

NEW YORK DEPARTMENT OF FINANCIAL SERVICES
Small Business Marketplace Checklist

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Review Standards for

Small Business Marketplace (SHOP) Checklist

As of 4/26/16

Instructions for SERFF Checklist:

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

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LINE OF BUSINESS: **Small Business Marketplace (SHOP)**

<u>TOI</u> H15G H16G	<u>LINE(S) OF INSURANCE</u> Health – Hospital/Surgical/Medical Expense Health – Major Medical	<u>Sub-TOI</u> H15G.003 - Small Group Only H16G.003A - Small Group Only - PPO H16G.003D - Small Group Only - POS H16G.003G - Small Group Only - Other
HOrg02G	Group Health Organization - HMO	HOrg02G.004C - POS Basic HOrg02G.004D - POS Standard HOrg02G.004F – HMO

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

REVIEW REQUIREMENT	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD IN FILING
GENERAL REQUIREMENTS FOR ALL FILINGS	<i>Note: Unless otherwise noted, all references are to Insurance Law, Insurance Regulations, and Department of Financial Services Circular Letters and OGC opinions</i>	<i>Note: This checklist is intended to provide guidance in the preparation of policy forms for submission and is not intended as a substitute for statute or regulation.</i>	Form/Page/Para Reference
Complete Policy or Contract Submission or Pages/Rider/Endorsement	§ 3201(a) § 3221(a) § 4306(d) § 4306(e)	<p>This submission contains a complete policy or contract form. Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>No statement by the individual in his application for a contract or policy shall avoid the contract or be used in legal proceedings thereunder, unless such application or an exact copy thereof is included in or attached to such contract.</p> <p>No agent or representative of such corporation and no broker, other than an officer or officers designated therein, is authorized to change the contract or waive any of its provisions.</p> <p>If this submission contains insert pages, riders or endorsements, then the policy or contract in its entirety complies with all the statutory and regulatory provisions stated below. Yes <input type="checkbox"/> No <input type="checkbox"/></p>	

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		(If no is checked, explain in the space provided above.) This rider, insert pages, or endorsements are being attached to a policy or contract that was approved by the Department on _____, submission number _____.	
Form Requirements	11 NYCRR 52.31(b), (c), (d), (e), (f), (l)	Each form in the filing must meet the following requirements: <ul style="list-style-type: none"> • This form contains no strikeouts. § 52.31(b) • 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 group” to describe the variable material. § 52.31(l) • All policy or contract forms must be placed on the Form Schedule tab in SERFF. 	
Flesch Score	§ 3102(c)	Provide Flesch score certification (the Flesch score should be at least 45). The number of words, sentences and syllables in the form should be set forth as part of the certification, which must be signed by an officer of the company.	
SERFF Filing Description or Letter of Submission	11 NYCRR 52.33 Circular Letter No. 33 (1999) Supplement 1 to CL No. 33 (1999)	The filing must include a SERFF filing description or a letter of submission that contains the following: <ul style="list-style-type: none"> • The identifying form number of each form submitted. § 52.33(a) • If the form is a policy or contract, the letter must indicate that the policy or contract is submitted pursuant to 11 NYCRR 52.7. § 52.33(b) • Whether the form is new or supersedes an approved or filed form. § 52.33(c) • If the form supersedes an approved or filed form, the letter must state the form number and date of approval or filing of the superseded form and any material differences from the superseded form. § 52.33(d) • If the approval of the superseded form is still pending, the letter must include the form number, control number assigned by the Department and the submission date. § 52.33(d) • If the form had previously been submitted for preliminary review, the letter must include a reference to the previous submission and a statement setting out either that the form agrees precisely with the previous submission; or the differences from the form submitted for preliminary review. § 52.33(e) • If the form is other than a policy or contract form, the letter must identify the form number and approval date of the policy or contract with which it will be used. If the form is for general use, the Department may accept a description of the type of policy or contract with 	

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		<p>which it may be used in lieu of the form number and approval date. § 52.33(g)</p> <ul style="list-style-type: none"> If the policy or contract is designed to be used with insert pages, the letter must contain a statement of the insert page forms which must always be included in the policy or contract and a list of all optional pages, together with an explanation of their use. § 52.33(i) 	
Group Status and Recognition	§ 3201(b)(1) § 3231(a) § 4235(c)(1) § 4317(a) 11 NYCRR 59	The SERFF filing description or submission letter should include a statement that this policy or contract forms will only be sold to a small group specified in Insurance Law § 4235(c)(1).	
Statement of ERISA Rights Is the insurer providing document as the plan administrator or for the plan administrator? Yes <input type="checkbox"/> No <input type="checkbox"/>	29 CFR § 2520.104b-2 29 CFR § 2520.102-3(t)	Plan administrators of an employee benefit plan are required to furnish a copy of a Statement of ERISA rights as provided for in 29 CFR § 2520.102-3(t). If the insurer is providing this document as the plan administrator, or for the plan administrator, please indicate in the adjacent box.	
Discrimination	§ 2606 § 2607 § 2608 § 2612	This policy or contract form does not contain any unfair discrimination provisions because of race, color, creed, national origin, disability (including treatment of mental disability), sex, marital status, or status as a victim of domestic violence.	
APPLICATION FORMS			Form/Page/Para Reference
Authorization	11 NYCRR 420.18(b)	If the application provides 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) 11 NYCRR 86.4	The application contains the prescribed fraud warning statement immediately above the insured's signature.	
Prohibited Questions and Provisions	§ 3204 § 3221(q)(1) § 4305(k)(1) 11 NYCRR 52.51	<p>The application does NOT contain:</p> <ul style="list-style-type: none"> 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 OR CONTRACT FORM PROVISIONS			Form/Page/Para Reference
COVER PAGE	Model Language		

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Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Insurer Name		This policy or contract form contains the name and full address of the issuing insurer on the front or back cover.	
Signature of Company Officer		The signature of company officer(s) appears prominently on the policy or contract form (such as on the cover page).	
Table of Contents Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3201(c)(1)(G) Model Language	A table of contents is required.	
DEFINITIONS Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	Model Language	<i>Definitions included in the policy or contract form <u>must</u> comply with the Model Language. For a complete listing of the required definitions, click on the adjacent Model Language link.</i>	Form/Page/Para Reference
Services Performed at Comprehensive Care Center for Eating Disorders	§ 3221(k)(14) § 4303(dd)	This policy or contract form may not exclude coverage for services covered under the policy or contract when provided by a comprehensive care center for eating disorders pursuant to Article 27-J of the Public Health Law. Reimbursement for services provided through such comprehensive care centers shall, to the extent possible or practicable, be structured in a manner to facilitate the individualized, comprehensive and integrated plans of care which such centers' network of practitioners and providers are required to provide.	
HOW THIS COVERAGE WORKS			Form/Page/Para Reference
Selecting a Primary Care Provider			
Selecting, Accessing and Changing Participating Providers Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3217-a(a)(9), (10) § 4324(a)(9): (10) PHL § 4408(1)(i), (j) Model Language	Where applicable, this policy or contract form provides a description of the procedures for insureds to select, access and change primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients.	
Designation of Primary Care Provider ("PCP") and Access to Pediatricians Does this product require a PCP to be designated? Yes <input type="checkbox"/> No <input type="checkbox"/> Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3217-e § 4306-d PHL § 4403(7) 42 USC § 300gg-19a 45 CFR § 147.138(a) Model Language	If this policy or contract form requires the designation of a primary care provider ("PCP"), this policy or contract form permits an insured to designate any participating PCP who is available to accept the insured. If designation of a PCP for a child is required, the insured is permitted to designate a physician who specializes in pediatrics as the child's PCP if the provider is in-network and available to accept the child.	

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<p>Direct Access to OB/GYN Services</p> <p>Does this product require a PCP to be designated? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3217-a(a)(16-a) § 3217-c § 4306-b(a) § 4324(16-a) PHL § 4406-b PHL § 4408(1)(p-1) 42 USC § 300gg-19a 45 CFR § 147.138(a) Model Language</p>	<p>If this policy or contract requires the designation of a PCP, it must provide a female insured direct access to primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions from a qualified participating provider of such services of her choice or for any care related to pregnancy provided that:</p> <ul style="list-style-type: none"> • Such qualified provider discusses such services and treatment plan with the individual’s primary care practitioner in accordance with the insurer’s requirements; and • Such qualified provider agrees to adhere to the insurer’s policies and procedures, including any procedures regarding referrals and obtaining prior authorization for services other than obstetric and gynecologic services rendered by such qualified provider, and agrees to provide services pursuant to a treatment plan approved by the insurer. 	
<p>Direct Access to Maternal Depression Screenings</p>	<p>§ 3217-g § 4306-f PHL § 2500-k PHL § 4406-f</p>	<p>This policy or contract form must not limit a insured’s direct access to screening and referral for maternal depression, as defined § 2500-k of the Public Health Law, from a provider of obstetrical, gynecologic, or pediatric services of her choice; provided that the insured’s access to such services, coverage and choice of provider is otherwise subject to the terms and conditions of the contract or policy under which the insured is covered.</p>	
Preauthorization			
<p>Preauthorization Requirements</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3217-a(a)(2) § 3238 § 4324(a)(2) PHL § 4408(1)(b) Model Language</p>	<p>This policy or contract form provides a description of all preauthorization or other notification requirements for treatments and services. If the policy or contract form requires a gatekeeper, the preauthorization requirements may not be imposed on the insured for in-network services. A preauthorization or notification penalty of either 50% of the allowable amount for services rendered or \$500.00, whichever is less, is permissible.</p>	
Medical Necessity			
<p>Definition of Medical Necessity</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3217-a(a)(1) § 4324(a)(1) PHL § 4408(1)(b) Model Language</p>	<p>This policy or contract form provides a definition of “medical necessity” used in determining whether benefits will be covered.</p>	
<p>Contact Information</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3217-a(a)(16) § 4324(a)(16) PHL § 4408(1)(q) Model Language</p>	<p>This policy or contract form provides all appropriate mailing addresses and telephone numbers to be utilized by insureds seeking information or authorization.</p>	
Protection from Surprise Bills			
<p>Protection from Surprise Bills and IDR Process</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Article 6 of the Financial Services Law; Chapter 60 of the Laws of 2014 Model Language</p>	<p>The policy or contract form shall provide that the insured will be held harmless for any non-participating physician charges for a surprise bill that exceeds an insured’s copayment, coinsurance or deductible if the insured assigns benefits in writing to the non-participating physician. The non-participating physician may only bill an insured for a copayment, coinsurance or deductible.</p> <p>The policy or contract form also provides a description of the independent dispute resolution process.</p>	

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Delivery of Covered Services Using Telehealth			
Delivery of Covered Services Using Telehealth Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3217-h § 4306-g PHL § 4406-g Model Language	<p>This policy or contract form shall not exclude from coverage a service that is otherwise covered under the policy or contract form because the service is delivered via telehealth, however, it may exclude from coverage a service by a health care provider where the provider is not otherwise covered under the policy. Coverage of services delivered via telehealth may be subject to reasonable utilization review and quality assurance requirements that are at least as favorable as those requirements for the same service when not delivered using telehealth.</p> <p>Services delivered via telehealth may be subject to copayments, coinsurance or deductibles provided that they are at least as favorable to the insured as those established for the same service when not delivered via telehealth.</p> <p>“Telehealth” means the use of electronic information and communication technologies by a provider to deliver health care services to an insured individual while the individual is located at a site that is different from the site where the provider is located.</p>	
Case Management			
Case Management Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	Model Language	Where applicable, this policy or contract form provides a description of the case management procedures for members with health care needs due to serious, complex, and/or chronic health conditions.	
ACCESS TO CARE AND TRANSITIONAL CARE			
Referral or Authorization to Non-Participating Providers Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3217-a(a)(11) § 3217-d(d) § 4306-c(d) § 4324(a)(11) § 4804(a) PHL § 4403(6)(a) PHL § 4408(1)(k) Model Language	If this policy or contract form is a managed care product as defined in § 4801(c) or a HMO, or an EPO or a comprehensive insurance product that uses a network of providers, it must describe how an insured may obtain a referral or authorization to a health care provider outside of the insurer’s network when the insurer does not have a health care provider with appropriate training and experience in the network to meet the health care needs of the insured and the procedure by which the insured can obtain such referral or authorization.	
Specialty Care Provider as PCP Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3217-a(a)(13) § 3217-d(b) § 4306-c(b) § 4324(a)(13) § 4804 (b) PHL § 4403(6)(c) PHL § 4408(1)(m) Model Language	If this policy or contract form requires (i) the designation of a PCP, and (ii) that specialty care must be provided pursuant to a referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, is permitted to request that a specialist be designated as their PCP to provide or coordinate the insured’s medical care and describe the procedure for requesting and obtaining a specialist as a PCP.	
Standing Referrals Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3217-a(a)(12) § 3217-d(b) § 4306-c(b) § 4324(a)(12)	If this policy or contract form requires (i) the designation of a PCP, and (ii) that specialty care must be provided pursuant to a referral from a PCP, it must include a notice that an insured with a condition which requires on-going care from a specialist, may request a standing referral to such specialist and describe the procedure for requesting and obtaining such a standing referral.	

