☐		*The following are the only termination provisions permissible under the Insurance Law. Use of the model language is required.*	Form/Page/Para Reference
Termination for Failure to Pay Premiums	§ 3221(a)(4) § 3221(p)(2)(A) § 4305(j)(2)(A) Model Language	This policy or contract form includes a provision permitting the insurer to terminate coverage if the employer or such other person designated has failed to pay premiums or contributions to the insurer in accordance with the terms of the policy or contract form, or the insurer has not received timely premium payments, with a grace period as specified.	
Termination for Fraud	§ 3105 § 3221(p)(2)(B) § 4305(j)(2)(B) Model Language	This policy or contract form includes a provision permitting the insurer to terminate coverage if the group or a subscriber has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in writing on an enrollment application or in order to obtain coverage for a service.	
Discontinuation of a Class of Coverage	§ 3221(p)(2)(D) § 3221(p)(3)(A) § 4305(j)(2)(D) § 4305(j)(3)(A) Model Language	This policy or contract form includes a provision permitting the insurer to discontinue this class of policy or contract upon written notice to each group, participant, and beneficiary not less than 90 days prior to the date of discontinuance. The insurer must offer groups 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 groups 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/Contracts in the Large Group Market	§ 3221(p)(2)(D) § 3221(p)(3)(E) § 4305(j)(2)(D) § 4305(j)(3)(E) Model Language	This policy or contract form (other than an HMO) includes a provision permitting the insurer to discontinue all hospital, surgical and medical expense coverage in the large group market upon written notice to the Superintendent and to each group, participant, and beneficiary at least 180 days prior to the date of discontinuance.	
Termination for Failure to Meet Requirements of Group	§ 3221(p)(2)(E) § 4235(c)(1) § 4305(j)(2)(E) Model Language	This policy or contract form includes a provision permitting the insurer to terminate coverage if the group ceases to meet the requirements of a group under § 4235. 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	§ 3221(p)(2)(F) § 4305(j)(2)(F) Model Language	This policy or contract form includes a provision permitting the insurer, in regard to a network plan, to terminate coverage 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 for Spouses in Cases of Divorce	§ 3221(p)(2)(G) § 4305(j)(2)(G) Model Language	This policy or contract form provides that in cases of divorce, coverage for the spouse shall terminate as of the date of the divorce.	

Termination upon Death of Subscriber	§ 3221(p)(2)(G) § 4305(j)(2)(G) Model Language	This policy or contract form provides that upon the subscriber's death, the coverage will terminate unless there are dependents covered. If there is coverage for dependents, then coverage will terminate as of the last day of the month for which the premium has been paid.	
Termination by Subscriber	Model Language	This policy or contract form provides that termination will occur at the end of the month during which the subscriber provides written notice requesting termination or on such later date requested for such termination by the notice.	
Rescission	§ 3105 § 3204 42 USC § 300gg-12 45 CFR § 147.128 Model Language	No misrepresentation shall avoid coverage or defeat any recovery thereunder 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 led the insurer to refuse to issue the coverage.	
Notice of Termination	11 NYCRR 52.18(c) Model Language	Unless otherwise specified under the Insurance Law, the insurer must provide at least 30 days' prior written notice of termination. The policy may establish the amount of prior written notice (typically 30 days) required for the group to terminate coverage. Coverage will terminate at the end of the month in which the group's written notice takes effect.	
Renewal	§ 3221(a)(5) § 3221(p) § 4305(j) 11 NYCRR 52.18(c) Model Language	This policy or contract form 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. This policy or contract form specifies the conditions under which the insurer may refuse to renew the policy or contract.	
LOSS OF COVERAGE Model Language Used? Yes ☐ No ☐		*Use of the model language is required.*	Form/Page/Para Reference
Extension of Benefits	11 NYCRR 52.18(b)(4), (5), (6) Model Language	This policy or contract form provides that when coverage under this policy or contract ends, benefits will be provided during a period of total disability for a hospital stay commencing, or surgery performed, within 31 days from the date coverage ends. The hospital stay or surgery must be for the treatment of the injury, sickness, or pregnancy causing the total disability. If the covered person's coverage terminates by reason of the termination of active employment, an extended benefit will be provided during a period of for up to 12 months from the date coverage ends for covered services to treat the injury, sickness, or pregnancy that caused the total disability, unless these services are covered under another group health plan.	
