NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Review Standards for Basic Hospital Insurance for Group Commercial Insurers Subject to Article 32

(As of 9/18/12)

Instructions for SERFF Checklist:

A. For **ALL** filings, the "General Requirements for All Filings" section must be completed:

B. For a **FORM** filing, completion of additional sections may be required as follows, depending on the type of form being submitted:

- Policy – Also complete all sections except the section entitled "Application Forms."
- Application – Also complete the section entitled "Application Forms."
- Rider or endorsement – Also complete all items relevant to the form being submitted in all sections.

C. For filing of initial rates, complete the section entitled "Actuarial Section For Initial Rate Filings Only" in addition to completion of the applicable form sections identified above.

D. For each item, enter in the last column the form number(s), page number(s) and paragraph(s) where the requirement is met in the filing or insert a bookmark connecting to the appropriate location in the filing.

E. Do not make any changes or revisions to this checklist.

F. **Updates to Checklist:** Any items on the checklist that have been updated since the last posting are shaded.

G. **Instructions for Citations:** All citations to Insurance regulations link to the Department of State's website and an unofficial copy of the NYCRR. Please select title 11 for Insurance regulations. Most of the pertinent form and rate regulations are located in Chapter III Policy and Certificate Provisions, Subchapter A Life, Accident and Health Insurance. All citations to New York Laws (Insurance Laws or other New York laws) link to the public LRS website. To locate the Insurance Laws, please select the link labeled "ISC".

LINE OF BUSINESS:	**Basic Hospital Insurance**	LINE(S) OF INSURANCE	CODES
CODE:	H15G	Health – Hospital/Surgical/Medical Expense	H15G.001 H15G.002 H15G.003

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

REVIEW REQUIREMENT	**REFERENCE**	**DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS**	**LOCATION OF STANDARD IN FILING**
GENERAL REQUIREMENTS FOR ALL FILINGS	*Note: Unless otherwise noted, all references are to Insurance Law, Insurance Regulations, and Insurance Department Circular Letters and OGC opinions*	*Note: This is a checklist for basic hospital insurance as defined by 11 NYCRR 52.5. This checklist is intended to provide guidance in the preparation of policy forms for submission and is not intended as a substitute for statute or regulation.*	Form/Page/ Para Reference
Complete Policy Submission or Pages/Rider/Endorsement		This submission contains a complete policy form. Yes ☐ No ☐ If this submission contains insert pages, riders or endorsements, then the policy in its entirety complies with all the statutory and regulatory provisions stated below. Yes ☐ No ☐ (If no is checked, explain in the space provided above.) This rider, insert pages, or endorsements are being attached to a policy that was approved by the Department on _____, submission number _____.	
Form Requirements	11 NYCRR 52.31(b), (c), (d), (e), (f), (l)	Each form in the filing must meet the following requirements: • This form contains no strikeouts. § 52.31(b) • This form is submitted in duplicate. § 52.31(c) • This form is designated by a form number made up of numerical digits and/or letters in the lower left-hand corner of the first page. § 52.31(d) • This form is submitted in the form intended for actual use. § 52.31(e) • All blank spaces are filled in with hypothetical data. § 52.31(f) • If the form contains illustrative material, it does so only for items that may vary from case to	

		case, such as names, dates, eligibility requirements, premiums and schedules for determining the amount of insurance for each person. § 52.31(l) • Portions of other provisions, such as insuring clauses, benefit provisions, restrictions and termination of coverage provisions, may be submitted as variable, if suitably indicated by red ink, bracketing or underlining and an explanatory memorandum must be submitted that clearly indicates the nature and scope of the variations to be used. An explanatory memorandum may not use terms such as "will conform to law" or "as requested by policyholder" to describe the variable material. § 52.31(l)	
Flesch Score	§ 3102(c)	Provide Flesch score certification (the Flesch score should be at least 45). The number of words, sentences and syllables in the form should be set forth as part of the certification, which must be signed by an officer of the company.	
Letter of Submission	11 NYCRR 52.33 Circular Letter No. 33 (1999) Supplement 1 to CL No. 33 (1999)	The filing must include a letter of submission in duplicate, signed by a representative of the company authorized to submit forms for filing or approval, that contains the following: • The identifying form number of each form submitted. § 52.33(a) • If the form is a policy, the letter must indicate that the policy is submitted pursuant to 11 NYCRR 52.7. § 52.33(b) • Whether the form is new or supersedes an approved or filed form. § 52.33(c) • If the form supersedes an approved or filed form, the letter must state the form number and date of approval or filing of the superseded form and any material differences from the superseded form. § 52.33(d) • If the approval of the superseded form is still pending, the letter must include the form number, control number assigned by the Department and the submission date. § 52.33(d) • If the form had previously been submitted for preliminary review, the letter must include a reference to the previous submission and a statement setting out either that the form agrees precisely with the previous submission; or the differences from the form submitted for preliminary review. § 52.33(e) • If the form is submitted in accordance with 11 NYCRR 52.32(c), the letter must identify the prefiled group coverage. § 52.33(f) • If the form is other than a policy form, the letter must identify the form number and approval date of the policy or policies with which it will be used. If the form is for general use, the Department may accept a description of the type of policy with which it may be used in lieu of the form number and approval date. § 52.33(g) • If the form is a policy, the letter must identify the form numbers and dates of approval of any applications previously approved to be used with the policy unless the application is required to be attached to the policy upon submission. § 52.33(h) • If the policy is designed to be used with insert pages, the letter must contain a statement of the insert page forms which must always be included in the policy and a list of all optional pages, together with an explanation of their use. § 52.33(i) *Note: Submission letters should advise as to whether the policy is intended for internet sales and should describe any proposed electronic procedures and/or the proposed use of electronic signatures associated with the sale of the policy.*	
Group Status and Recognition	§ 4235 § 3201(b)(1)	The submission letter should include a statement that policy forms will be sold to a group specified in Insurance Law § 4235(c)(1). However, a more detailed statement must be included where discretionary group status is sought under Insurance Law § 4235(c)(1)(M). See below. The letter	

	11 NYCRR 59	should indicate whether the submission is for general use or is submitted on a one case basis. If the submission is for use on a one case basis, the group must be identified along with the subpart of Insurance Law § 4235(c)(1) in which the group fits and a confirmation that the group meets all of the requirements of the identified subpart. Requests for discretionary group recognition, pursuant to Insurance Law § 4235(c)(1)(M), must be accompanied by written documentation that demonstrates that the proposed group meets each and every element stated in the named statute. The documentation must also make clear that the request for discretionary group recognition is not a subterfuge, evasion technique, or a marketing tool to avoid compliance with other statutory or regulatory requirements and recognized marketing mechanisms. This provision is not intended to allow approval of groups recognized in the various subparagraphs of § 4235(c)(1) or § 4237(a)(3), but for which the proposed discretionary group does not meet one or more of the requisites specifically required or proscribed by § 4235 or § 4237. The request for allowance of a discretionary group must be granted before it may be used. Pursuant to § 3201(b)(1) and Insurance Regulation 123, an accident and health certificate is deemed delivered in New York and subject to review and approval regardless of the actual place of delivery, if the policy is issued to certain groups. In these cases, the group certificate is reviewed for compliance with New York Law. The group policy that is delivered out-of-state is not reviewed.	
Prefiled Group Coverage	11 NYCRR 52.32	A copy of the letter of confirmation sent to the policyholder by the insurer must be submitted to the Department within 30 days after the date the insurer agrees to provide insurance and must include the following: • 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 policyholder requested the insurer provide immediate coverage. Also, the actual forms must be submitted for approval within six months from the date the insurer agrees to provide insurance. § 52.32(c). Failure to meet any of the conditions within the time specified shall be a violation of the Insurance Law, unless reasons for delay, including its probable extent, satisfactory to the Department are submitted to the Department within the respective times specified.*	
Table of Contents	§ 3102(c)(1)(G)	A table of contents is required for policies that are over 3,000 words or more than 3 pages regardless of the number of words.	
Discrimination	§ 2606, § 2607, & § 2608	This form does not contain any unfair discrimination provisions because of race, color, creed, national origin, disability (including treatment of mental disability), sex, and marital status.	
APPLICATION FORMS			Form/Page/ Para Reference
Authorization	11 NYCRR 420.18(b)	If the application includes an authorization to disclose non-public personal health information, the authorization specifies the length of time the authorization will remain valid. The maximum	