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	§ 4804(c) PHL § 4403(6)(b) PHL § 4408(1)(l) Model Language		
Specialty Care Center Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3217-a(a)(14) § 3217-d(b) § 4306-c(b) § 4324(a)(14) § 4804(d) PHL § 4403(6)(d) PHL § 4408(1)(n) Model Language	If this policy or contract form requires (i) the designation of a PCP, and (ii) that specialty care must be provided pursuant to a referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request access to a specialty care center and describe the procedure for requesting and obtaining such a referral to a specialty care center.	
Transitional Care When a Provider Leaves the Network Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3217-d(c) § 4306-c(c) § 4804(e) PHL § 4403(6)(e) Model Language	If an insured is in an ongoing course of treatment when a provider leaves the network, then this policy or contract form must describe how an insured may to continue to receive treatment for the ongoing treatment from the former participating provider for up to 90 days from the date the provider’s contractual obligation to provide services terminated. If the insured is pregnant and in the second or third trimester, the insured may be able to continue care with a former participating provider through delivery and any postpartum care directly related to the delivery. In order for the insured to continue to receive care for up to 90 days or through a pregnancy with a former participating provider, the provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of the insurer’s contractual agreement with the provider and must also agree to provide the insurer with the necessary medical information related to the insured’s care and adhere to the insurer’s policies and procedures, including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.	
Transitional Care For a New Member in a Course of Treatment Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3217-d(c) § 4306-c(c) § 4804(f) PHL § 4403(6)(f) Model Language	If an insured is in an ongoing course of treatment with a non-participating provider when the insured’s coverage becomes effective for (i) a life-threatening disease or condition or a degenerative and disabling condition or disease, or (ii) for care for pregnancy if the insured is in the second or third trimester, then this policy or contract form must describe how the insured may continue to receive care for the ongoing course of treatment from the non-participating provider for up to 60 days from the effective date of the insured’s coverage. The insured may continue care through delivery and any post-partum services directly related to the delivery. In order for the insured to continue to receive care for up to 60 days or through pregnancy, the non-participating provider must agree to accept as payment the insurer’s fees for such services. The provider must also agree to provide the insurer with necessary medical information related to the insured’s care and to adhere to the insurer’s policies and procedures including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.	

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COST-SHARING EXPENSES AND ALLOWED AMOUNT			
Cost of Service Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3201(c)(3) 11 NYCRR 52.1(c) Model Language	If the cost of the service is less than the copayment for the service, the patient is responsible for the lesser amount.	
Maximum Out-of-Pocket Limit Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	IRC § 223(c)(2)(A)(ii) 42 USC § 300gg-6 45 CFR § 156.130 Model Language	The cost-sharing for in-network services may not exceed the dollar amounts in effect under § 223(c)(2)(A)(ii) of the Internal Revenue Code. For 2017, the amounts are \$7,150 for individual coverage and \$14,300 for other than individual coverage (e.g., individual/spouse, parent and child/children and family). The individual maximum out-of-pocket permitted by federal law applies to each individual regardless of whether the individual is covered by a plan providing individual coverage or coverage other than individual coverage.	
Non-Participating Providers and Non-Authorized Services Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3217-a(a)(6) § 4324(a)(6) PHL § 4408(1)(f) Model Language	This policy or contract form provides a description of the insured’s financial responsibility for payment when services are provided by a health care provider who is not part of the insurer’s network or by any provider without the required authorization or when a procedure, treatment or service is not a covered health care benefit.	
Reimbursement of Providers Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3217-a(a)(4) § 4324(a)(4) PHL § 4408(1)(d) Model Language	This policy or contract form provides a description of the types of methodologies the insurer uses to reimburse providers.	
WHO IS COVERED		For each of the following eligibility provisions, Model Language <u>must</u> be used.	Form/Page/Para Reference
Spouse Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 4235(f)(1)(A) § 4305(c)(1) Circular Letter No. 27 (2008) Model Language	For individual and spouse and/or family coverage, this policy or contract form provides coverage for the lawful spouse, unless there is a divorce or annulment of the marriage. This provides marriages between same-sex spouses.	
Dependents Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3221(a)(7) § 4235(f)(1)(A)(i) § 4305(c)(1) § 4306(i) 42 USC § 300gg-14 26 CFR 147.120 Model Language	For parent and child/children and/or family coverage, this policy or contract form provides coverage of children until the age of 26. <i>Note: Pursuant to § 2608-a of the Insurance Law, an insurer may not deny enrollment to a child under the health coverage of the child’s parent on the ground that the child was born out of wedlock, the child is not claimed as a dependent on the parent’s federal income tax return, or the child does not reside with the parent or in the insurer’s service area.</i>	
Unmarried Disabled Children	§ 4235(f)(1)(A)(ii) § 4305(c)(1)	For parent and child/children and/or family coverage, this policy or contract form provides coverage for unmarried disabled children, regardless of age, who are incapable of self-sustaining	

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<p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Model Language</p>	<p>employment by reason of mental illness, developmental disability, mental retardation, as defined in the Mental Hygiene Law, or physical handicap, and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate.</p> <p><i>Note: Such coverage shall not terminate while the coverage remains in effect and the dependent remains in such condition and is chiefly dependent on the insured for support and maintenance, if the insured has within 31 days of such dependent's attainment of the limiting age submitted proof of such dependent's incapacity.</i></p>	
<p>Newborn Infants</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 4235(f)(2) § 4305(c)(1) 45 CFR § 155.420 45 CFR § 155.725 Model Language</p>	<p>For parent and child/children and/or family coverage, this policy or contract form provides coverage of newborn infants, including newly born infants adopted by the insured if the insured takes physical custody of the infant upon the infant's release from the hospital and files a petition pursuant to § 115-c of the Domestic Relations Law within 30 days of birth; and provided further that no notice of revocation to the adoption has been filed and consent to the adoption has not been revoked. This shall be effective from the moment of birth, except that in cases of adoption, coverage of the initial hospital stay shall not be required where a birth parent has insurance coverage available for the infant's care.</p> <p><i>Note: In the case of individual or individual and spouse coverage, the insurer must permit the insured to elect such coverage of newborn infants from the moment of birth. If notification and/or payment of an additional premium is required to make coverage effective for a newborn infant, the coverage may provide that such notice and/or payment be made within no less than 30 days of the day of birth to make coverage effective from the moment of birth.</i></p>	
<p>Adopted Children and Step-Children</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 4235(f)(2) § 4305(c)(1) 11 NYCRR 52.18(e)(2), (3)</p>	<p>For parent and child/children and/or family coverage, this policy or contract form provides that adopted children and stepchildren are eligible for coverage on the same basis as natural children. Further, a policy or contract form 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.</p>	
<p>Domestic Partners</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 4235(f)(1)(A) § 4305(c)(1) OGC Opinion 01-11-23 Model Language</p>	<p>This policy or contract form may cover domestic partners, who are financially interdependent on the employee, but such coverage is not required.</p> <p>If such coverage is provided, the policy or contract form shall require the applicant to provide the following:</p> <ul style="list-style-type: none"> • Registration as a domestic partner, where such registry exists, or an affidavit of domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six (6) months; • Proof of cohabitation; and • Proof of financial interdependency by evidence of two (2) 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 	

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		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 Employees Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3221(a)(3) 11 NYCRR 52.18(f)	New employees or members of the class must be added to the class for which they are eligible.	
Enrollment Periods Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	11 NYCRR 52.70(e)(3) 45 CFR § 147.104 45 CFR § 155.420 45 CFR § 155.725 Model Language	This policy or contract form must provide for an annual open enrollment period and special enrollment periods, including those special enrollment periods that allow for the addition of a new family member.	
MANDATORY COVERED ESSENTIAL HEALTH BENEFITS	Standard Benefit Design Description Chart	<p><i>The following benefits <u>must</u> be included in the policy or contract form.</i></p> <p>Standard Products: Insurers may not: (i) substitute benefits (other than the wellness benefit); (ii) modify cost-sharing in any category ; (iii) add benefits to an essential health benefit category, including higher number of covered visits or days; and/or (iv) add benefits that are not considered essential health benefits.</p> <p>All standard products must use the cost-sharing specified in the Standard Benefit Design Description Chart. Substitution is permitted for wellness benefits in standard New York State of Health (“NYSOH”) plans.</p> <p>Non-Standard Products: Insurers may either: (i) substitute benefits within certain categories listed below; (ii) modify cost-sharing in any category; (iii) add benefits to an essential health benefit category, including a higher number of covered visits or days; and/or (iv) add benefits that are not considered essential health benefits, provided all changes are in accordance with federal and state regulation and guidance.</p> <p>The categories of benefits that may be substituted are:</p> <ul style="list-style-type: none"> • Preventive/Wellness/Chronic Disease Management • Rehabilitative and Habilitative Services and Devices 	Form/Page/Para Reference
PREVENTIVE CARE			
Primary and Preventive Health Services Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3221(h) § 3221(k)(18) § 3221(l)(8) § 4303(j), (ii), (ll) Circular Letter No. 3	<p>This policy or contract form provides the following coverage for primary and preventive health services for a covered child from the date of birth through the age of 19:</p> <ul style="list-style-type: none"> • An initial hospital check-up and well child visits scheduled in accordance with the American Academy of Pediatrics. • At each visit, services in accordance with the American Academy of Pediatrics, including a 	