Continuation Coverage	§ 3221(e)(7) § 3221(m) § 4305(e) COBRA, Title X of Public Law 99-272 Model Language	This policy or contract form contains a provision regarding continuation coverage. State law 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. The Insurance Law permits the group to charge an additional 2% administrative fee for continued coverage. The continuation benefits terminate:	

		• The date 36 months after the date the subscriber's coverage would have terminated because of termination of employment; • In the case of a covered spouse or child, the date 36 months after coverage would have terminated due to the death of the subscriber, divorce or legal separation, the subscriber's eligibility for Medicare, or the failure to qualify under the definition of "children"; • The date the insured becomes covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage; • The date the insured becomes entitled to Medicare. • The date to which premiums are paid if the insured fails to make a timely payment; or • The date the policy or contract terminates. However, if the policy or contract is replaced with similar coverage, the insured has the right to become covered under the new policy or contract for the balance of the period remaining for the insured's continued coverage.	
Young Adult Option	§ 3221(r) § 4305(l) Model Language	This policy or contract form 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) or 4305(l). 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 insurer must comply with the notice requirements to each employee or member as set forth in §§ 3221(r) or 4305(l).	
Temporary Suspension of Coverage	§ 3221(n), (o) § 4305(g), (h) Circular Letter No. 7 (2003) USERRA, 38 USC § 4317 Model Language	This policy or contract form provides that 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 of up to four (4) years. The insurer will refund any unearned premiums for the period of the suspension. Persons covered by the policy or contract form 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.	
Supplementary Coverage for Employees or Members who are Also Members of the Reserve Components of the Armed Services or the National Guard	§ 3221(n), (o) § 4305(g), (h) Circular Letter No. 7 (2003) Model Language	If the group does not choose to voluntarily maintain coverage for any employee or member when they enter active duty, then such member or employee shall be entitled to continuation or conversion coverage.	
Conversion – Right to New Policy After Termination	§ 3221(e), (f), (g) § 4305(d) Model Language	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 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 or contract as a direct pay member, covering such member and his eligible dependents.	

		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. 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.	
GENERAL PROVISIONS Model Language Used? Yes ☐ No ☐		*Use of model language is required.*	Form/Page/Para Reference
Assignment	Financial Services Law Article 6 23 NYCRR 400 Model Language	This policy or contract form states that assignment of benefits is prohibited. If the insured receives services from a non-participating provider, the insurer may pay the non-participating provider or the insured.	
Incontestability	§ 3221(a)(1) Model Language	This policy or contract form provides that statements by the insured must be in writing and signed in order to be used to reduce benefits or avoid the insurance.	
Who May Change This Policy	§ 3221(a)(2) Model Language	This policy or contract form provides 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 group and insurer.	
Action in Law or Equity	§ 3221(a)(14) PHL § 4406-a Model Language	This policy or contract form provides that no action in law or equity shall be brought to recover on the policy or contract prior to the expiration of 60 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 (2) years following the time such proof of loss is required by the policy or contract.	
Subrogation	General Obligations Law § 5-335 Civil Practice Law and Rules § 4545(a) Model Language	Although not required, if a subrogation provision is included in this policy or contract form, it must comply with General Obligations Law § 5-335 and Civil Practice Law and Rules § 4545(a). When an insured settles a claim, whether in litigation or otherwise, against one or more other persons for personal injuries, medical, dental, or podiatric malpractice, or wrongful death, it shall be conclusively presumed that the settlement does not include any compensation for the cost of health care services, loss of earnings or other economic loss to the extent those losses or expenses have been or are obligated to be paid or reimbursed by an insurer. By entering into any such settlement, an insured shall not be deemed to have taken an action in derogation of any right of any insurer that paid or is obligated to pay those losses or expenses; nor shall an insured's entry into such settlement constitute a violation of any contract between the insured and such insurer. No insured entering into such a settlement shall be subject to a subrogation claim or claim for reimbursement by an insurer and an insurer shall have no lien or right of subrogation or reimbursement against any such settling	

		person or any other party to such a settlement, with respect to those losses or expenses that have been or are obligated to be paid or reimbursed by said insurer.	