		allowable period is 24 months.	
Fraud Warning Statement	§ 403(d)	The application contains the prescribed fraud warning statement.	
Pre-Existing Conditions	11 NYCRR 52.51(j)	If the application is used with a policy that contains a "pre-existing conditions" provision, the application must include a statement describing the provision.	
Prohibited Questions and Provisions	§ 3221(q)(1) § 3204 11 NYCRR 52.51	The application does NOT contain: Questions as to the applicant's health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of domestic violence), disability or the applicant's race. A provision that changes the terms of the policy to which it is attached. A statement that the applicant has not withheld any information or concealed any facts. An agreement that an untrue or false answer material to the risk will render the policy void. An agreement that acceptance of any policy issued upon the application will constitute a ratification of any changes or amendments made by the insurer and inserted in the application, except to conform to § 3204(d).	
POLICY FORM PROVISIONS			Form/Page/ Para Reference
COVER PAGE			
Insurer name		This policy contains the name and full address of the issuing insurer on the front or back cover.	
Signature of Company Officer		The signature of company officer(s) appears prominently on the policy (such as on the cover).	
DEFINITIONS		*If definitions are included in the policy the definitions must comply with the following.*	
Continuous Hospital Confinement	11 NYCRR 52.2(f)	The definition of "continuous hospital confinement" complies with § 52.2(f).	
Creditable Coverage	§ 3232(c) 11 NYCRR 52.20	The definition of "creditable coverage" complies with § 3232(c) and § 52.20.	
Emergency Condition	§ 3221(k)(4)(B) § 4900(c)	The definition of "emergency condition" complies with § 3221(k)(4)(B) and § 4900(c).	
Enrollment Date	§ 3232(b) 11 NYCRR 52.20	The definition of "enrollment date" complies with § 3232(b) and § 52.20.	
Hospital	11 NYCRR 52.2(m)	The definition of "Hospital" complies with § 52.2(m).	
ELIGIBILITY			
Spouse Model Language Used? Yes ☐ No ☐	§ 4235(f)(1)(A) Circular Letter No. 27 (2008) Model Language	If dependent coverage is selected by the policyholder, this policy provides coverage for the lawful spouse, unless there is a divorce or annulment of the marriage. This includes the recognition of marriages between same-sex partners legally performed in this state and in other jurisdictions.	
Dependents Model Language Used? Yes ☐ No ☐	§ 4235(f)(1)(A)(i) § 3221(a)(7) 42 USC § 300gg-14 26 CFR §§ 144.101, 146.101, 147.100 and 147.120 Model Language (PPACA Rider)	If dependent coverage is selected by the policyholder, this policy provides coverage of children until age 26. *Note: Pursuant to § 2608-a, an insurer may not deny enrollment to a child under the health coverage of the child's parent on the ground that the child was born out of wedlock, the child is not claimed as a dependent on the parent's federal income tax return, or the child does not reside with the parent or in the insurer's service area.*	

Extended Dependent Coverage Model Language Used? Yes ☐ No ☐	§ 4235(f)(1)(B) Model Language	If dependent coverage is selected by the policyholder, this policy must make available and if requested by the policyholder, provide coverage for unmarried children through the age of 29 (up to age 30); regardless of financial dependence; who are not insured by or eligible for coverage under an employer-sponsored health benefit plan covering them as an employee or member, whether insured or self-insured; and who live, work or reside in New York State or the service area of the insurer. The company must comply with the notice requirements set forth in § 4235(f)(1)(B).	
Unmarried Students on Medical Leave of Absence	§ 3237 42 USC §300gg-28	If this policy provides coverage for dependent children who are full-time students to a higher age than other dependent children, then coverage shall continue when such dependent takes a medical leave of absence from school due to illness or injury for a period of 12 months from the last day of attendance at school, provided, however, that coverage of a dependent student is not required beyond the age at which coverage would otherwise terminate. To qualify for such coverage, the insurer may require that the medical necessity of the leave be certified to by the student's attending physician who is licensed to practice in the state of New York.	
Unmarried Disabled Children Model Language Used? Yes ☐ No ☐	§ 4235(f)(1)(A)(ii) Model Language	If dependent coverage is selected by the policyholder, this policy provides coverage for unmarried disabled children, regardless of age, who are incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap, and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate. *Note: Such coverage shall not terminate while the policy remains in effect and the dependent remains in such condition and is chiefly dependent on the insured for support and maintenance, if the insured has within 31 days of such dependent's attainment of the limiting age submitted proof of such dependent's incapacity.*	
Newborn Infants	§ 4235(f)(2)	If dependent coverage is selected by the policyholder, this policy provides coverage of newborn infants, including newly born infants adopted by the insured if the insured takes physical custody of the infant upon the infant's release from the hospital and files a petition pursuant to § 115-c of the domestic relations law within 30 days of birth; and provided further that no notice of revocation to the adoption has been filed and consent to the adoption has not been revoked, shall be effective from the moment of birth, except that in cases of adoption, coverage of the initial hospital stay shall not be required where a birth parent has insurance coverage available for the infant's care. *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.*	
Adopted Children and Step-Children	11NYCRR52.18(e)(2); (3)	If dependent coverage is selected by the policyholder, this policy provides that adopted children and stepchildren dependent upon the insured are eligible for coverage on the same basis as natural children. Further, a family policy covering a proposed adoptive parent, on whom the child is dependent, shall provide that such child be eligible for coverage on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption.	
Domestic Partners	§ 4235(f)(1)(A) OGC Opinion 01-11-23	This policy may cover domestic partners, who are financially interdependent on the employee or member, but such coverage is not required. If such coverage is provided, the policy shall require the applicant to provide the following: • Registration as a domestic partner or an affidavit of domestic partnership	