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	<p>(1994) Circular Letter No. 13 (2006) Required Immunizations 42 USC § 300gg-13 45 CFR § 147.130 45 CFR § 156.100 Model Language</p>	<p>medical history, complete physical examination, developmental assessment, anticipatory guidance, laboratory tests and necessary immunizations in accordance with the Advisory Committee on Immunization Practices.</p> <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance.</p> <p><i>Note: For new items or services added to the list of recommended preventive services receiving an A or B rating from the United States Preventive Services Task Force, or new recommendations from HRSA, insurers should provide the required coverage for such items or services no later than six months from when the recommendation is made.</i></p> <p><i>Note: This policy or contract form must provide coverage for a physical or well care visit once every calendar year even if 365 days have not passed since the previous physical or well care visit.</i></p>	
<p>Federal Mandated Preventive Health Services</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 4303(II) 42 USC § 300gg-13 45 CFR § 147.130 Model Language HRSA Guidelines</p>	<p>This policy or contract form provides coverage for the following preventive care and screenings for children and adults with no cost-sharing:</p> <ul style="list-style-type: none"> • Evidence-based items or services for children and adults with a rating of “A” or “B” by the U.S. Preventive Services Task Force (“USPSTF”). • Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. • Preventive care and screenings for infants, children and adolescents in guidelines supported by the Health Resources and Services Administration (“HRSA”). • Preventive care and screenings for women in guidelines supported by the HRSA. <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance.</p> <p><i>Note: For new items or services added to the list of recommended preventive services receiving an A or B rating from the United States Preventive Services Task Force, or new recommendations from HRSA, insurers should provide the required coverage for such items or services no later than six months from when the recommendation is made.</i></p>	
<p>Cervical Cytology Screening</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 3221(I)(14) § 4303(t), (II) 42 USC § 300gg-13 45 CFR § 147.130 Model Language HRSA Guidelines</p>	<p>This policy or contract form provides coverage for annual cervical cytology screening for cervical cancer and its precursor states for women age 18 and older. Cervical cytology screening provides an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.</p> <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.</p> <p><i>Note: For new items or services added to the list of recommended preventive services receiving an A or B rating from the United States Preventive Services Task Force, or new recommendations from HRSA, insurers should provide the required coverage for such items or services no later than six months from when the recommendation is made.</i></p>	
<p>Mammography Screening</p>	<p>§ 3221(h)</p>	<p>This policy or contract form provides the following coverage for mammography screening for</p>	

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<p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(l)(11) § 4303(p), (ll) 42 USC § 300gg-13 45 CFR § 147.130 Model Language HRSA Guidelines</p>	<p>occult breast cancer:</p> <ul style="list-style-type: none"> • Upon the recommendation of a physician, a mammogram at any age for covered persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer. • A single, baseline mammogram for covered persons age 35-39, inclusive. • An annual mammogram for covered persons age 40 and older. • Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are covered whenever they are medically necessary. <p>Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.</p> <p><i>Note: For new items or services added to the list of recommended preventive services receiving an A or B rating from the United States Preventive Services Task Force, or new recommendations from HRSA, insurers should provide the required coverage for such items or services no later than six months from when the recommendation is made.</i></p>	
<p>Family Planning and Reproductive Health Services</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 3221(l)(16) § 4303(cc), (ll) 42 USC § 300gg-13 45 CFR § 147.130 Model Language HRSA Guidelines</p>	<p>This policy or contract form provides coverage for family planning services which consist of federal Food and Drug Administration (“FDA”) approved contraceptive methods prescribed by a provider (not covered under the prescription drug benefits), counseling on use of contraceptives, related topics and sterilization procedures for women. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF.</p> <p>This policy or contract form provides coverage for vasectomies. Such coverage may be subject to deductibles, copayments and/or coinsurance.</p> <p><i>Note: For new items or services added to the list of recommended preventive services receiving an A or B rating from the United States Preventive Services Task Force, or new recommendations from HRSA, insurers should provide the required coverage for such items or services no later than six months from when the recommendation is made.</i></p>	
<p>Bone Mineral Density Measurements or Tests, Drugs and Devices</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 3221(k)(13) § 4303(bb), (ll) 42 USC § 300gg-13 45 CFR §147.130 Model Language</p>	<p>This policy or contract form provides coverage for bone mineral density measurements or tests, prescription drugs, and devices approved by the FDA or generic equivalents as approved substitutes. Bone mineral density measurements or tests, drugs or devices include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. Individuals qualifying for coverage, at a minimum, include individuals:</p> <ul style="list-style-type: none"> • Previously diagnosed as having osteoporosis or having a family history of osteoporosis; • With symptoms or conditions indicative of the presence or significant risk of osteoporosis; • On a prescribed drug regimen posing a significant risk of osteoporosis; • With lifestyle factors to a degree as posing a significant risk of osteoporosis; or • With such age, gender, and/or other physiological characteristics which pose a significant 	

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		<p>risk for osteoporosis.</p> <p>Such coverage, when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF, shall not be subject to deductibles, copayments and/or coinsurance. Other such coverage provided may be subject to deductibles, copayments and/or coinsurance.</p> <p><i>Note: For new items or services added to the list of recommended preventive services receiving an A or B rating from the United States Preventive Services Task Force, or new recommendations from HRSA, insurers should provide the required coverage for such items or services no later than six months from when the recommendation is made.</i></p>	
<p>Prostate Cancer Screening</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 3221(l)(11-a) § 4303(z-1) § 4303(ll) Model Language</p>	<p>This policy or contract form provides coverage for the diagnostic screening for prostate cancer including:</p> <ul style="list-style-type: none"> • Standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer; and • An annual standard diagnostic examination for men age 50 and over who are asymptomatic and for men age 40 or older with a family history of prostate cancer or other prostate cancer risk factors. <p>Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent of the New York State Department of Financial Services (“Superintendent”) and as are consistent with other benefits within the policy or contract form.</p>	
<p>AMBULANCE, EMERGENCY SERVICES AND URGENT CARE</p>			
<p>Ambulance and Pre-Hospital Emergency Medical Services</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 3221(l)(15) § 4303(aa), (ll) 45 CFR §156.100 Model Language</p>	<p>Emergency Ambulance Transportation:</p> <p>This policy or contract form provides coverage for pre-hospital emergency medical services for the treatment of an emergency condition when such services are provided by an ambulance service. “Pre-hospital emergency medical services” means the prompt evaluation and treatment of an emergency condition and/or non-airborne transportation to a hospital. The services must be provided by an ambulance service issued a certificate under the Public Health Law. This policy or contract form will, however, only covers transportation to a hospital provided by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:</p> <ul style="list-style-type: none"> • Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; • Serious impairment to such person’s bodily functions; • Serious dysfunction of any bodily organ or part of such person; or • Serious disfigurement of such person. 	

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		<p>An ambulance service may not charge or seek reimbursement from the insured for pre-hospital emergency medical services except for the collection of any applicable copayment, deductible or coinsurance.</p> <p>This policy or contract form provides coverage for emergency ambulance transportation by a licensed ambulance service (either ground, water or air ambulance) to the nearest hospital where the emergency services can be performed.</p> <p><u>Non-Emergency Ambulance Transportation:</u> This policy or contract form provides coverage for non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between facilities when the transport is any of the following:</p> <ul style="list-style-type: none"> • From a non-participating hospital to a participating hospital. • To a hospital that provides a higher level of care that was not available at the original hospital. • To a more cost-effective acute care facility. • From an acute facility to a sub-acute setting. 	
<p>Emergency Services</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3217-a(a)(8) § 3221 (h) § 3221(k)(4) § 3241(c) § 4303(a)(2) § 4303(l) § 4900(c) PHL § 4408(1)(h) 10 NYCRR 98-1.13 Circular Letter No.1 (2002) 42 USC § 300gg-19a 45 CFR § 147.138(b) 45 CFR § 156.100 Model Language Article 6 of the Financial Services Law Ch. 60 of the Laws of 2014</p>	<p>This policy or contract form provides coverage for the treatment of an emergency condition in a hospital:</p> <ul style="list-style-type: none"> • Without the need for any prior authorization; • Regardless of whether the provider is a participating provider; • Without imposing any administrative requirement or limitation on out-of-network coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers; • The cost-sharing (deductibles, copayments and/or coinsurance) shall be the same regardless of whether the services are provided by a participating or a non-participating provider; and • The benefits for out-of-network emergency services must at a minimum equal the greatest of the following amounts: (i) the amount negotiated with in-network providers for the emergency service; (ii) the amount for the emergency service calculated using the same method the insurer uses to determine payments for out-of-network services excluding any in-network copayment or coinsurance; or (iii) the amount that would be paid under Medicare for the emergency service excluding any in-network copayment or coinsurance. • This policy or contract form shall provide that the insured shall be held harmless for any non-participating provider charge for emergency services that exceeds the in-network deductibles, copayments, and/or coinsurance. • If a dispute involving a payment for emergency services provided by a physician is submitted to an independent dispute resolution entity (“IDRE”), the insurer must pay the amount, if any, determined by the IDRE for physician services. <p><i>Note: The following definitions must be used: “Emergency condition” means a medical or behavioral condition that manifests itself by acute</i></p>	

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		<p><i>symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (ii) serious impairment to such person’s bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person; or a condition described in § 1867(e)(1)(A)(i), (ii) or (iii) of the Social Security Act.</i></p> <p><i>With respect to an emergency condition, “emergency services” means: (i) a medical screening examination as required under 42 USC § 1395dd, which is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and (ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under 42 USC § 1395dd to stabilize the patient. For purposes of this paragraph, “to stabilize” means, with respect to an emergency condition, to provide such medical treatment of 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).</i></p>	
Urgent Care Services Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3221(h) § 4303(l) 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for urgent care. Urgent care is medical care for an illness, injury or condition that is serious enough for a reasonable person to seek care right away, but not so severe as to require emergency care.	
OUTPATIENT SERVICES, INPATIENT SERVICES, EQUIPMENT AND DEVICES			
Advanced Imaging Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3221(h) § 4303(l) 45 CFR § 156.100 Model Language	<p>This policy or contract form provides coverage for PET scans, MRI, nuclear medicine, and CAT scans.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
Allergy Testing and Treatment Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3221(h) § 4303(l) 45 CFR § 156.100 Model Language	<p>This policy or contract form provides coverage for testing and evaluations including: injections, and scratch and prick tests to determine the existence of an allergy. This policy or contract form also provides coverage for allergy treatment, including desensitization treatments, routine allergy injections and serums.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
Ambulatory Surgery Center Model Language Used?	§ 3221(h) § 4303(l) 45 CFR § 156.100	This policy or contract form provides coverage for surgical procedures performed at an ambulatory surgical center including services and supplies provided by the center the day the surgery is performed.	