Unilateral Modification	11 NYCRR 52.18(a)(8) Model Language	Unilateral modifications by an insurer to an existing policy or contract must be made with at least 30 days prior written notice to the group. Unilateral modification by the insurer may be made only at the time of renewal. If the policy or contract form requires the group policyholder or contract holder to provide written notice to terminate coverage, the notice of the unilateral modification by the insurer must be provided to such group no less than 14 days prior to the date by which the group is required to provide notice to terminate coverage.	
Non-English Speaking Insureds and Translation Services	§ 3217-a(a)(15) § 4324(a)(15) PHL § 4408(1)(p) Model Language	This policy or contract form includes a description of how the insurer addresses the needs of non-English speaking insureds.	
HMO MEMBER HANDBOOK REQUIREMENTS Model Language Used? Yes ☐ No ☐		*If the insurer uses the policy or contract form to satisfy HMO member handbook requirements, the following provisions are required. Use of the model language is required.*	Form/Page/Para Reference
Input in Developing Our Policies	Model Language	This policy or contract form includes a description of how the insurer may participate in the development of the insurer's policies.	
More Information about Your Health Plan	PHL § 4408(2) Model Language	The insured can request additional information about his/her coverage. Upon the insured's request, the insurer must provide the following information: • 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 disbursements. • 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, including clinical review criteria relating to a step therapy protocol override determination. • Written application procedures and minimum qualification requirements for providers. • Whether a health care provider scheduled to provide a health care service is an in-network provider. • With respect to out-of-network coverage, the approximate dollar amount that the insurer will pay for a specific out-of-network health care service.	
Your Medical Records and Reports	Model Language	This policy or contract form includes a description of the mandatory release of insured's medical information for the purpose of managing the insured's health care.	

Your Rights	10 NYCRR 98-1.14(b)(1) Model Language	This policy or contract form contains a provision which outlines the insured's right to access and utilize his/her medical information under this policy or contract.	
SCHEDULE OF BENEFITS Model Language Used? Yes ☐ No ☐		*Use of model language is required.*	Form/Page/Para Reference
Prohibition on Annual and Lifetime Dollar Limits on Essential Health Benefits	§ 3217-f § 4306-e 42 USC § 300gg-11 45 CFR § 147.126 Model Language	This policy or contract form must not include an annual or 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; rehabilitation and habilitation services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.	
Insured's Financial Responsibility for Payment	§ 3217-a(a)(5) § 4324(a)(5) PHL § 4408(1)(e) Model Language	This policy or contract form includes a description of the insured's financial responsibility for payment of premiums, deductibles, copayments and/or coinsurance, 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. Coinsurance values imposed on the insured should not exceed 50%.	