Model Language Used? Yes ☐ No ☐	Model Language	• Proof of cohabitation • Proof of financial interdependency by evidence of two or more of the following: joint bank account; joint credit or charge card; joint obligation on a loan; status as authorized signatory on the partner's bank account, credit card or charge card; joint ownership or holding of investments; joint ownership of residence; joint ownership of real estate other than residence; listing of both partners as tenants on lease; shared rental payments; shared household expenses; shared household budget for purposes of receiving government benefits; joint ownership of major items of personal property; joint ownership of a motor vehicle; joint responsibility for child care; shared child-care expenses; execution of wills naming each other as executor and/or beneficiary; designation as beneficiary under the other's life insurance policy or retirement benefits account; mutual grant of durable power of attorney; mutual grant of authority to make health care decisions; affidavit by creditor or other individual able to testify to partners' financial interdependence; other items of sufficient proof to establish economic interdependency under the circumstances of the particular case.	
New Family Members		The policy describes the requirements to add new family members to the policy.	
New Employees	§ 3221(a)(3)	New employees or members of the class must be added to the class for which they are eligible.	
Open Enrollment Period	11 NYCRR52.70(e)(3)	This policy must insure all persons without evidence of insurability, provided that coverage is elected during an initial period of eligibility of at least 30 days. Rules may be established limiting future enrollment to specific time periods. However, specified periods of open enrollment must be provided once every 12 months, for a period of not less than 30 days. No enrollment limitation shall apply to insureds who apply for coverage under the conditions described in § 3221(q)(5). *Note: If a certificate holder fails to timely enroll a newborn pursuant to the terms of the policy, 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.*	
MANDATORY COVERED BENEFITS		*The following benefits must be included in the policy.* *Note: All accident and health insurance products whether indemnity or expense incurred that meet or exceed the level of benefits described in 11 NYCRR 52.5 require the mandated benefits listed below.*	
Hospital Confinement (Daily Room and Board)	11NYCRR52.5(a)	This policy includes coverage subject to no deductible in excess of $500 for a period of not less than 60 days for any continuous hospital confinement for an insured for services rendered while confined in a hospital for at least: Daily room and board, consisting of bed and board, including general nursing care and special diets, in an amount not less than the lesser of: • 80 percent of the charges for semiprivate accommodations; • 100 percent of the charges for semiprivate accommodations for the first 20 days of confinement and at least 50 percent of such charges for the next 40 days; or • $240 per day; except that $240 may be reduced to $165 for policies issued for delivery outside of the metropolitan area.	
Hospital Confinement (Miscellaneous Hospital Services)	11NYCRR52.5(b)	Miscellaneous hospital services, during each period of continuous hospital confinement as an inpatient, in an amount not less than 80 percent of the charges incurred, up to at least $5,000 or 20 times the daily room and board rate if specified in dollar amounts for at least: • the use of operating, recovery and cytoscopic rooms and equipment; • the use of intensive care or special care units and equipment to the extent not otherwise provided in the policy;	

		• diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous and visualizing dyes for care in the hospital, and administration thereof, but not including those which are not commercially available for purchase and readily obtainable by the hospital; • dressings and plaster casts; • supplies and use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, X-ray examinations and radiation therapy, laboratory and pathological examinations, blood products, except when participation in a volunteer blood replacement program is available to the insured; • radiation therapy and chemotherapy; and • any medical services and supplies which are customarily provided by hospitals, unless specifically excluded in the insurance or subscriber contract and the individual certificates issued in connection with group insurance.	
Outpatient Hospital Services	11NYCRR52.5(c)	This policy includes coverage for outpatient hospital services, consisting of the following: • Hospital services on the day surgery is performed; and • Hospital services rendered within 24 hours after accidental injury, in an amount not less than the lesser of the reasonable charges incurred or the per-day amount provided for daily room and board if specified in dollar amounts.	
Home Health Services	§ 3221(k)(1)	This policy includes coverage of home care for not less than 40 visits in any calendar year or continuous twelve month period for each person covered under the policy if hospitalization or confinement in a nursing facility would otherwise be required. Home care must be provided by an agency possessing a valid certificate of approval or license issued pursuant to Article 36 of the Public Health Law and shall consist of one or more of the following: • 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, drugs and medications prescribed by a physician and laboratory services by or on behalf of a certified or licensed home health agency. • Each visit by a member of a home care team shall be considered as one home care visit. • Four hours of home health aide service shall be considered as one home care visit	
Preadmission Testing	§ 3221(k)(2)	This policy includes coverage for preadmission testing ordered by a physician performed in the out-patient facilities of a hospital as a planned preliminary to admission of the patient as an in-patient for surgery in the same hospital provided that: tests are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed; reservations for a hospital bed and for an operating room were made prior to the performance of the tests; the surgery actually takes place within seven days of the tests; and the patient is physically present at the hospital for the tests.	
Emergency Services Model Language Used? Yes ☐ No ☐	§ 3221(k)(4) § 3217-a(a)(8) § 4900(c) Circular Letter No.1 (2002)	This policy includes coverage for the treatment of an emergency condition in hospital facilities: • without the need for any prior authorization; • regardless of whether the provider is a participating provider; • without imposing any administrative requirement or limitation on out-of-network coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers; • the cost-sharing (co-payment or coinsurance) shall be the same regardless of whether the	

	42 USC § 300gg-19a 45 CFR § 147.138(b) Model Language (PPACA Rider)	services are provided by a participating or a non-participating provider; and • The benefits for out-of-network emergency services must at a minimum equal the greatest of the following amounts: (i) the amount negotiated with in-network providers for the emergency service; (ii) the amount for the emergency service calculated using the same method the insurer uses to determine payments for out-of-network services excluding any in-network co-payment or coinsurance; or the amount that would be paid under Medicare for the emergency service excluding any in-network co-payment or coinsurance. *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 in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy, or (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 §1867(e)(1)(A)(i), (ii) or (iii) of the Social Security Act.* *Emergency services means with respect to an emergency condition (i) a medical screening examination as required under 42 U.S.C. §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 U.S.C. §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 the 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 insured from a facility or to deliver a newborn child (including the placenta).*	
Maternity Care	§ 3221(k)(5)	This policy includes coverage for maternity care, to the same extent as coverage provided for illness or disease under the policy. • Such coverage, other than for perinatal complications, includes inpatient hospital coverage for mother and newborn for at least 48 hours after childbirth for any delivery other than a caesarean section, and for at least 96 hours following a caesarean section. • The mother has the option to be discharged earlier than the time periods listed above, and, in such cases, is entitled to one home care visit in addition to any home care provided under § 3221(k)(1). Such home care is not subject to deductibles, coinsurance or co-payments. • Maternity coverage also includes coverage of the services of a midwife licensed pursuant to Article 140 of the Education Law, practicing consistent with a collaborative relationship with a physician or a hospital licensed pursuant to Article 28 of the Public Health Law, consistent with the requirements § 6951 of the Education Law • Maternity coverage also includes parent education, training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments.	
Treatment of Correctable Medical Conditions that Cause Infertility/Infertility Treatments	§ 3221(k)(6) 11 NYCRR	This policy shall not exclude coverage for hospital care for the diagnosis and treatment of correctable medical conditions otherwise covered under the policy solely because the medical condition results in infertility.	

	52.18(a)(10) Definition of Infertility OGC Opinion 05-11-10	• Coverage shall not exclude surgical or medical procedures which would correct malformation, disease or dysfunction resulting in infertility. • Coverage shall not exclude diagnostic tests and procedures including hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysterogram, post coital tests, testis biopsy, semen analysis, blood tests, ultrasound and artificial insemination, or prescription drugs if prescription drug coverage is otherwise provided under the policy. • Coverage shall be provided for persons aged 21-44 years; however, coverage beyond this age range is not precluded. Such coverage may be subject to annual deductibles and coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy. • This mandate does not require coverage of the following treatments in connection with infertility: in vitro fertilization; gamete intrafallopian tube transfers; zygote intrafallopian tube transfers; the reversal of elective sterilizations; sex change procedures; cloning; or medical or surgical services or procedures determined to be experimental. These are the only infertility treatments that may be expressly excluded in the policy.	
Mastectomy Care	§ 3221(k)(8) Women's Health and Cancer Rights Act of 1999, 29 USC 1185(b)	This policy includes coverage for a period of inpatient hospital care as is determined by the attending physician in consultation with the patient to be medically appropriate for a person undergoing a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered under the policy, and any physical complications arising from the mastectomy, including lymphedema. Such coverage may be subject to annual deductibles and coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy.	
Experimental/Investigational Services Recommended by an External Appeal Agent	§ 3221(k)(12) Article 49	This policy shall not exclude coverage of a health care service on the basis that it is experimental or investigational, or rendered as part of a clinical trial, if coverage of the service has been recommended by an external appeal agent pursuant to an external appeal performed according to Title II of Article 49.	
Mental, Nervous and Emotional Disorders	§ 3221(l)(5) Circular Letter No. 20 (2009) Supplement 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136	This policy includes coverage for the diagnosis and treatment of mental, nervous and emotional disorders, at least equal to the following: • 30 days of inpatient treatment in any contract, plan or calendar year. • 20 outpatient visits in any contract, plan or calendar year for outpatient treatment in a facility issued an operating certificate by the Commissioner of Mental Health or a facility operated by the Office of Mental Health. • Benefits for partial hospitalization program services shall be provided as an offset to covered inpatient days at a ratio of two partial hospitalization visits to one inpatient day treatment. • Coverage for adults and children with biologically based mental illnesses as defined in § 3221(l)(5)(B)(ii) and for children with serious emotional disturbances, as defined in § 3221(l)(5)(C) must be comparable to other coverage provided under the policy. However, this provision is not mandatory for groups with fifty or fewer employees, but must be made available to the policyholder for purchase. Such coverage may be subject to annual deductibles, co-pays and coinsurance as may be deemed appropriate by the Superintendent and shall be consistent with those imposed on other benefits under the policy. *Note: If a group has more than 50 total employees, regardless of eligibility, the Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) applies and the above 30/20 treatment limits will typically be impermissible. Under MHPAEA, group health policies that provide both medical*	