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Yes <input type="checkbox"/> No <input type="checkbox"/>	Model Language	Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Chemotherapy Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3221(h) § 4303(l) 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for chemotherapy in an outpatient facility or in a professional provider office. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Chiropractic Care Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3221(h) § 3221(k)(11) § 4303(y), (ll) 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for chiropractic care in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment, or subluxation in the vertebral column. Chiropractic care and services may be subject to reasonable deductible, copayment and coinsurance amounts, reasonable fee or benefit limits, and reasonable utilization review, provided that any such amounts, limits and review: shall not function to direct treatment in a manner discriminative against chiropractic care and individually and collectively shall be no more restrictive than those applicable under the coverage to care or services provided by other health care professionals in the diagnosis, treatment and management of the same or similar conditions, injuries, complaints, disorders or ailments even if differing nomenclature is used to describe the condition, injury, complaint, disorder or ailment. <i>Note: A policy or contract forms may not subject a visit to a chiropractor or to a provider of chiropractic care to higher cost-sharing than that which applies to other specialty office visits under the policy or contract. Additionally, a policy or contract may not impose a greater level of utilization review to chiropractic care and services than that which applies to specialty office care in general under the policy or contract. This means, for example, that a policy or contract may not require pre-certification or preauthorization of chiropractic care and services if it does not require the same for specialty office visits in general.</i>	
Clinical Trials Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	42 USC § 300gg-8 Model Language	This policy or contract form provides coverage for the routine patient costs for participation in an approved clinical trial and such coverage shall not be subject to utilization review if the insured is: (i) eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition; and (ii) referred by a participating provider who has concluded that the insured's participation in the approved clinical trial would be appropriate. An "approved clinical trial" means a phase I, II III, or IV clinical trial that is: (i) a federally funded or approved trial; (ii) conducted under an investigational drug application reviewed by the FDA; or (iii) a drug trial that is exempt from having to make an investigational new drug application.	
Dialysis Coverage Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3221(h) § 3221(k)(16) § 4303(gg), (ll) 45 CFR § 156.100	This policy or contract form provides coverage for dialysis treatment of an acute of chronic kidney ailment. If the policy or contract form does not otherwise cover out-of-network services, dialysis treatment or services provided by a non-participating provider must be covered if the following conditions are met:	

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	<p>Model Language</p>	<ul style="list-style-type: none"> • The out-of-network provider is duly licensed to practice and authorized to provide such treatment; • The out-of-network provider is located outside the service area of the insurer; • The in-network provider treating the insured for the condition issues a written order stating that the dialysis treatment is necessary; • The insured notifies the insurer in writing 30 days in advance of the proposed date(s) of the out-of-network dialysis treatment and attaches the written order of the in-network provider. If the insured must travel on sudden notice due to family or other emergency, shorter notice may be permitted, provided that the insurer has a reasonable opportunity to review the travel and treatment plans of the insured; • The insurer has the right to pre-approve the dialysis treatment schedule; and • Such coverage may be limited to 10 out-of-network treatments in a calendar year. <p>Benefits for services of a non-participating provider are subject to any applicable cost-sharing that applies to dialysis treatments by a participating provider. However, the insured will also be responsible for paying any difference between the amount the insurer would have paid had the service been provided by a participating provider and the non-participating provider's charge.</p>	
<p>Outpatient Habilitative Services</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><i>Note: Substitution and the addition of benefits to EHB categories are only permissible in non-standard products.</i></p> <p>Non-standard product? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Is this benefit being substituted? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Are additional benefits being added to this EHB category? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, please explain how</p>	<p>§ 3221(h) § 4303(II) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for habilitation therapy, including physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a professional provider's office for 60 visits per condition, per plan year. The visit limit applies to all therapies combined.</p> <p>For purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p> <p><i>Note: Standard NYSOH plans must use 60 visits per condition per plan year for all therapies combined. Non-standard NYSOH plans may: (i) cover 60 or more visits or remove the visit limit; or (ii) remove the per condition and/or the limit on all therapies combined.</i></p>	

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<p>this substitution or addition differs from the standard benefit in the space provided below.</p>			
<p><u>Benefit explanation:</u></p>			
<p>Home Health Services</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 3221(k)(1) § 4303(a)(3) § 4303(l) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage of home care for not less than 40 visits in a plan year for each person covered under the policy or contract if hospitalization or confinement in a nursing facility would otherwise be required. Home care must be provided by an agency possessing a valid certificate of approval or license issued pursuant to Article 36 of the Public Health Law and shall consist of one (1) or more of the following:</p> <ul style="list-style-type: none"> • Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse. • Part-time or intermittent home health aide services which consist primarily of caring for the patient. • Physical, occupational or speech therapy if provided by the home health service or agency. • Medical supplies, prescription drugs and medications prescribed by a physician and laboratory services by or on behalf of a certified or licensed home health agency. • Each visit by a member of a home care team shall be considered as one (1) home care visit. • Four (4) hours of home health aide service shall be considered as one (1) home care visit. <p>Such coverage may be subject to an annual deductible of not more than \$50 per person covered under the policy or contract form and may be subject to a coinsurance provision which provides not less than 75% of reasonable charges for services. Such coverage may be subject to copayments.</p> <p><i>Note: Standard NYSOH plans must cover 40 visits. Non-standard NYSOH plans may increase the number of covered home health care visits.</i></p>	
<p>Treatment of Correctable Medical Conditions that Cause Infertility/Infertility Treatments</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 3221(k)(6) § 4303(s), (l) 11 NYCRR 52.18(a)(10) Definition of Infertility OGC Opinion 05-11-10 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form shall not exclude coverage for hospital, surgical or medical care for the diagnosis and treatment of correctable medical conditions otherwise covered under the policy or contract solely because the medical condition results in infertility.</p> <ul style="list-style-type: none"> • Coverage shall not exclude surgical or medical procedures which would correct malformation, disease or dysfunction resulting in infertility. • Coverage shall not exclude diagnostic tests and procedures including hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysteroqram, post coital tests, testis biopsy, semen analysis, blood tests, ultrasound and artificial insemination, or prescription drugs if prescription drug coverage is otherwise provided under the policy or contract. • Coverage shall be provided for persons age 21-44 years; however, coverage beyond this age range is not precluded for non-standard products. <p>Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate</p>	

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		<p>by the Superintendent and as are consistent with other benefits within the policy or contract.</p> <p>This mandate does not require coverage of the following treatments in connection with infertility:</p> <ul style="list-style-type: none"> • In vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers; • The reversal of elective sterilizations; • The cost for an ovum donor or donor sperm; • Sperm storage costs; • Cryopreservation and storage of embryos; • Ovulation predictor kits; • Reversal of tubal ligations; • Cloning; or • Medical or surgical services or procedures determined to be experimental. <p>These are the only infertility treatments that may be expressly excluded in the policy or contract form.</p> <p><i>Note: The exclusions listed above may be removed for non-standard NYSOH plans.</i></p>	
<p>Infusion Therapy</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 4303(II) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for infusion therapy, which is the administration of drugs using specialized delivery systems which otherwise would have required hospitalization.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Interruption of Pregnancy</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 4303(II) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for therapeutic abortions. Non-therapeutic abortions in cases of rape, incest or fetal malformation are also covered. Elective abortions are covered for one (1) procedure per member, per year.</p> <p><i>Note: Plans must include the one procedure limit for standard NYSOH plans and may provide coverage that is more favorable for non-standard NYSOH plans.</i></p>	
<p>Laboratory Procedures, Diagnostic Testing and Radiology Services</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 4303(II) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Medications for Use in the Office</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 4303(II) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for medications and injectables (excluding self-injectables) used by the insured's provider in the provider's office for preventive and therapeutic purposes. Such benefit applies then the insured's provider orders the prescription drug and administers it to the insured.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Office Visits</p>	<p>§ 3221(h) § 4303(II)</p>	<p>This policy or contract form provides coverage for office visits for the diagnosis and treatment of injury, disease, and medical conditions. Office visits may include house calls. This policy or</p>	

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<p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language</p>	<p>contract form may also, if applicable, include coverage for a telemedicine program. The policy or contract form should include a description of the telemedicine program, including how members can access the program.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Outpatient Hospital Services</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 4303(l) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for hospital services and supplies described in the inpatient hospital section of the policy or contract form that can be provided while being treated in an outpatient facility.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Preadmission Testing</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 3221(k)(2) § 4303(l) § 4303(a)(1) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for preadmission testing ordered by a physician performed in the outpatient facilities of a hospital as a planned preliminary to admission of the patient as an inpatient for surgery in the same hospital provided that: tests are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed; reservations for a hospital bed and for an operating room were made prior to the performance of the tests; the surgery actually takes place within seven (7) days of the tests; and the patient is physically present at the hospital for the tests.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Outpatient Rehabilitative Services</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><i>Note: Substitution and the addition of benefits to EHB categories are only permissible in non-standard products.</i></p> <p>Non-standard product? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Is this benefit being substituted? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Are additional benefits being added to this EHB category? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 4303(l) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for rehabilitation therapy, including physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a professional provider's office for 60 visits per condition, per plan year. The visit limit applies to all therapies combined.</p> <p>For purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.</p> <p>Speech and physical therapy are covered only when such therapy is related to the treatment or diagnosis of a physical illness or injury (in the case of a dependent child, this provides a medically diagnosed congenital defect); is ordered by a physician; and the insured has been hospitalized or has undergone surgery for such illness or injury.</p> <p>All services must begin within six (6) months of the later to occur:</p> <ul style="list-style-type: none"> • The date of the injury or illness that caused the need for the therapy; • The date the insured is discharged from a hospital where surgical treatment was rendered; or • The date outpatient surgical care is rendered. <p>In no event will the therapy continue beyond 365 days after such event.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p> <p><i>Note: Standard NYSOH plans must use 60 visits per condition per plan year for all therapies</i></p>	

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<p>If yes, please explain how this substitution or addition differs from the standard benefit in the space provided below.</p>		<p><i>combined. Non-standard NYSOH plans may: (i) cover 60 or more visits or remove the visit limit; (ii) remove the per condition and/or the limit on all therapies combined; or (iii) remove the post-hospitalization/post-surgical requirement for speech and physical therapies.</i></p>	
<p><u>Benefit explanation:</u></p>			
<p>Second Medical Opinion for Cancer Diagnosis</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 3221(k)(9) § 4303(w), (ll) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer.</p> <ul style="list-style-type: none"> • This benefit provides coverage for a second medical opinion from a non-participating specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer when the attending physician provides a written referral to the non-participating specialist, at no additional cost to the insured beyond what such insured would have paid for services from a participating specialist. • This benefit also provides coverage for a second medical opinion by a non-participating specialist where there is no referral from the attending physician and where the insurer has not pre-authorized the service. In such cases, the insurer is responsible for covering the medically necessary services at a usual, customary and reasonable rate. <p>Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.</p>	
<p>Second Surgical Opinion</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 3221(k)(3) § 4303(b), (ll) 45 CFR § 156.100 Circular Letter No. 29 (1979) Model Language</p>	<p>This policy or contract form provides coverage for a second surgical opinion by a qualified physician on the need for surgery.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Mandatory Second Surgical Opinion</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(k)(3) § 4303(b) Circular Letter No. 29 (1979) Model Language</p>	<p>The policy or contract form may contain a mandatory second surgical opinion provision only if such provision is consistent with Circular Letter No. 29 (1979).</p> <p>Such coverage may not be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Second Opinion in Other Cases</p> <p>Model Language Used?</p>	<p>§ 3221(h) § 4303(ll) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for a second opinion in cases when a subscriber disagrees with a provider's recommended course of treatment.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	

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Yes <input type="checkbox"/> No <input type="checkbox"/>			
Surgical Services Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3221(h) § 4303(l) 45 CFR § 156.100 11 NYCRR 52.6 Model Language	This policy or contract form provides coverage for physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or specialist, assistant (including a physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Oral Surgery Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3221(h) § 4303(l) 45 CFR § 156.100 11 NYCRR 52.16(c)(9) Model Language	This policy or contract form provides coverage for the following limited dental and oral surgical procedures: <ul style="list-style-type: none"> • Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is covered only when repair is not possible. Dental services must be obtained within 12 months of the injury. • Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly. • Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment. • Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not covered. • Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Post-Mastectomy Reconstruction Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3221(h) § 3221(k)(10) § 4303(x), (ll) Women's Health and Cancer Rights Act of 1998, 29 USC 1185(b) 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for breast reconstruction surgery after a mastectomy or partial mastectomy including all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of mastectomy including lymphedemas in the manner determined by the attending physician and the patient to be appropriate. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract.	
Transplants Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3221(h) § 4303(l) 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for transplants determined to be nonexperimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Autism Spectrum Disorder Model Language Used?	§ 3221(h) § 3221(l)(17) § 4303(ee), (ll)	This policy or contract form provides coverage for the screening, diagnosis and treatment of autism spectrum disorder, including the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a	