Consistent Cost-Sharing Across Categories of Benefits	11 NYCRR 52.16(c)	This policy or contract form does not apply different cost-sharing by type of illness, accident, treatment, or medical condition within the same category of benefits. *Note: Cost-Sharing applied to Advanced Imaging Services may not exceed the cost-sharing applied to Diagnostic Radiology Services by more than $100, including the applicability of the deductible.*	
RIDERS		*Use of model language is required.*	
Out-of-Network Coverage Model Language Used? Yes ☐ No ☐ If out-of-network coverage is offered, answer the following: Out-of-network coverage in the base policy/contract or by rider? ☐ Policy/Contract ☐ Rider	Model Language	If out-of-network coverage has been selected, this policy or contract form provides benefits for covered services that are received from out-of-network providers and have not been approved by the insurer to be covered on an in-network basis. Out-of-network coverage may be provided in the base policy or contract, or by rider. *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.*	
Rider for Contraceptive Drugs, Devices, or Products and Family Planning Services for Employees of Religious Employers Model Language Used? Yes ☐ No ☐	§ 3221(l)(16)(A) § 4303(cc)(1)(A) Model Language	This policy or contract form includes a rider for when a group has elected not to purchase coverage for contraceptive drugs, devices, or products pursuant to the religious employer exemption in §§ 3221(l)(16)(E) or 4303(cc)(5)(A). In accordance with law, if elected by an insured, this rider provides coverage for contraceptive drugs, devices, or products including over-the-counter contraceptive drugs, devices, and other products, approved by the FDA and as prescribed or otherwise authorized under State or Federal law. "Over-the-counter contraceptive products" means those products provided for in comprehensive guidelines supported by HRSA. Coverage also includes emergency contraception when provided pursuant to a prescription or order or when	

		lawfully provided over-the-counter. The insured may request coverage for an alternative version of a contraceptive drug, device or other product if the covered contraceptive drug, device or other product is not available or is deemed medically inadvisable, as determined by the insured's attending health care provider. Such coverage shall not be subject to deductibles, copayments and/or coinsurance.	
Rider for Abortion Services for Employees of Religious Employers Model Language Used? Yes ☐ No ☐	11 NYCRR 52.16(o) Model Language	This policy or contract form includes a rider for when a group has elected not to purchase coverage for abortion services pursuant to the religious employer exemption in 11 NYCRR 52.16(o). For groups that meet the definition of a religious employer in §§ 3221(l)(16)(E) or 4303(cc)(5)(A), the insurer may exclude coverage for abortion services only if the insurer: (1) receives an annual certification from the group policyholder that it is a religious employer requesting removal of such coverage; and (2) issues a rider to each certificate holder at no premium cost that provides coverage for abortion services without cost-sharing.	
Rider for Reimbursement for Travel and Lodging Expenses	Model Language	This policy or contract form provides benefits for certain travel and lodging expenses for travel to another state to access covered services when access to covered services is not available due to a law or regulation in the state in which the insured resides.	
PROVIDER NETWORKS Has the network been filed in PNDS? Yes ☐ No ☐	§ 3241	If the policy or contract uses a network of providers, the insurer must ensure that the network is adequate to meet the health needs of the insureds and provide an appropriate choice of providers sufficient to render the services covered under the policy or contract. The network must be filed in PNDS. If the network has not been filed in PNDS, it must be filed within 60 days of approval. See the Department of Financial Services' website for additional instructions and guidance relating to the submission of networks for review.	
MAJOR MEDICAL INSURANCE	11 NYCRR 52.7	*If the policy or contract being issued is major medical insurance as defined by 11 NYCRR 52.7, the following benefits must be included.*	
Copayments	11 NYCRR 52.7	Copayments may not exceed 25%.	
Deductible	11 NYCRR 52.7	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: • 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. *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.*	
Out-of-Hospital Care	11 NYCRR 52.7(g)	This policy or contract form 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	11 NYCRR 52.7(h)	This policy or contract form 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 warranty.	
ACTUARIAL SECTION FOR NEW PRODUCT RATE FILINGS ONLY		*Complete this section for all new product forms filings except those filings where a rate filing is unnecessary because: (**select one**)* ☐ *The submission contains only application forms, disclosure statements, and/or advertising, OR* ☐ *The form submission has no premium rate implications and a letter or actuarial memorandum is enclosed that states and justifies this as appropriate.* *For rate changes to existing products, do NOT complete this section – complete the Existing Products-Rate Requirements section below.*	Form/Page/Para Reference
ACTUARIAL MEMORANDUM	11 NYCRR 52.40(a)(1)	Actuarial qualifications: a. Member of Society of Actuaries, Casualty Actuarial Society, or American Academy of Actuaries; and b. Meets "Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States" as adopted by the American Academy of Actuaries.	