		and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy. The MHPAEA also prohibits such policies from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy provides coverage for out-of-network services, such policy must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.	
Outpatient Substance Abuse Services	§ 3221(l)(7) Circular Letter No. 20 (2009) Supplement 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136	This policy includes coverage for at least 60 outpatient visits in any calendar year for the diagnosis and treatment of chemical dependence, of which up to twenty visits may be for family members. Such coverage may be limited to facilities in New York State, certified by the Office of Alcoholism and Substance Abuse Services (OASAS) or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs and, in other states, to those accredited by the joint commission on accreditation of hospitals as alcoholism or chemical dependence treatment programs. Such coverage may be subject to annual deductibles and coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within a given policy. *Note: By the express terms of the statute, this benefit must be provided on a calendar year basis. It may not be provided on a policy or plan year basis.* *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.* *Note: The coverage provided under this statute includes treatment as a family member pursuant to such family member's own policy 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: If a group has more than 50 total employees, regardless of eligibility, the Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) applies and the above 60 day visit limit will typically be impermissible. Under MHPAEA, group health policies that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy. The MHPAEA also prohibits such policies from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy provides coverage for out-of-network services, such policy must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	
Inpatient Substance Abuse Services	Circular Letter No. 20 (2009) Supplement.1 to Circular Letter No. 20 (2009)	If a group has more than 50 total employees, regardless of eligibility, the Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) applies. If the policy covers outpatient substance abuse services it must also cover inpatient substance abuse services. Under MHPAEA, group health policies that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost sharing) and treatment limitations (day/visit	

	Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Public Law 110-343 45 CFR 146.136	limits) applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy. The MHPAEA also prohibits such policies from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy provides coverage for out-of-network services, such policy must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.	
Preventive Care Model Language Used? Yes ☐ No ☐	42 USC § 300gg-13 45 CFR §147.130 Model Language (PPACA Rider)	If the policy is not "grandfathered" pursuant to 42 U.S.C. §18011(e) it must also provide coverage for the following services with no cost-sharing: • Evidence-based items or services for children and adults with a rating of A or B by the U.S. Preventive Services Task Force. • Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. • Preventive care and screenings for infants, children and adolescents in guidelines supported by the Health Resources and Services Administration. • Preventive care and screenings for women in guidelines supported by the Health Resources and Services Administration.	
Mammography Screening	§ 3221(l)(11) 42 USC § 300gg-13 45 CFR §147.130	This policy 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 aged 35-39, inclusive. • An annual mammogram for covered persons aged 40 and older. • Mammography screening means an X-ray examination of the breast using dedicated equipment. Such coverage may be subject to annual deductibles and coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy. If the policy is not "grandfathered" pursuant to 42 U.S.C. §18011(e) it must also provide coverage for the following mammography screening services with no cost-sharing: • Evidence-based items or services for children and adults with a rating of A or B by the U.S. Preventive Services Task Force. • Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. • Preventive care and screenings for infants, children and adolescents in guidelines supported by the Health Resources and Services Administration. • Preventive care and screenings for women in guidelines supported by the Health Resources and Services Administration.	
Cervical Cytology Screening	§ 3221(l)(14) 42 USC § 300gg-13 45 CFR § 147.130	This policy includes coverage for annual cervical cytology screening for cervical cancer and its precursor states for women aged eighteen and older. Cervical cytology screening includes an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear. Such coverage may be subject to annual deductibles and coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy.	

		If the policy is not "grandfathered" pursuant to 42 U.S.C. §18011(e) it must also provide coverage for the following cervical cytology screening services with no cost-sharing: • Evidence-based items or services for children and adults with a rating of A or B by the U.S. Preventive Services Task Force. • Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. • Preventive care and screenings for infants, children and adolescents in guidelines supported by the Health Resources and Services Administration. • Preventive care and screenings for women in guidelines supported by the Health Resources and Services Administration.	
Autism Spectrum Disorder	§ 3221(l)(17)	This policy includes coverage for the screening, diagnosis and treatment of autism spectrum disorder, including the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist: • 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 provides coverage for therapeutic care; and • pharmacy care in the event that the policy provides coverage for prescription drugs. This policy shall include a definition of "autism spectrum disorder" which means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder; Asperger's disorder; Rett's disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS). The policy shall include a definition of "behavioral health treatment" which means counseling and treatment programs, when provided by a licensed provider and applied behavior analysis, when provided or supervised by a behavior analyst certified pursuant to the behavior analyst certification board, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. The policy shall include coverage for "applied behavior analysis" which means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. Coverage for applied behavioral analysis shall be subject to a maximum benefit of $45,000 per year per covered individual and such maximum annual benefit will increase by the amount calculated from the average ten year rolling average increase of the medical component of the consumer price index. The policy shall include a definition of "assistive communication devices" which at a minimum shall include dedicated devices which are specifically designed to aid in communication and are not generally useful to a person in the absence of a communication impairment and software applications	

		that enable a non-covered device to function as a communication device. Such coverage may be subject to annual deductibles, copayments and coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy.	
Limitations on Annual Dollar Limits Model Language Used? Yes ☐ No ☐	§ 3217-f 42 USC §300gg-11 45 CFR §147.126 Model Language (PPACA Rider)	The policy may impose "restricted" annual dollar limits for essential health benefits for plan years prior to January 1, 2014 as follows: • For a policy year beginning on or after 9/23/10 but before 9/23/11 the limit is $750,000. • For a policy year beginning on or after 9/23/11 but before 9/23/12 the limit is $1,250,000. • For a policy year beginning on or after 9/23/12 but before 9/23/14 the limit is $2,000,000. Essential health benefits are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorders, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including oral and vision care.	
Prohibition on Lifetime Dollar Limits Model Language Used? Yes ☐ No ☐	§ 3217-f 42 USC §300gg-11 45 CFR §147.126 Model Language (PPACA Rider)	The policy may not include a lifetime limit on essential health benefits. Essential health benefits are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorders, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including oral and vision care.	
Contraceptive Drugs and Devices	§ 3221(l)(16) 42 USC § 300gg-13	If coverage for prescription drugs is provided under the policy, then coverage for contraceptive drugs and devices must be included. Coverage for contraceptive drugs and devices must be included in policies and certificates only through the addition of a rider, subject to provisions in statute regarding religious employers. Such coverage may be subject to annual deductibles and coinsurance deemed appropriate by the Superintendent and as are consistent with those established for other drugs or devices covered under the policy if the policy is "grandfathered" pursuant to 42 U.S.C. §18011(e). *Note: Since the statute refers to contraceptive drugs and devices prescribed by a physician "or other licensed health care provide legally authorized to prescribe under title eight of the education law…," the policy may not limit coverage to contraceptive drug and devices prescribed by a physician.* Policies that are not "grandfathered" must cover contraceptive drugs and devices regardless of whether the policy covers prescription drugs. All FDA approved contraceptive methods, sterilization procedures and patient education and counseling for women with reproductive capacity must be covered. Contraceptive coverage must be provided with no cost sharing.	
If prescription drugs are covered under this policy, the following mandates apply:			
Enteral Formulas	§ 3221(k)(11)	If coverage for prescription drugs is provided under the policy, then coverage must be provided for enteral formulas for home use for which a physician or other licensed health care provider legally authorized to prescribe under Title 8 of the Education Law has issued a written order. The order must state that the formula is medically necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from	