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<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language</p>	<p>licensed psychologist:</p> <ul style="list-style-type: none"> • Behavioral health treatment; • Psychiatric care; • Psychological care; • Medical care provided by a licensed health care provider; • Therapeutic care, including therapeutic care which is deemed habilitative or nonrestorative, in the event that the policy provides coverage for therapeutic care; and • Pharmacy care in the event that the policy or contract provides coverage for prescription drugs. <p>This policy or contract form provides a definition of “autism spectrum disorder”, which means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.</p> <p>The policy or contract form provides a definition of “behavioral health treatment”, which means counseling and treatment programs, when provided by a licensed provider and applied behavior analysis, when provided or supervised by a licensed or certified behavior analysis provider, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.</p> <p>The policy or contract form provides coverage for “applied behavior analysis”, which means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.</p> <p>The policy or contract form provides a definition of “assistive communication devices”, which at a minimum provides dedicated devices which are specifically designed to aid in communication and are not generally useful to a person in the absence of a communication impairment and software applications that enable a non-covered device to function as a communication device.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.</p>	
<p>Diabetes Equipment, Supplies and Self-Management Education</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 3221(k)(7) § 4303(u), (II) 10 NYCRR 60-3.1 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for equipment, supplies and self-management education described in § 3221(k)(7) or § 4303(u) for the treatment of diabetes. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits.</p> <p><i>Note: For standard plans, the medical benefit cost-sharing must apply. For non-standard plans, plans may apply the benefit as a prescription benefit if the cost sharing is more favorable to the insured than when treated as a medical benefit.</i></p>	

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		<p><i>Note: Since the statute refers to equipment, supplies and self-management education that are prescribed by a physician “or other licensed health care provider legally authorized to prescribe under title eight of the education law...,” the policy or contract form may not limit coverage to care prescribed by a physician.</i></p>	
<p>Durable Medical Equipment and Braces</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 4303(l) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for the rental or purchase of durable medical equipment and braces, including orthotic braces. Coverage is for standard equipment only. Repairs or replacement are covered when made necessary by normal wear and tear. Coverage does not include the cost of repairs or replacement that are the result of misuse or abuse.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Hearing Aids</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 4303(l) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.</p> <p>Coverage must be provided for a single purchase (including repair and/or replacement) of hearing aids for one or both ears once every three (3) years.</p> <p>Bone anchored hearing aids must be covered only if an insured has either of the following:</p> <ul style="list-style-type: none"> • Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or • Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. <p>Coverage must be provided for one (1) bone anchored hearing aid per ear during the period of time the insured is enrolled. Replacements and/or repairs for a bone anchored hearing aid are covered only for malfunctions.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p> <p><i>Note: The three-year limit on hearing aids is required for standard NYSOH plans but the limit may be removed or modified so that coverage is more favorable as an option for non-standard NYSOH plans. The limit on bone anchored hearing aids is required for standard NYSOH plans but may be removed or modified so that coverage is more favorable as an option for non-standard NYSOH plans.</i></p>	
<p>Hospice Care</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(1)(10) § 4303(o), (l) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides hospice care to members who have been certified by their primary attending physician as having a life expectancy of six (6) 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. Coverage will include inpatient hospice care in a hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210 days</p>	

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		<p>of hospice care. This policy or contract form will also cover five (5) visits for supportive care and guidance for the purpose of helping the member and the member’s immediate family cope with the emotional and social issues related to the member’s death.</p> <p>Hospice care will be covered only when provided as part of a hospice care program certified pursuant to Article 40 of the Public Health Law. If care is provided outside New York State, the hospice must have an operating license issued by the state in which the hospice is located under a certification process that is similar to that used in New York. Coverage is not provided for: funeral arrangements; pastoral, financial, or legal counseling; homemaker, caretaker, or respite care.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with those imposed on other benefits.</p> <p><i>Note: Standard NYSOH plans must cover 210 days of hospice care. Non-standard NYSOH plans may cover more than 210 days.</i></p>	
<p>Medical Supplies</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 3221(k)(19) § 4303(u-1) § 4303(l) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for medical supplies required for the treatment of a disease or injury, including maintenance supplies.</p>	
<p>Prosthetics</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 4303(l) 45 CFR § 156.100 Model Language</p>	<p><u>External Prosthetic Devices:</u> This policy or contract form provides coverage for prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. Coverage is limited to one (1) external prosthetic device per limb per lifetime. Coverage is also provided for the cost of repair and replacement of the prosthetic device and its parts except when otherwise covered under warranty or when repair or replacement is the result of misuse or abuse. Coverage is for standard equipment only.</p> <p><i>Note: The limit on prosthetic devices is required for standard NYSOH plans. Non-standard NYSOH plans may remove the limit.</i></p> <p><u>Internal Prosthetic Devices:</u> This policy or contract form provides coverage for surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This provides implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by the insured and his/her attending physician to be appropriate. Coverage also provides repair and replacement due to normal growth or normal wear and tear. Coverage is for standard equipment only.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	

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<p>Hospital Services</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 4303(l) 11 NYCRR 52.5 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for inpatient hospital services for acute care, for an illness, injury or disease of a severity that must be treated on an inpatient basis including:</p> <ul style="list-style-type: none"> • Semiprivate room and board; • General, special, and critical nursing care; • Meals and special diets; • The use of operating, recovery, and cystoscopic rooms and equipment; • The use of intensive care, special care, or cardiac care units and equipment; • Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the hospital; • Dressings and casts; • Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, x-ray examinations and radiation therapy, laboratory and pathological examinations; • Blood and blood products except when participation in a volunteer blood replacement program is available • Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation; • Short-term physical, speech and occupational therapy; and • Any additional medical services and supplies which are customarily provided by hospitals. <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Maternity Care</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 3221(k)(5) § 4303(c), (l) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for maternity care, to the same extent as coverage is provided for illness or disease under the policy or contract. Such coverage, other than for perinatal complications, provides inpatient hospital coverage for mother and newborn for at least 48 hours after childbirth for any delivery other than a caesarean section, and for at least 96 hours following a caesarean section. Such coverage may be subject to deductibles, copayments and/or coinsurance.</p> <p>The mother has the option to be discharged earlier than the time periods listed above, and, in such cases, is entitled to one (1) home care visit in addition to any home care provided under § § 3221(k)(1) or § 4303(a)(3). Such home care is not subject to deductibles, copayments and/or coinsurance.</p> <p>Maternity coverage also provides 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 Education Law § 6951.</p> <p>Maternity coverage also provides parent education, training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments. The cost of renting one</p>	

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		(1) breast pump per pregnancy in conjunction with childbirth is covered in full. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
Mastectomy Care Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3221(h) § 3221(k)(8) § 4303(v), (ll) Women’s Health and Cancer Rights Act of 1998, 29 USC 1185(b) 45 CFR § 156.100 Model Language	This policy or contract form providesprovides coverage for a period of inpatient hospital care as is determined by the attending physician in consultation with the patient to be medically appropriate for a person undergoing a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered under the policy or contract, and any physical complications arising from the mastectomy, including lymphedema. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
Autologous Blood Banking Services Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3221(h) § 4303(ll) 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for autologous blood banking services when they are being provided in connection with a scheduled, covered inpatient procedure for the treatment of a disease or injury. In such instances, this policy or contract form will cover storage fees for what are determined to be a reasonable storage period that is appropriate for having the blood available when it is needed. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Inpatient Habilitative Services Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Note: Substitution and the addition of benefits to EHB categories are only permissible in non-standard products.</i> Non-standard product? Yes <input type="checkbox"/> No <input type="checkbox"/> Is this benefit being substituted? Yes <input type="checkbox"/> No <input type="checkbox"/> Are additional benefits being added to this EHB category?	§ 3221(h) § 4303(ll) 45 CFR § 156.100 Model Language	This policy or contract form providesprovides coverage for inpatient habilitation services, including physical therapy, speech therapy, and occupational therapy for 60 days per plan year. The visit limit applies to all therapies combined. Such coverage may be subject to deductibles, copayments and/or coinsurance. <i>Note: Standard NYSOH plans must cover 60 days per plan year for all therapies combined. Non-standard NYSOH plans may: (i) cover 60 or more days or remove the day limit; or (ii) remove the limit on all therapies combined.</i>	

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Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please explain how this substitution or addition differs from the standard benefit in the space provided below.			
<u>Benefit explanation:</u>			
Inpatient Rehabilitative Services Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Note: Substitution and the addition of benefits to EHB categories are only permissible in non-standard products.</i> Non-standard product? Yes <input type="checkbox"/> No <input type="checkbox"/> Is this benefit being substituted? Yes <input type="checkbox"/> No <input type="checkbox"/> Are additional benefits being added to this EHB category? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please explain how this substitution or addition differs from the standard benefit in the space provided below.	§ 3221(h) § 4303(l) 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for rehabilitation services including physical therapy, speech therapy, and occupational therapy for 60 days per plan year in a rehabilitation facility. The visit limit applies to all therapies combined. <i>Note: Standard NYSOH plans must cover 60 days per plan year for all therapies combined. Non-standard NYSOH plans and plans offered outside the NYSOH may: (i) cover 60 or more days or remove the day limit; or (ii) remove the limit on all therapies combined.</i> Such coverage may be subject to deductibles, copayments and/or coinsurance.	
<u>Benefit explanation:</u>			

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<p>Skilled Nursing Facility</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 3221(l)(2) § 4303(d), (ll) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, for up to 200 days, per calendar year, for non-custodial care. Custodial, convalescent or domiciliary care is not covered.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p> <p><i>Note: Standard NYSOH plans must cover 200 days. Non-standard NYSOH plans may cover more than 200 days.</i></p>	
<p>End of Life Care</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 4303(ll) § 4805 PHL § 4406-e 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for acute care provided in a licensed Article 28 facility or acute care facility that specializes in the care of terminally ill patients if the subscriber is diagnosed with advanced cancer and has fewer than 60 days to live.</p>	
<p>Centers of Excellence</p>	<p>§ 3201(c)</p>	<p>This policy or contract form may provide coverage for centers of excellence which are hospitals approved and designated for certain services.</p>	
<p>MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES</p>			
<p>Inpatient Mental Health Care Services</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Confirm that the cost-sharing for Mental Health services complies with all requirements under MHPAEA. Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 3221(l)(5) § 4303(g), (ll) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Public Law 110-343 45 CFR § 146.136 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders at least equal to the coverage provided for other health conditions under this policy or contract. Coverage for inpatient services for mental health care is limited to facilities as defined in Mental Hygiene Law § 1.03(10) and, in other states, to similarly licensed or certified facilities.</p> <p>Coverage for inpatient mental health care also provides services received at residential treatment facilities, including room and board charges. Coverage for residential treatment services is limited to facilities defined in Mental Hygiene Law § 1.03(33) and, in other states, to similarly licensed or certified facilities.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with the federal Mental Health Parity Addiction Equity Act (“MHPAEA”).</p> <p><i>Note: Under MHPAEA, small group health policies or contracts that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost-sharing) and treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policy or contract forms from imposing separate cost-sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for</i></p>	