Justification of Rates	§3221 §4303 10 NYCRR 98-1.5(b)(18) 10 NYCRR 98-1.6(j) 10 NYCRR 98-1.8 11 NYCRR 52.40(e) 11 NYCRR 52.40(f) 11 NYCRR 52.45(f) 11 NYCRR 59.5(b)	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 and rating variables used. Any rating variables must be clearly defined and consistently applied. e. Provide rating methodology and assumptions used in rate calculation for mental health coverage provided pursuant to §§ 3221(l)(5); 4303(g); (h). f. Non-claim expense components as a percentage of gross premium. g. Expected loss ratio(s) 0.00% %.	
Loss Ratios	11 NYCRR 52.45(f) 11 NYCRR 59.5(b)	Expected loss ratio(s) – with actuarial justification	
Reserve Basis	11 NYCRR 94	Description of bases for unpaid claim liabilities and extra reserves (if any).	
Actuarial Certification	11 NYCRR 52.40(a)(1)	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: 0.00% %.	
GROUP RATE MANUAL	11 NYCRR 52.40(e)(2) 11 NYCRR 52.40(e)(3) 11 NYCRR 52.42(e) 11 NYCRR 52.45(f) 11 NYCRR 59.5(b) Insurance Circular Letter No. 20 (2017) Supplement No. 1 to Insurance Circular Letter No. 20 (2017) Guidance Regarding Rate Guarantees and New Business Discounts	a. Table of contents. b. Insurer name on each consecutively numbered rate page. c. Identification by form number of each policy, rider, or endorsement to which the rates apply. d. Brief description of benefits, types of coverage, limitations, exclusions, and issue limits. e. Description of rating classes, factors, rating variables, and premium discounts. f. Examples of rate calculations. g. Commission schedule(s) and fees. Must comply with Insurance Circular Letter No. 20 (2017) and the Supplement No. 1 to Insurance Circular Letter No. 20 (2017). h. Must comply with guidance regarding Rating Guarantees and New Business Discounts. i. Underwriting guidelines and/or underwriting manual. j. Expected loss ratio(s).	
ACTUARIAL SECTION FOR EXISTING PRODUCT RATE FILINGS ONLY		*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.)*	
ACTUARIAL MEMORANDUM	11 NYCRR 52.40(a)(1)	Actuarial qualifications: a. Member of Society of Actuaries, Casualty Actuarial Society, or American Academy of Actuaries; and b. Meets "Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States" as adopted by the American Academy of Actuaries.	
Justification of Rates	11 NYCRR 52.40(e) 11 NYCRR 42.40(f) 11 NYCRR 52.40(g) 11 NYCRR 52.45(f) 11 NYCRR 59.5(b)	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: (i) Earned premium; (ii) Paid and incurred claims; and (iii) Incurred loss ratios. d. Actuarial justification of proposed rates revision (increase/decrease) including any revisions to rating variables. Any rating variables must be clearly defined and consistently applied. 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	11 NYCRR 52.45(f) 11 NYCRR 59.5(b)	Expected loss ratio(s) – with actuarial justification	
Reserve Basis	11 NYCRR 94	Description of bases for unpaid claim liabilities and extra reserves (if any).	
Actuarial Certification	11 NYCRR 52.40(a)(1)	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: 0.00% %	
REVISED RATE MANUAL PAGES	11 NYCRR 52.40(e)(2) 11 NYCRR 52.42(e) 11 NYCRR 52.45(f) 11 NYCRR 59.5(b) Insurance Circular Letter No. 20 (2017) Supplement No. 1 to Insurance Circular Letter No. 20 (2017) Guidance Regarding Rate Guarantees and New Business Discounts	a. Table of contents. b. Insurer name on each consecutively numbered rate page. c. Identification by form number of each policy, rider, or endorsement to which the rates apply. d. Brief description of benefits, types of coverage, limitations, exclusions, and issue limits. e. Description of revised rating classes, factors, rating variables, and discounts. f. Examples of rate calculations. k. Commission schedule(s) and fees. Must comply with Insurance Circular Letter No. 20 (2017) and the Supplement No. 1 to Insurance Circular Letter No. 20 (2017). l. Must comply with guidance regarding Rating Guarantees and New Business Discounts. g. Underwriting guidelines and/or underwriting manual. h. Expected loss ratio(s).	