		disorders, which if left untreated, cause chronic physical disability, mental retardation or death. Specific diseases that enteral formulas are effective for include, but are not limited to: inherited amino-acid or organic acid metabolism; Crohn's Disease; gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which if left untreated will cause malnutrition, chronic physical disability, mental retardation or death. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include coverage of modified solid food products, which is not required to exceed $2,500 for any insured individual in any calendar year or continuous period of 12 months.	
Off-Label Cancer Drug Usage	§ 3221(l)(12)	If coverage for prescription drugs is provided under the policy, then coverage may not be excluded because the drug is being prescribed to treat a type of cancer for which the FDA has not approved the drug. The drug must be recognized for treatment of the specific type of cancer for which it has been prescribed in one of the following reference compendia: the American Hospital Formulary Service Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.	
Usual and Customary Cost of Prescribed Drugs	§ 4325(h)	If coverage for prescription drugs is provided under the policy, the co-payment shall not exceed the usual and customary cost of such prescribed drug.	
Prohibition for Tier IV Drugs	§ 3221(a)(16)	If coverage for prescription drugs is provided under the policy, then the policy shall not impose cost-sharing (co-payment, coinsurance and deductible) for any prescription drug that exceeds the cost-sharing for non-preferred brand drugs or its equivalent (or brand drugs if there is no non-preferred brand drug category).	
Eye Drops	§ 3221(k)(17)	If coverage for prescription drugs is provided under the policy, then the policy shall allow for the limited refilling of eye drop medication requiring a prescription prior to the last day of the approved dosage period. Any refill dispensed prior to the expiration of the approved coverage period shall, to the extent practicable, be limited in quantity so as not to exceed the remaining dosage initially approved for coverage. The limited refilling shall not limit or restrict coverage with respect to any previously or subsequently approved prescription for eye drop medication.	
Mail Order Drugs for Policies With a Provider Network	§ 3221(l)(18)	If coverage for prescription drugs is provided under the policy, then the policy shall permit an insured to fill any prescription that may be obtained at a network participating mail order or other non-retail pharmacy, at the insured's option, at a network participating non-mail order retail pharmacy provided that the network participating non-mail order retail pharmacy agrees in advance, through a contractual network agreement, to the same reimbursement amount and the same terms and conditions that the insurer has established for the network participating mail order or other non-retail pharmacy.	
MAKE AVAILABLE BENEFITS		*The following benefits must be made available to policyholders annually, in writing, and must be included in the policy if requested by the policyholder.*	
Care in a Nursing Home or Skilled Nursing Facility	§ 3221(l)(2)	This policy 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.	
Ambulatory Care	§ 3221(l)(3)	This policy 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 nonexperimental cancer chemotherapy and cancer hormone therapy. However, physical therapy services are to be provided in connection for the same illness for which the insured 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 nonexperimental cancer chemotherapy and cancer hormone therapy. *Note: It is a violation of section 52.16(c) of Insurance Regulation 62 (11 NYCRR 52) to subject certain services within a class of service to a higher level of cost sharing. For example, it is impermissible to subject high cost radiologic services such as PET scans or CAT scans or other similar services to an increased level of cost sharing as compared to less expensive radiologic services, such as x-rays.*	
Mental, Nervous and Emotional Disorders for Policies that are not subject to MHPAEA	§ 3221(l)(5)	This policy must make available to policyholders in the small group market coverage of mental, nervous and emotional disorders comparable to other coverage provided under the policy for adults and children with biologically based mental illnesses as defined by 3221(l)(5)(B)(ii). This policy must also make available to policyholders in the small group market comparable coverage for children with serious emotional disturbances, as defined by 3221(l)(5)(C). Such mental health coverage may be subject to the terms and conditions otherwise applicable under the policy, such as network limitations and variations, exclusions, co-pays, coinsurance, deductibles or other specific cost sharing mechanisms.	
Chemical Abuse and Dependence Diagnosis and Treatment for Policies that are not subject to MHPAEA	§ 3221(l)(6)	This policy must make available coverage for the diagnosis and treatment of chemical abuse and chemical dependence which includes the treatment of alcohol and substance abuse and dependence as follows: • Inpatient benefits in a hospital or detoxification facility for the treatment of detoxification of not less than 7 days in any calendar year. • Inpatient rehabilitation benefits of not less than 30 days in any calendar year. • Such coverage may be limited to facilities in New York which are certified by OASAS and, in other states, to those which are accredited by the joint commission on accreditation of hospitals as alcoholism, substance abuse or chemical dependence treatment programs. Such coverage may be subject to annual deductibles and coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy.	
Registered Professional Nurse	§ 3221(l)(9)	If this policy provides coverage for any service within the lawful scope of practice of a duly licensed registered professional nurse, the policy must make available reimbursement when such service is performed by a duly licensed registered professional nurse.	
Hospice Care	§ 3221(l)(10)	This policy must make available at least 210 days of inpatient hospice care in a hospice or in a hospital and home care and outpatient services provided by the hospice, including drugs and medical supplies, and 5 visits for bereavement counseling. Such coverage may be subject to annual deductibles and coinsurance deemed appropriate by the Superintendent and as are consistent with those imposed on other benefits within the policy.	