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<p>Outpatient Mental Health Care Services</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Confirm that the cost-sharing for Mental Health services complies with all requirements under MHPAEA. Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 3221(l)(5) § 4303(g), (h), (ll) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Public Law 110-343 45 CFR § 146.136 45 CFR § 156.100 Model Language</p>	<p><i>the treatment of mental health conditions and substance use disorder consistent with the federal law.</i></p> <p>This policy or contract form provides coverage for outpatient mental health care services including, but not limited to, partial hospitalization program and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Such coverage is limited to facilities that have been issued an operating certificate pursuant to Article 31 of the Mental Hygiene Law or are operated by the New York State Office of Mental Health and, in other states, to similarly licensed or certified facilities; services provided by a psychiatrist or psychologist licensed to practice in this state; a licensed clinical social worker who meets the requirements of Insurance Law §§ 3221(l)(4)(D) and 4303(h)(1); or a professional corporation or a university faculty practice corporation thereof.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA.</p> <p><i>Note: Under MHPAEA, group health policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost-sharing) and treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policy or contract forms from imposing separate cost-sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.</i></p>	
<p>Inpatient Substance Use Services</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Confirm that the cost-sharing for Substance Use services complies with all requirements under MHPAEA. Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 3221(l)(6) § 4303(k), (ll) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Public Law 110-343 45 CFR § 146.136 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for inpatient substance use services relating to the diagnosis and treatment of substance use disorder, including detoxification and rehabilitation services. Inpatient substance use services are limited to facilities in New York which are certified by the Office of Alcoholism and Substance Abuse Services (“OASAS”), and in other states, to those facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.</p> <p>Coverage for inpatient substance use services also provides services received at residential treatment facilities, including room and board charges. Coverage for residential treatment services is limited to facilities certified by OASAS; and, in other states, to those facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA.</p>	

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		<p><i>Note: Under MHPAEA, group health policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost-sharing) and treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost-sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.</i></p>	
<p>Outpatient Substance Use Services</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Confirm that the cost-sharing for Substance Use services complies with all requirements under MHPAEA. Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 3221(l)(7) § 4303(i), (ll) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Public Law 110-343 45 CFR § 146.136 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for outpatient substance use services relating to the diagnosis and treatment of substance use disorder, including but not limited to partial hospitalization program services, intensive outpatient program services, and methadone treatment. Such coverage is limited to facilities in New York State, certified by the OASAS or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs or by physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the acute detoxification stage of treatment or during stages of rehabilitation, and, in other states, to those facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use disorder services related to the diagnosis and treatment of alcoholism and/or substance use and/or dependency.</p> <p>Coverage must also be provided for up to 20 outpatient visits for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member: (i) identifies himself or herself as a family member of a person suffering from substance use disorder; and (ii) is covered under the same family policy or contract that covers the person receiving, or in need of, treatment for substance use, and/or dependence. Payment for a family member should be the same amount regardless of the number of family members who attend the family therapy session.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA.</p> <p><i>Note: The insurer may not deny coverage to a family member who identifies himself or herself as a family member of a person suffering from substance abuse or dependency and who seeks treatment as a family member who is otherwise covered by the policy or contract. The coverage provided under this statute provides treatment as a family member pursuant to such family member's own policy or contract provided such family member does not exceed the allowable number of family visits and is otherwise entitled to the coverage pursuant to this mandate.</i></p>	

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		<p><i>Note: Under MHPAEA, group health policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost-sharing) and treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost-sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.</i></p>	
PRESCRIPTION DRUGS			
<p>Prescription Drugs</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 4303(l) 45 CFR § 156.100 45 CFR § 156.122 Model Language</p>	<p>This policy or contract form provides coverage for prescription drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and that are required by law to bear the legend “Caution – Federal Law prohibits dispensing without a prescription” so long as they are FDA approved, ordered by a provider authorized to prescribe, prescribed within the approved FDA administration and dosing guidelines, and are dispensed by a pharmacy. This policy or contract form covers at least the greater of one drug in every United States Pharmacopia Category and Class; or the same number of prescription drugs in each category and class as the benchmark plan.</p> <p>This policy or contract form may have up to a three tier cost-sharing plan design.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Enteral Formulas</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 3221(k)(11) § 4303(y), (ll) 45 CFR § 156.100 OGC Opinion 10-12-03 Model Language</p>	<p>This policy or contract form provides coverage for enteral formulas for home use, whether administered orally or via feeding tube, for which a physician or other licensed health care provider legally authorized to prescribe under Title 8 of the Education Law has issued a written order. The order must state that the formula is medically necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic physical disability, mental retardation or death. Specific diseases that enteral formulas are effective for include, but are not limited to: inherited amino-acid or organic acid metabolism; Crohn’s Disease; gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which if left untreated will cause malnutrition, chronic physical disability, mental retardation or death. Coverage for certain inherited diseases of amino acid and organic acid metabolism provides coverage of modified solid food products.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Off-Label Cancer Drug Usage</p>	<p>§ 3221(h) § 3221(l)(12) § 4303(g), (ll)</p>	<p>This policy or contract form may not exclude, or deny, prescription drug coverage 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</p>	

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<p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.100 Model Language</p>	<p>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.</p>	
<p>Usual and Customary Cost of Prescribed Drugs Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 4325(h) PHL § 4406-c(6) Model Language</p>	<p>Copayments relating to prescription drugs shall not exceed the usual and customary cost of such prescribed drug.</p>	
<p>Prohibition for Tier IV Drugs</p>	<p>§ 3221(a)(16) § 4303(gg) PHL § 4406-c(7)</p>	<p>The policy or contract form shall not impose cost-sharing (copayment, coinsurance and deductible) for any prescription drug that exceeds the cost-sharing for non-preferred brand drugs or its equivalent (or brand drugs if there is no non-preferred brand drug category).</p>	
<p>Eye Drops Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(k)(17) § 4303(hh) Model Language</p>	<p>The policy or contract form shall allow for the limited refilling of eye drop medication requiring a prescription prior to the last day of the approved dosage period. Any refill dispensed prior to the expiration of the approved coverage period shall, to the extent practicable, be limited in quantity so as not to exceed the remaining dosage initially approved for coverage. The limited refilling shall not limit or restrict coverage with respect to any previously or subsequently approved prescription for eye drop medication.</p>	
<p>Orally Administered Anticancer Medications Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 3221(l)(12-a) § 4303(q-1) § 4303(ll) 45 CFR § 156.100 Model Language</p>	<p>The policy or contract form provides coverage for a prescribed orally administered anticancer medication used to kill or slow the growth of cancerous cells. Such coverage may be subject to deductibles, copayments and/or coinsurance that are at least as favorable as those that apply to coverage for intravenous or injected anticancer medications.</p>	
<p>Mail Order Drugs for Policies With a Provider Network Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(l)(18) § 4303(kk) Model Language</p>	<p>If this policy or contract form provides coverage for mail order drugs, then this policy or contract shall permit an insured to fill any prescription that may be obtained at a network participating mail order or other non-retail pharmacy, at the insured’s option, at a network participating non-mail order retail pharmacy provided that the network participating non-mail order retail pharmacy agrees in advance, through a contractual network agreement, to the same reimbursement amount and the same terms and conditions that the insurer has established for the network participating mail order or other non-retail pharmacy.</p>	
<p>Contraceptive Drugs and Devices Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(h) § 3221(l)(16) § 4303(cc), (ll) 45 CFR § 147.130 45 CFR § 156.100 42 USC § 300gg-13 Model Language</p>	<p>This policy or contract form provides coverage for contraceptive drugs and devices or generic equivalents approved as substitutes by the FDA. For groups that meet the definition of a religious employer in §§ 3221(l)(16)(A) and 4303(cc)(1)(A), the subscriber will have the option to purchase the stand-alone contraceptive coverage rider. Contraceptive coverage must be provided with no cost-sharing.</p> <p><i>Note: Since the statute refers to contraceptive drugs and devices prescribed by a physician “or other licensed health care provider legally authorized to prescribe under title eight of the education law...,” the policy or contract may not limit coverage to contraceptive drugs and devices</i></p>	

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		<i>prescribed by a physician.</i>	
Formulary Exceptions	45 CFR § 156.122(c)	<p>This policy or contract form must provide for a standard and expedited formulary exception process for prescription drugs not on the insurer’s formulary. The insured, the insured’s designee or their prescribing health care professional may request a formulary exception for a clinically-appropriate prescription drug in writing, electronically or telephonically.</p> <p>For standard formulary exception requests, the insurer must make a decision and notify the insured or the insured’s designee and the prescribing health care professional no later than 72 hours after receipt of the request. If the insurer approves the request, the insurer must cover the prescription drug while the insured is taking the prescription drug, including any refills.</p> <p>An expedited formulary exception may be requested if the insured is suffering from a health condition that may seriously jeopardize the insured’s health, life or ability to regain maximum function or if the insured is undergoing a current course of treatment using a non-formulary prescription drug. The insurer must make a decision and notify the insured or the insured’s designee and the prescribing health care professional no later than 24 hours after receipt of the request. If the insurer approves the request, the insurer must cover the prescription drug while the insured suffers from the health condition that may seriously jeopardize the insured’s health, life or ability to regain maximum function or for the duration of the insured’s current course of treatment using the non-formulary prescription drug.</p>	
Disclosure of Formulary	45 CFR § 156.122(d)(1)	The insurer must publish an up-to-date, accurate, and complete list of all covered drugs on its formulary drug list, including any tiering structure that it has adopted and any restrictions on the manner in which the drug can be obtained in a manner that is easily accessible to insureds, prospective insureds, the State, NYSOH, the U.S. Department of Health and Human Services, the U.S. Office of Personnel Management, and the general public. The insurer’s website cannot require the individual to create or access an account or enter a policy number to view the formulary. If the insurer offers more than one plan, the insurer’s website must identify which formulary drug list applies to which plan.	
WELLNESS			
<p>Exercise Facility Reimbursement/Other Wellness Benefits</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><i>Note: Substitution is permitted for the wellness benefit in standard and non-standard products.</i></p> <p>Non-standard product?</p>	<p>§ 3221(h) § 3239 § 4224 § 4303(l)</p> <p>45 CFR § 146.121 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form partially reimburses the subscriber and the subscriber’s covered spouse or each covered dependent for certain exercise facility fees or membership fees. Additional and or substituted wellness benefits may be covered under standard and non-standard NYSOH plans. All wellness benefits must comply with § 3239 of the Insurance Law.</p> <p>The policy or contract should provide a detailed description of the wellness program and/or reward being offered as part of the wellness program. All wellness programs and any rewards must have a nexus to accident and health insurance.</p> <p>Participation in the wellness program must be available to similarly situated members of the group and must be voluntary on the part of the member.</p>	

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Yes <input type="checkbox"/> No <input type="checkbox"/> Is this benefit being substituted? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Note: If an insurer is substituting for this benefit, the benefit that is substituted must comply with § 3239.</i> Are additional benefits being added to this EHB category? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please explain how this substitution or addition differs from the standard benefit in the space provided below.			
<u>Benefit explanation:</u>			
VISION CARE			
Pediatric Vision Care Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3221(h) § 4303(l) 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for pediatric vision care including: emergency, preventive and routine vision care for members through the end of the month in which the member turns 19 years of age; one (1) vision examination in any 12-month period, unless more frequent examinations are medically necessary as evidenced by appropriate documentation; and prescribed lenses and frames; and contact lenses. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
DENTAL CARE			
Pediatric Dental Care Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> Is dental coverage being provided by this QHP filing? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3221(h) § 4303(l) 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for pediatric dental care including the following dental care services for members through the end of the month in which the member turns 19 years of age: emergency dental care; preventive dental care; routine dental care; endodontics; periodontics; prosthodontics; oral surgery; and orthodontics used to help restore oral structures to health and function and to treat serious medical conditions. Such coverage may be subject to deductibles, copayments and/or coinsurance.	

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ADDITIONAL BENEFITS		Additional benefits may be covered in non-standard NYSOH plans only.	
Acupuncture Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	Model Language	This policy or contract form provides coverage for acupuncture.	
Advanced Infertility Services Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	Model Language	This policy or contract form covers advanced infertility services.	
Family Vision Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	Model Language	This policy or contract form provides coverage for vision care including: emergency, preventive and routine vision care; including one (1) vision examination in any 12-month period; one (1) time per plan year, unless more frequent examinations are medically necessary as evidenced by appropriate documentation; prescribed lenses and frames; and contact lenses.	
Shoe Inserts Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	Model Language	This policy or contract form covers orthotic devices (e.g., shoe inserts) that are necessary to: support, restore or protect body function; redirect, eliminate or restrict motion of an impaired body part; or relieve or correct a condition caused by an injury or illness.	
Telemedicine Program Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	Model Language	In addition to providing covered services via telehealth, this policy or contract form covers online internet consultations between the insured and providers who participate in the telemedicine program for medical conditions that are not an emergency condition.	
Additional Benefits Provided in Policy or Contract, or By Rider Additional benefits provided? Yes <input type="checkbox"/> No <input type="checkbox"/> If additional benefits are provided, please explain in the space provided below.	11 NYCRR 52.1(c)	The policy or contract form, or by rider, may provide new forms of coverage and new ways of reducing health care costs by rider. Innovations should provide health care benefits of real economic value. Innovations should not be designed merely to produce superficial differences or play upon people’s fears of particular diseases, be unduly complex and serve to confuse and make intelligent choice more difficult. Benefits which are contrary to the health care needs of the public and only serve to confuse or obfuscate and provide no economic value are prohibited.	
<u>Benefit explanation:</u>			
PERMISSIBLE EXCLUSIONS AND LIMITATIONS		<i>No policy or contract form shall limit or exclude coverage by type of illness, accident, treatment or medical condition, with an exception for the following exclusions.</i> <i>The following exclusions are permissible except Conversion Therapy which must be included. A plan does not need to include all the exclusions. However, if an exclusion is included, the language below must be used.</i>	Form/Page/Para Reference
Aviation Model Language Used?	11 NYCRR 52.16(c)(4)(iii) Model Language	This policy or contract form excludes coverage for services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.	

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Yes <input type="checkbox"/> No <input type="checkbox"/>			
Convalescent and Custodial Care Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	11 NYCRR 52.16(c)(11) Model Language	This policy or contract form excludes coverage for services related to rest cures, custodial care or transportation. Custodial care means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include covered services determined to be medically necessary.	
Conversion Therapy Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	11 NYCRR 52.16(n) Model Language	This policy or contract form excludes coverage for conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of an insured under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity. <i>Note: This exclusion is required.</i>	
Cosmetic Services Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	11 NYCRR 52.16(c)(5) Model Language 11 NYCRR 56 Model Language	This policy or contract form excludes coverage for cosmetic services, prescription drugs, or surgery, except that cosmetic surgery does not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.	
Coverage Outside of the United States, Canada or Mexico Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	11 NYCRR 52.16(c)(12) Model Language	This policy or contract form excludes coverage for care or treatment provided outside of the United States, its possessions, Canada or Mexico except for emergency services, pre-hospital emergency medical services and ambulance services to treat an emergency condition.	
Dental Services Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	11 NYCRR 52.16(c)(9) Model Language	This policy or contract form excludes coverage for dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or except as required in the oral surgery or pediatric dental benefits, as applicable.	
Experimental or Investigational Treatment Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§3221(k)(12) § 4303(z) Article 49 Model Language	This policy or contract form excludes coverage for any health care service, procedure, treatment, device, or prescription drug that is experimental or investigational. However, coverage will be provided for experimental or investigational treatments, including, treatment of rare diseases, or patient costs for the insured's participation in a clinical trial, when the denial of services is overturned by an external appeal agent certified by the State. However, for clinical trials, no coverage will be provided for the costs of any investigational drugs or devices, non-health services required for the patient to receive the treatment, the costs of managing the research, or costs that would not be covered under this policy or contract form for non-investigational treatments.	

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<p>Felony Participation</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>11 NYCRR 52.16(c)(4)(i) Model Language</p>	<p>This policy or contract form excludes coverage for any illness, treatment or medical condition due to participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of a medical condition, including both physical and mental health conditions.</p>	
<p>Foot Care</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>11 NYCRR 52.16(c)(6) Model Language</p>	<p>This policy or contract form excludes coverage for routine foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, this policy or contract form provides coverage for routine foot care for a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in a covered person’s legs or feet.</p>	
<p>Government Facility</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>11 NYCRR 52.16(c)(8) Model Language</p>	<p>This policy or contract form excludes coverage for care or treatment provided in a hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.</p>	
<p>Medically Necessary</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3201(c)(3) Article 49 Model Language</p>	<p>This policy or contract form generally excludes coverage for any health care service, procedure, treatment, test, device or prescription drug that is determined to not be medically necessary; however, coverage will be provided when the denial of services is overturned by an external appeal agent certified by the State. Any denial of coverage should be treated as a medical necessity denial unless the denial is based on a benefit limit that is described in the contract or policy form.</p>	
<p>Medicare or Other Governmental Program</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>11 NYCRR 52.16(c)(8) 52.26(c) Model Language</p>	<p>This policy or contract form excludes coverage for services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).</p> <p>This policy or contract form may exclude Medicare benefits when coverage continues beyond the insured’s eligibility for Medicare, provided appropriate adjustment is made to the premium.</p>	
<p>Military Service</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>11 NYCRR 52.16(c)(4)(i) Model Language</p>	<p>This policy or contract form excludes coverage for an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.</p>	
<p>No-Fault Automobile Insurance</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>11 NYCRR 52.16(c)(8) Model Language</p>	<p>This policy or contract form excludes coverage for any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even the insured does not make a proper or timely claim for the benefits available under a mandatory no-fault policy.</p>	
<p>Services Separately Billed by Hospital Employees</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>11 NYCRR 52.16(c)(8) Model Language</p>	<p>This policy or contract form excludes coverage for services rendered and separately billed by employees of hospitals, laboratories or other institutions.</p>	
<p>Services Provided by a Family Member</p>	<p>11 NYCRR 52.16(c)(8)</p>	<p>This policy or contract form excludes coverage for services performed by a member of the covered person’s immediate family. “Immediate family” shall mean a child, spouse, mother, father, sister,</p>	

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Services With No Charge Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	11 NYCRR 52.16(c)(8) Model Language	This policy or contract form excludes coverage for services for which no charge is normally made.	
Services not Listed Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3201(c)(3) Model Language	This policy or contract form excludes coverage for services that are not listed in this policy or contract form as being covered.	
Vision Services Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	11 NYCRR 52.16(c)(10) Model Language	This policy or contract form excludes coverage for the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the pediatric vision benefit.	
Workers' Compensation Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	11 NYCRR 52.16(c)(8) Model Language	This policy or contract form excludes coverage for services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.	
War Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	11 NYCRR 52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for an illness, treatment or medical condition due to war, declared or undeclared.	
CLAIM DETERMINATIONS			Form/Page/Para Reference
Notice of Claim	§ 3221(a)(8) § 3224-a(d) Model Language	The policy or contract form provides that the insured has to provide the insurer with written notice of claim as applicable. A claim may be submitted electronically. However, failure to give notice within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such notice and the notice was provided as soon as reasonably possible.	
Submission of Claim Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3221(a)(9) § 4305(m) Model Language	The policy or contract must provide that the insured has a minimum of 120 days to provide the insurer with proof of loss after the date of such loss. However, failure to give proof within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such proof and the proof was provided as soon as reasonably possible.	
GRIEVANCE, UTILIZATION REVIEW AND EXTERNAL APPEAL			Form/Page/Para Reference
Grievance Procedures Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3217-a(a)(7) § 3217-d(a) § 4306-c(a) § 4324(a)(7)	A policy or contract form that is a managed care product as defined in § 4801(c), or a comprehensive policy that utilizes a network of providers, or a HMO, provides a description of the grievance procedure to be used to resolve disputes between the insurer and the insured, including: <ul style="list-style-type: none"> • The right to file a grievance regarding any dispute between an insured and the insurer; 	

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	<p>§ 4802 PHL § 4408(1)(p) PHL § 4408-a 10 NYCRR 98-1.14 42 USC § 300gg-19 29 CFR § 2560.503-1 45 CFR § 147.136 Model Language</p>	<ul style="list-style-type: none"> • 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. 	
<p>Utilization Review Policies and Procedures</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3217-a(a)(3) § 3217-d(d) § 4306-c(d) § 4324(a)(3) Article 49 PHL § 4408(1)(c) 42 USC § 300gg-19 29 CFR § 2560.503-1 45 CFR § 147.136 Model Language</p>	<p>This policy or contract form provides a description of the utilization review policies and procedures, including:</p> <ul style="list-style-type: none"> • The circumstances under which utilization review will be undertaken; • The toll-free telephone number of the utilization review agent; • The timeframes under which utilization review decisions must be made for prospective, retrospective and concurrent decisions; • The right to reconsideration; • The right to appeal, including the expedited and standard appeals processes and the timeframes for such appeals; • The right to designate a representative; • A notice that all denials of claims will be made by qualified clinical personnel and that all notices of denials will include information about the basis of the decision; • A notice of the right to an external appeal, together with a description, jointly promulgated by the Commissioner of Health and Superintendent, of the external appeal process and the timeframes for such appeals; and • Further appeal rights, if any. 	
<p>External Appeal Procedures</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Article 49 PHL Article 49 42 USC § 300gg-19 45 CFR § 147.136 45 CFR § 156.122 45 CFR § 156.122(c)(3) Model Language</p>	<p>This policy or contract form provides a description of the external appeal procedures, including:</p> <ul style="list-style-type: none"> • Instructions on how to request an external appeal; • The circumstances under which an external appeal may be pursued, including a service denied as: <ul style="list-style-type: none"> ○ not medically necessary; ○ experimental/investigational, including clinical trials and treatment for rare diseases; ○ out-of-network denials when the service is not available in-network and the insurer recommends an alternate treatment); ○ out-of-network referral denials on the basis that the insurer has a health care provider in-network with appropriate training and experience to meet the particular health care needs of the insured, and who is able to provide the service; and ○ formulary exception denials. • The timeframe for submitting an external appeal. 	
<p>COORDINATION OF BENEFITS</p>	<p>11 NYCRR 52.23 Model Language</p>	<p>If the policy or contract form contains a coordination of benefits provision, then it must comply with 11 NYCRR 52.23.</p>	<p>Form/Page/Para Reference</p>