		Hospice care is defined as the care and treatment of an insured who has been certified by the insured's primary attending physician as having a life expectancy of six months or less which is provided by a hospice organization certified pursuant to Article 40 of the Public Health Law or under a similar certification process required by the state in which the hospice is located.	
MANDATORY STANDARD PROVISIONS		*Note: These provisions MUST be included in each policy. The provision must be no less favorable to the insured than the statutory provision.*	
Cost of Service	§ 3201(c)(3) 11NYCRR52.1(c)	If the cost of the service is less than the copayment for the service, the patient is responsible for the lesser amount.	
Renewal	§ 3221(p) § 3221(a)(5) 11NYCRR52.18(c)	This policy provides that except as specified in §3221(p), the insurer must renew or continue in force such coverage at the option of the policyholder. The policy must specify the conditions under which the insurer may refuse to renew the policy.	
Right to New Policy After Termination (Conversion)	§ 3221(e)	This policy provides that if the employee or member insured under the group policy ceases to be covered because of termination of: (1) employment or membership in the class or classes eligible for coverage under the policy or (2) the policy for any reason whatsoever, unless the policyholder has replaced the group coverage with similar and continuous coverage for the same group, such employee or member, who has been insured for at least 3 months under the group policy, shall be entitled to be issued, without evidence of insurability, upon application made within 45 days after the termination and payment of the quarterly, or at the option of the employee or member, a less frequent premium applicable to the class of risk to which the person belongs, an individual policy of insurance. The insurer is not required to issue a converted policy to any person who is eligible or covered for similar benefits by another insurance policy. The policy shall, at the option of employee or member, provide identical benefits to the employee's or member's dependents. The effective date of the converted policy shall be the date of the termination of the individual's insurance with the group policy. Conversion must also be made available, upon the death of the employee or member, to the surviving spouse and dependents, if they were covered under the group policy, and the former spouse of the employee or member upon the divorce or annulment of the marriage to the employee or member. Conversion must also be made available to a child covered under the policy who reaches the age limiting coverage under the group policy. The policy provides that the certificate holder be given written notice of its conversion privilege within 15 days before or after termination of the group coverage. However, if the notice is sent more than 15 days, but less than 90 days after termination of the group policy, the time allowed for conversion is extended for 45 days past the date on which notice was given. If the notice is not given within 90 days of termination of group coverage, the time allowed for the exercise of the conversion privilege shall expire at the end of the 90 days.	
Continuation Coverage	§3221(e)(11) §3221(m) COBRA, Title X of Public Law 99-272	This policy contains a provision regarding continuation coverage. §3221(m) provides continuation coverage in circumstances when federal COBRA requirements do not apply, including for groups under 20 and upon application of the employee or member to continue hospital, surgical or medical expense insurance for himself or herself and his or her eligible dependents. An employee or member who wishes continuation of coverage must request continuation in writing and remit the first premium payment within the 60-day period following the later of: the date of termination or the date the employee is sent notice by first class mail of the right to continuation by the group policyholder. The Insurance Law permits the policyholder to charge an additional 2%	

Model Language Used? Yes ☐ No ☐	Model Language	administrative fee for continued coverage. The continuation benefits terminate: • 36 months after the date the employee or member's benefits would otherwise have terminated because of termination of employment or membership. • In the case of an eligible dependent, 36 months after the date such person's benefits would otherwise have terminated by reason of the death of the employee or member, divorce or legal separation of the employee or member from his or her spouse, the employee or member becoming eligible for Medicare, or a dependent child ceasing to be a dependent child under the generally applicable requirements of the policy. • On the date which the employee or member becomes entitled to coverage under Medicare. • On the date which the employee or member becomes covered by an insured or uninsured arrangement which provides hospital, surgical or medical coverage for individuals in a group which does not contain any exclusion or limitation with respect to any pre-existing condition. • The end of the period for which premiums were made if the employee or member fails to make timely payment.	
Young Adult Option Model Language Used? Yes ☐ No ☐	§ 3221(r) Model Language	This policy provides notice of a young adult's right, through the age of 29 (up to age 30), to independently purchase coverage through a parent group member's policy, regardless of whether the parent's coverage includes coverage for dependents, as described in 3221(r). If a young adult or the young adult's parent elects this coverage, the young adult is issued a separate individual policy. The company must comply with the notice requirements to each employee or member as set forth in 3221(r).	
Suspension of Coverage	§ 3221(n) 11NYCRR52.17(a)(9) Circular Letter No. 7 (2003) USERRA, 38 USC § 4317	This policy 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. • The insurer will refund any unearned premiums for the period of the suspension. • Persons covered by this policy shall be entitled to resumption of coverage, upon written application and payment of the required premium within 60 days after the date of termination of the period of active duty. • 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) Circular Letter No. 7 (2003)	If the policyholder does not choose to voluntarily maintain coverage for any employee or member of when they enter active duty, then such member or employee shall be entitled to continuation or conversion coverage.	
Extension of Benefits	11NYCRR 52.18(b)(4) and (6)	Upon termination of insurance, whether due to termination of employment, termination of eligibility or termination of the policy, an extension of benefits shall be provided during a period of total disability for hospital confinements commencing during the next 31 days for the injury, sickness or	

		pregnancy causing the total disability. This extension of benefits provision also includes a specific extension for conditions as a result of pregnancy, childbirth or related medical condition if the pregnancy commenced while coverage was in force.	
Misstatement	§ 3221(a)(1)	The policy must provide that statements by the insured must be in writing and signed in order to be used to reduce benefits or avoid the insurance.	
Changes	§ 3221(a)(2)	The policy must provide that no agent has the authority to change the policy or waive any provisions and that no change shall be valid unless approved by an officer of the insurer and evidenced by endorsement on the policy, or by amendment to the policy signed by the policyholder and insurer.	
Premiums	§ 3221(a)(4)	The policy must provide that premiums are to be paid to the insurer by the employer or such other person designated, by the due date, with a grace period as specified.	
Certificate	§ 3221(a)(6)	The insurer shall issue either to the employer or person in whose name the policy is issued, for delivery to each member of the insured group, a certificate setting forth in summary form a statement of the essential features of the insurance coverage.	
Notice of Claim	§ 3221(a)(8)	The policy must provide that the insured has a minimum of 20 days to provide the insurer with written notice of claim. However, failure to give notice within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such notice and the notice was provided as soon as reasonably possible.	
Proof of Loss	§ 3221(a)(9)	The policy must provide that the insured has a minimum of 120 days to provide the insurer with proof of loss after the date of such loss. However, failure to give proof within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such proof and the proof was provided as soon as reasonably possible	
Filing Proof of Loss	§ 3221(a)(10)	The policy must provide that the insurer will furnish the insured or the policyholder such forms as are usually furnished for filing proof of loss. If such forms are not furnished before the expiration of fifteen days after the insurer receives notice of the claim, the insured shall be deemed to have complied with the proof of loss requirements upon submitting within the time fixed written proof covering the occurrence, character and extent of the loss for which the claim is made.	
Examination	§3221(a)(11)	The insurer shall have the right and opportunity to examine the insured making a claim as required during the pendency of the claim and the right and opportunity to conduct an autopsy in the case of death unless prohibited by law.	
Action in Law or Equity	§3221(a)(14)	The policy must provide that no action in law or equity shall be brought to recover on the policy prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy and that no such action shall be brought after the expiration of two years following the time such proof of loss is required by the policy.	
Prompt Payment of Claims	§3224-a	This policy must pay claims to the policyholder, covered person or health care provider according to §3224-a.	
OPTIONAL STANDARD PROVISIONS		*If optional standard provisions are included in the policy, they must comply with the following.*	
Pre-existing Condition Limitation Model Language Used? Yes ☐ No ☐	§ 3232 11NYCRR52.20 42 USC § 300gg-1 42 USC § 300gg-3 42 USC § 300gg-4	This policy includes a pre-existing condition provision for insureds age 19 and above which: • Defines a pre-existing condition as one which relates to a condition (whether physical or mental), regardless of the cause of the condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the enrollment date. • Excludes pre-existing conditions for a period of 12 months from the enrollment date. • Credits the time the individual was covered under creditable coverage. • Does not treat genetic information as a pre-existing condition in the absence of a diagnosis of the condition related to such information.	

	45 CFR §§ 144.103, 146.111(a)(1)(i) and 147.108 Model Language	• Does not exclude coverage in the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage. • Does not exclude coverage in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of adoption, is covered under creditable coverage. • Does not exclude coverage for pregnancy. • Does not exclude coverage in the case of an individual, and any dependent of such individual, who is eligible for a federal tax credit under the federal Trade Adjustment Assistance Reform Act of 2002 and who has 3 months or more of creditable coverage. Groups over 300 may not impose a pre-existing condition provision.	
Wellness Programs	§ 3239	Wellness programs are permitted and are defined as programs designed to promote health and prevent disease that may contain rewards and incentives for participation. A wellness program may include but is not limited to: the use of a health risk assessment tool; a smoking cessation program; a weight management program; a stress management program; a worker injury prevention program; a nutrition education program; and a health or fitness incentive program. A wellness program may use rewards and incentives for participation provided that where the group health insurance policy or subscriber contract is required to be community-rated, the rewards and incentives shall not include a discounted premium rate or a rebate or refund of premium. Permissible rewards and incentives include: full or partial reimbursement of the cost of participating in smoking cessation or weight management programs; full or partial reimbursement of the cost of membership in a health club or fitness center; the waiver or reduction of copayments, coinsurance and deductibles for preventive services covered under the group policy or subscriber contract; and monetary rewards in the form of gift cards or gift certificates, so long as the recipient of the reward is encouraged to use the reward for a product or a service that **promotes good health**, such as healthy cook books, over the counter vitamins or exercise equipment. Participation in the wellness program must be available to similarly situated members of the group and must be voluntary on the part of the member. The terms of the wellness program must be set forth in the policy or contract.	
Subrogation	General Obligations Law § 5-335 Civil Practice Law and Rules § 4545(a)	If a subrogation provision is included in this policy or certificate, it must comply with NYS General Obligations Law § 5-335 and Civil Practice Law and Rules § 4545(a).	
Coordination of Benefits Model Language Used? Yes ☐ No ☐	11NYCRR52.23 Model Language	If this policy contains a coordination of benefits provision, then it must comply with 11 NYCRR 52.23.	
Unilateral Modification	11NYCRR52.18(a)(8)	Unilateral modifications by an insurer to an existing policy must be made with at least 30 days prior written notice to the policyholder. Unilateral modification by the insurer may be made only at the time of renewal. If the policy requires the policy holder to provide written notice to terminate coverage, the notice of the unilateral modification by the insurer must be provided to such policy holder no less than 14 days prior to the date by which the policy holder is required to provide notice to terminate coverage.	
TERMINATION		*The following are the only termination provisions permissible under the Insurance Law and the*	

PROVISIONS		*policy may, but is not required to include these termination provisions.*	
Notice of Termination	11 NYCRR 52.18(c)	Unless otherwise specified under the Insurance Law, notices of nonrenewal or termination shall provide at least 30 days prior written notice.	
Termination for Failure to Pay Premiums	§ 3221(p)(2)(A)	This policy includes a provision permitting the insurer to terminate the policy if the policyholder or a participating entity has failed to pay premiums or contributions in accordance with the terms of the policy or the insurer has not received timely premium payments.	
Termination for Fraud	§ 3221(p)(2)(B)	This policy includes a provision permitting the insurer to terminate the policy if the policyholder or a participating entity has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the policy.	
Termination for Failure to Comply With a Material Plan Provision	§ 3221(p)(2)(C)	This policy includes a provision permitting the insurer to terminate the policy if the policyholder has failed to comply with a material plan provision relating to employer contribution or group participation rules, as permitted in §4235.	
Discontinuation of a Class of Policy	§ 3221(p)(2)(D); § 3221(p)(3)(A)	This policy includes a provision permitting the insurer to discontinue this class of policy upon written notice to each policyholder, participant, and beneficiary not less than 90 days prior to the date of discontinuance. The insurer must offer policyholders the option to purchase all (or with respect to the large group market, any) other hospital, surgical, and medical expense coverage currently being offered by the insurer to a group in such market and in exercising the option to discontinue coverage of this class, the insurer must act uniformly without regard to the claims experience of those policyholders or any health status-related factor relating to any insureds covered or new insureds who may become eligible for such coverage.	
Discontinuation of all Policies in the Small or Large Group Market	§ 3221(p)(2)(D); § 3221(p)(3)(B)	This policy includes a provision permitting the insurer to discontinue all hospital, surgical and medical expense coverage in the small or large group market upon written notice to the superintendent and to each policyholder, participant, and beneficiary at least 180 days prior to the date of discontinuance.	
Termination for Failure to Meet Requirements of Group	§ 3221(p)(2)(E); § 4235(c)(1)	This policy includes a provision permitting the insurer to terminate the policy if the policyholder ceases to meet the requirements of a group under §4235, or a participating employer, labor union, association or entity ceases membership in the group to which the policy was issued. Coverage terminated pursuant to this provision shall be done uniformly without regard to any health status factor relating to any individual.	
Termination if there are No Longer Insureds in the Insurer's Service Area	§ 3221(p)(2)(F)	This policy includes a provision permitting the insurer, in regard to a network plan, to terminate the policy if there is no longer any insured who lives, resides, or works in the service area of the insurer, or in the area for which the insurer is authorized to do business.	
Rescission Model Language Used? Yes ☐ No ☐	§ 3105 § 3204 42 USC § 300gg-12 45 CFR §147.128 Model Language (PPACA Rider)	No misrepresentation shall avoid the policy or defeat any recovery thereunder unless the insured makes a misrepresentation that is material and intentional. Notification must be given to the insured 30 calendar days prior to cancellation.	
PERMISSIBLE EXCLUSIONS AND LIMITATIONS		*No policy shall limit or exclude coverage by type of illness, accident, treatment or medical condition, with an exception for the following exclusions which may, but are not required to be included in the policy.*	
War or Act of War, Participation in Felony, Riot or Insurrection,	11NYCRR52.16(c)(4)(i)	This policy excludes coverage for illness, accident, treatment or medical condition arising out of war or act of war (whether declared or undeclared), participation in a felony, riot or insurrection and	

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

Transportation	(11)	transportation. *Note: All exclusions for custodial care that exceed the definition contained in 11NYCRR52.16(l) must be based on medical necessity, with the insured receiving all utilization review and external appeal rights.*	
Rest Cures	11NYCRR52.16(c)(11)	This policy excludes coverage for rest cures.	
Outside the U.S.	11NYCRR52.16(c)(12)	This policy excludes coverage while the insured is outside the United States, its possessions or the countries of Canada or Mexico.	
Illegal Occupation	§ 3221(c) § 3216(d)(2)(J)	The policy excludes losses to which a contributing cause was the insured's participation in a felony or attempted felony. If included, the exclusion can be no more restrictive than to provide that the insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.	
Intoxicants and Narcotics	§ 3221(c) § 3216(d)(2)(K)	The policy excludes losses in consequence of the insured's being intoxicated or under the influence of a narcotic. If included, the exclusion can be no more restrictive than to provide that the insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.	
PROVISIONS THAT MUST BE INCLUDED IN THE POLICY OR WRITTEN DISCLOSURE STATEMENT		*Insurers shall provide insureds and upon request prospective insureds the following written disclosure information, which may be incorporated into the policy. In the event of any inconsistency between any separate written disclosure statement and the policy, the terms of the policy shall be controlling.*	
Benefits and Exclusions	§ 3217-a(a)(1)	This policy includes a description of coverage provisions; health care benefits; benefit maximums, including benefit limitations; and exclusions of coverage.	
Definition of Medical Necessity	§ 3217-a(a)(1)	This policy includes a definition of "medical necessity" used in determining whether benefits will be covered.	
Prior Authorization Requirements	§ 3217-a(a)(2) § 3238	This policy includes a description of all prior authorization or other requirements for treatments and services. If the policy requires pre-authorization for health care services, it will do so in compliance with Section 3238 of the Insurance Law. The Department will not approve a penalty greater than 50% for failure to obtain pre-authorization of health care services.	
Utilization Review Policies and Procedures Model Language Used? Yes ☐ No ☐	§ 3217-a(a)(3) Article 49 42 USC § 300gg-19 29 CFR 2560.503-1 45 CFR §147.136 Model Language	This policy includes a description, consistent with Article 49, 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 insurance, of the external appeal process and the timeframes for such appeals; and	

		• further appeal rights, if any.	
External Appeal Procedures Model Language Used? Yes ☐ No ☐	Article 49 45 CFR §147.136 42 USC §300gg-19 Model Language	This policy 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 (service denied as not medically necessary or experimental/investigational, including clinical trials and treatment for rare diseases; and for managed care health insurance contracts as defined as §4801(c), out-of-network denials when the service is not available in-network and the insurer recommends an alternate treatment); and • The timeframe for submitting an external appeal.	
Reimbursement of Providers	§ 3217-a(a)(4)	This policy includes a description of the types of methodologies the insurer uses to reimburse providers.	
Insured's Financial Responsibility for Payment	§ 3217-a(a)(5)	This policy includes a description of the insured's financial responsibility for payment of premiums, coinsurance, co-payments, deductibles, and any other charges, annual limits on an insured's financial responsibility, caps on payments for covered services and financial responsibility for non-covered health care procedures, treatment or services.	
Non-Participating Providers and Non-Authorized Services	§ 3217-a(a)(6)	This policy includes a description of the insured's financial responsibility for payment when services are provided by a health care provider who is not part of the insurer's network of providers or by any provider without the required authorization or when a procedure, treatment or service is not a covered health care benefit.	
Grievance Procedures	§3217-a(a)(7) § 3217-d(a) § 4802 42 USC § 300gg-19 29 CFR 2560.503-1 45 CFR §147.136	A policy that is a managed care product as defined in §4801(c) or a comprehensive policy that utilizes a network of providers shall include a description of the grievance procedure to be used to resolve disputes between the insurer and the insured, including: • 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.	
Selecting, Accessing and Changing Participating Providers	§ 3217-a(a)(9) § 3217-a(a)(10)	Where applicable, this policy includes a description of the procedures for insureds to select, access and change primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients.	
Referral to Non-Participating Providers	§ 3217-a(a)(11)	Where applicable, this policy includes notice that an insured enrolled in a managed care product as defined in §4801(c) may obtain a referral to a health care provider outside of the insurer's network or panel when the insurer does not have a health care provider with appropriate training and experience in the network or panel to meet the health care needs of the insured and the procedure by which the insured can obtain such referral.	
Standing Referrals	§ 3217-a(a)(12) § 3217-d(b)	Where applicable, this policy includes notice that an insured enrolled in a managed care product as defined in §4801(c) or covered under a comprehensive policy that utilizes a network of providers and requires that specialty care be provided pursuant referral from a primary care provider, with a condition which requires on-going care from a specialist may request a standing referral to such	

		specialist and the procedure for requesting and obtaining such standing referral.	
Specialty Care Provider as PCP	§ 3217-a(a)(13) § 3217-d(b)	Where applicable, this policy includes notice that an insured enrolled in a managed care product as defined in §4801(c) or covered under a comprehensive policy that utilizes a network of providers and requires that specialty care be provided pursuant referral from a primary care provider, with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request a specialist responsible for providing or coordinating the insured's medical care and the procedure for requesting and obtaining such a specialist.	
Specialty Care Center	§ 3217-a(a)(14) § 3217-d(b)	Where applicable, this policy includes notice that an insured enrolled in a managed care product as defined in §4801(c) or covered under a comprehensive policy that utilizes a network of providers and requires that specialty care be provided pursuant referral from a primary care provider, with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request access to a specialty care center and the procedure by which such access may be obtained.	
Non-English Speaking Insureds	§ 3217-a(a)(15)	This policy includes a description of how the insurer addresses the needs of non-English speaking insureds.	
Contact Information	§ 3217-a(a)(16)	This policy includes all appropriate mailing addresses and telephone numbers to be utilized by insureds seeking information or authorization.	
PROVIDER NETWORKS	§ 3201(c)	If the policy will be used in conjunction with a provider network, then the following items or information must be submitted: • Participating provider directory; • Whether the provider network is capitated; • Provider selection criteria; • Quality assurance procedures; • Breakdown of geographic service area by county; • The underlying assumptions for the network regarding ratios of providers to insureds, the travel times and distances to participating providers; • Sample participating provider agreement; and, • Listing of providers by specialty type. The Department will not approve more than a 30% differential between in-network and out-of-network coverage unless supported by scholarly literature or actual claims experience of the insurer.	
FOR POLICIES ISSUED TO SMALL GROUPS (Groups of 2-50)	11NYCRR360	Special rules apply to small groups that limit the way insurers may restrict or limit coverage. These rules are found in 11NYCRR360, and if this policy is being issued in the small group market, they must be followed.	
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 submission is an out-of-state filing pursuant to Section 3201(b)(2), 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	11NYCRR52.40(a)(1)	Actuarial qualifications:	

MEMORANDUM		a. Member of the Society of Actuaries; and b. Meet the "Qualification Standards of Actuarial Opinion" as adopted by the American Academy of Actuaries.	
Justification of Rates	§3103 & §3221 11NYCRR52.40(e) 11NYCRR52.40(f) 11NYCRR360.10 11NYCRR360.11 11NYCRR52.45(f) 11NYCRR59.5(b)	Small Group: a. Provide community rated rating methodology and assumptions used in calculating rates. b. Provide rating methodology and assumptions used in rate calculation for mental health coverage provided pursuant to §3221(l)(5). c. Actuarial justification for the use of claim costs and other assumptions. d. Non-claim expense components as a percentage of gross premium. e. Expected loss ratio(s). Large Group: a. Development of manual rates including actuarial assumptions used and justification thereof. b. Provide rating methodology including experience rating formula. c. Provide all elements of the formula, such as claims run-off, credibility and trend factors. d. Provide actuarial justification of all assumptions used. e. Provide rating methodology and assumptions used in rate calculation for mental health coverage provided pursuant to §3221(l)(5). f. Non-claim expense components as a percentage of gross premium. g. Expected loss ratio(s).	
Loss Ratios	11NYCRR52.45(f) 11NYCRR59.5(b)	Expected loss ratio(s) – with actuarial justification	
Reserve Basis	11NYCRR94	Description of bases for unpaid claim liabilities and extra reserves (if any).	
Actuarial Certification	11NYCRR52.40(a)(1)	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:	
GROUP RATE MANUAL	11NYCRR52.40(e)(2) 11NYCRR52.40(e)(3) 11NYCRR52.45(f) 11NYCRR59.5(b)	a. Table of contents. b. Rate pages. c. Insurer name on each consecutively numbered rate page. d. Identification by form number of each policy, rider, or endorsement to which the rates apply. e. Brief description of benefits, types of coverage, limitations, exclusions, and issue limits. f. Description of rating classes, factors and premium discounts. g. Examples of rate calculations. h. Commission schedule(s) and fees. i. Underwriting guidelines and/or underwriting manual. j. Expected loss ratio(s).	
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	11NYCRR52.40(a)(1)	Actuarial qualifications: a. Member of the Society of Actuaries; and b. Meet the "Qualification Standards of Actuarial Opinion" as adopted by the American Academy of Actuaries.	
Justification of Rates	11NYCRR52.40(e) 11NYCRR52.40(g)(3) 11NYCRR52.45 11NYCRR59.5(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). 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.	
Actuarial Certification	11NYCRR52.40(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:	
REVISED RATE MANUAL PAGES	11NYCRR52.40(e)(2) 11NYCRR52.45(f) 11NYCRR59.5(b)	a. Table of contents. b. Rate pages. c. Insurer name on each consecutively numbered rate page. d. Identification by form number of each policy, rider, or endorsement to which the rates apply. e. Brief description of benefits, types of coverage, limitations, exclusions, and issue limits. f. Description of revised rating classes, factors and discounts. g. Examples of rate calculations. h. Commission schedule(s) and fees. i. Underwriting guidelines and/or underwriting manual. j. Expected loss ratio(s).	