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Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>			
TERMINATION OF COVERAGE Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	Model Language	<i>The following are the only termination provisions permissible under the Insurance Law.</i> <i>The Model Language must be used for each of the following termination provisions.</i>	Form/Page/Para Reference
Termination for Failure to Pay Premiums	§ 3221(p)(2)(A) § 4305(j)(2)(A)	This policy or contract form provides a provision permitting the insurer to terminate coverage if the group or subscriber has failed to pay premiums or contributions within 30 days of when premiums are due in accordance with the terms of the policy or contract form if the insurer has not received timely premium payments.	
Termination for Fraud	§ 3105 § 3221(p)(2)(B) § 4305(j)(2)(B)	This policy or contract form provides a provision permitting the insurer to terminate coverage if the group or a subscriber has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in writing on an enrollment application or in order to obtain coverage for a service.	
Termination for Failure to Comply With a Material Plan Provision	§ 3221(p)(2)(C) § 4305(j)(2)(C)	This policy or contract form (other than a HMO) provides a provision permitting the insurer to terminate coverage if the group 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 Coverage	§ 3221(p)(2)(D) § 3221(p)(3)(A) § 4305(j)(2)(D) § 4305(j)(3)(A)	This policy or contract form provides a provision permitting the insurer to discontinue this class of policy or contract upon written notice to each group, participant, and beneficiary not less than 90 days prior to the date of discontinuance. The insurer must offer groups the option to purchase all other hospital, surgical, and medical expense coverage currently being offered by the insurer to a group in such market and in exercising the option to discontinue coverage of this class, the insurer must act uniformly without regard to the claims experience of those groups or any health status-related factor relating to any insureds covered or new insureds who may become eligible for such coverage.	
Discontinuation of All Policies/Contracts in the Small Market	§ 3221(p)(2)(D) § 3221(p)(3)(E) § 4305(j)(2)(D) § 4305(j)(3)(E)	This policy or contract form (other than a HMO) provides a provision permitting the insurer to discontinue all hospital, surgical and medical expense coverage in the small group market upon written notice to the superintendent and to each group, participant, and beneficiary at least 180 days prior to the date of discontinuance.	
Termination for Failure to Meet Requirements of Group	§ 3221(p)(2)(E) § 4235(c)(1) § 4305(j)(2)(E)	This policy or contract form provides a provision permitting the insurer to terminate coverage if the group ceases to meet the requirements of a group under § 4235. Coverage terminated pursuant to this provision shall be done uniformly without regard to any health status factor relating to any individual.	
Termination if There Are No Longer Insureds in the Insurer's Service Area	§ 3221(p)(2)(F) § 4305(j)(2)(F)	This policy or contract form provides a provision permitting the insurer, in regard to a network plan, to terminate coverage if there is no longer any insured who lives, resides, or works in the service area of the insurer, or in the area for which the insurer is authorized to do business.	
Termination for Spouses in Cases of Divorce	§ 3221(p)(2)(G) § 4235(j)(2)(G)	This policy or contract form provides that in cases of divorce, coverage for the spouse shall terminate as of the date of the divorce.	
Termination Upon Death of Subscriber	§ 3221(p)(2)(G) § 4235(j)(2)(G)	This policy or contract form provides that upon the subscriber's death, the coverage will terminate unless there are dependents covered. If there is coverage for dependents, then coverage will	

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		terminate as of the last day of the month for which the premium has been paid.	
Termination by Subscriber		This policy or contract form provides that termination will occur at the end of the month during which the subscriber provides written notice requesting termination or on such later date requested for such termination by the notice.	
Rescission Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3105 § 3204 42 USC § 300gg-12 45 CFR § 147.128 Model Language	No misrepresentation shall avoid coverage or defeat any recovery there under unless the insured makes a misrepresentation that is material and intentional. This policy or contract form may include a provision that in the event a subscriber makes an intentional misrepresentation of material fact in writing upon his/her enrollment application, coverage may be rescinded if the facts misrepresented would have lead the insurer to refuse to issue the coverage.	
Renewal	§ 3221(p) § 3221(a)(5) § 4305(j) 11 NYCRR 52.18(c)	This policy or contract provides that except as specified in § 3221(p) or § 4305(j), the insurer must renew or continue in force such coverage at the option of the group. The policy or contract must specify the conditions under which the insurer may refuse to renew the policy or contract.	
Premiums	§ 3221(a)(4)	The policy or contract form must provide that premiums are to be paid to the insurer by the employer or such other person designated, by the due date, with a grace period as specified.	
LOSS OF COVERAGE			Form/Page/Para Reference
Extension of Benefits Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	11 NYCRR 52.18(b)(4), (5), (6) Model Language	This policy or contract form provides that when coverage under this policy or contract form ends, benefits will be provided during a period of total disability for a hospital stay commencing, or surgery performed, within 31 days from the date coverage ends. The hospital stay or surgery must be for the treatment of the injury, sickness, or pregnancy causing the total disability. If the covered person's coverage terminates by reason of the termination of active employment, an extended benefit will be provided during a period of total disability for up to 12 months from the date coverage ends for covered services to treat the injury, sickness, or pregnancy that caused the total disability, unless these services are covered under another group health plan.	
Continuation Coverage Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3221(e)(7) § 3221(m) § 4305(e) COBRA, Title X of Public Law 99-272 Model Language	This policy or contract form contains a provision regarding continuation coverage. §§ 3221(m) and 4305(e) provide continuation coverage in circumstances when federal COBRA requirements do not apply, including for groups under 20 and upon application of the employee or member to continue hospital, surgical or medical expense insurance for himself or herself and his or her eligible dependents. An employee or member who wishes continuation of coverage must request continuation in writing and remit the first premium payment within the 60-day period following the later of: the date of termination or the date the employee is sent notice by first class mail of the right to continuation by the group. The Insurance Law permits the group to charge an additional 2% administrative fee for continued coverage. The continuation benefits terminate: <ul style="list-style-type: none"> • The date 36 months after the date the subscriber's coverage would have terminated because of termination of employment; 	

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		<ul style="list-style-type: none"> • In the case of a covered spouse or child, the date 36 months after coverage would have terminated due to the death of the subscriber, divorce or legal separation, the subscriber’s eligibility for Medicare, or the failure to qualify under the definition of “children”; • The date the insured becomes covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage; • The date the insured becomes entitled to Medicare; • The date which the employee or member becomes covered by an insured or uninsured arrangement which provides hospital, surgical or medical coverage; • The date to which premiums are paid if the insured fails to make a timely payment; or • The date the policy or contract terminates. However, if the policy or contract is replaced with similar coverage, the insured has the right to become covered under the new policy or contract for the balance of the period remaining for the insured’s continued coverage. 	
<p>Young Adult Option</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(r) § 4305(l) Model Language</p>	<p>This policy or contract form provides notice of a young adult’s right, through the age of 29 (up to age 30), to independently purchase coverage through a parent group member’s policy or contract, regardless of whether the parent’s coverage provides coverage for dependents, as described in § 3221(r) and/or § 4305(l). If a young adult or the young adult’s parent elects this coverage, the young adult is issued a separate individual policy or contract.</p> <p>The insurer must comply with the notice requirements to each employee or member as set forth in § 3221(r) and/or § 4305(l).</p>	
<p>Suspension of Coverage</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(n), (o) § 4305(g), (h) Circular Letter No. 7 (2003) USERRA, 38 USC § 4317 Model Language</p>	<p>This policy or contract form provides that:</p> <ul style="list-style-type: none"> • Any covered persons who are also members of a reserve component of the armed forces of the United States, including the National Guard, shall be entitled, upon request, to have their coverage suspended during a period of active duty. • The insurer will refund any unearned premiums for the period of the suspension. • Persons covered by this policy or contract shall be entitled to resumption of coverage, upon written application and payment of the required premium within 60 days after the date of termination of the period of active duty. • Coverage shall be retroactive to the date of termination of the period of active duty. <p>No exclusion or waiting period may be imposed for any condition unless the condition arose during the period of active duty and the condition has been determined by the Secretary of Veterans Affairs to be a condition incurred in the line of duty or a waiting period had been imposed and was not completed at the time of suspension.</p>	
<p>Supplementary Coverage for Employees or Members Who Are Also Members of the Reserve Components of the Armed Services or the National Guard</p>	<p>§ 3221(n), (o) §§ 4305(g), (h) Circular Letter No. 7 (2003) Model Language</p>	<p>If the group does not choose to voluntarily maintain coverage for any employee or member of when they enter active duty, then such member or employee shall be entitled to continuation or conversion coverage.</p>	

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Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Conversion – Right to a New Contract After Termination Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3221(e), (f), (g) § 4305(d) Model Language	This policy or contract form provides that if the employee under the group contract ceases to be covered because of termination of coverage because of: (i) termination for any reason of his employment; or (ii) termination for any reason whatsoever of the group policy or contract itself, unless the group policy or contract holder has replaced the group policy or contract with similar and continuous coverage for the same group, such employee shall be entitled to a new policy or contract as a direct pay member, covering such member and his eligible dependents. Conversion must also be made available, upon the death of the employee, to the surviving spouse and dependents, and the former spouse of the employee upon the divorce or annulment of the marriage to the employee or member. Conversion must also be made available to a child covered under the contract who reaches the age limiting coverage under the group contract or whose young adult coverage terminates. The policy or contract form provides that the employee or his eligible dependents must request conversion within 60 days of the termination of the group coverage at which time they will be offered an individual direct pay contract at each level of coverage (i.e., bronze, silver, gold or platinum) that covers all benefits required by state and federal law. The employee or his eligible dependents must also pay the first premium of the new contract at the time they apply for coverage.	
GENERAL PROVISIONS			Form/Page/Para Reference
Assignment	Article 6 of the Financial Services Law; Chapter 60 of the Laws of 2014 Model Language	The policy or contract form should state whether or not assignment of benefits is permitted, and the policy or contract form must permit the assignment of benefits for a surprise bill.	
Incontestability Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3221(a)(1) § 4306(e) Model Language	The policy or contract form 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.	
Who May Change this Policy or Contract Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3221(a)(2) Model Language	The policy or contract form must provide that no agent has the authority to change the policy or contract or waive any provisions and that no change shall be valid unless approved by an officer of the insurer and evidenced by endorsement on the policy or contract, or by amendment to the policy or contract signed by the group and insurer.	
Action in Law or Equity Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3221(a)(14) Model Language	The policy or contract must provide that no action in law or equity shall be brought to recover on the policy or contract prior to the expiration of 60 days after proof of loss has been filed in accordance with the requirements of the policy or contract and that no such action shall be brought after the expiration of two (2) years following the time such proof of loss is required by the policy or contract.	
Subrogation	General Obligations	Although not required, if a subrogation provision is included in this policy or contract form, it must	

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Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	Law § 5-335 Civil Practice Law and Rules § 4545(a) Model Language	comply with General Obligations Law § 5-335 and Civil Practice Law and Rules § 4545(a).	
Unilateral Modification Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	11 NYCRR 52.18(a)(8) Model Language	Unilateral modifications by an insurer to an existing policy or contract must be made with at least 30 days prior written notice to the group. Unilateral modification by the insurer may be made only at the time of renewal. If the policy or contract form requires the group to provide written notice to terminate coverage, the notice of the unilateral modification by the insurer must be provided to such group no less than 14 days prior to the date by which the group is required to provide notice to terminate coverage.	
Non-English Speaking Insureds Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3217-a(a)(15) § 4324(a)(15) PHL § 4408(1)(p) Model Language	This policy or contract form provides a description of how the insurer addresses the needs of non-English speaking insureds.	
SCHEDULE OF BENEFITS Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	Standard Benefit Design Description Chart Model Language	This policy or contract must contain a Schedule of Benefits. All services subject to Preauthorization and/or referral requirements must be clearly indicated in the Schedule of Benefits. All standard products must use the cost-sharing specified in the Standard Benefit Design Description Chart.	Form/Page/Para Reference
Prohibition on Lifetime Dollar Limits	§ 3217-f § 4306-e 42 USC § 300gg-11 45 CFR § 147.126 Model Language	The policy or contract form must 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.	
Limitations on Annual Dollar Limits	§ 3217-f § 4306-e 42 USC § 300gg-11 45 CFR § 147.126 Model Language	The policy or contract form must not impose “restricted” annual dollar limits for essential health benefits.	
Insured’s Financial Responsibility for Payment	§ 3217-a(a)(5) § 4324(a)(5) PHL § 4408(1)(e)	This policy or contract form provides a description of the insured’s financial responsibility for payment of premiums, deductibles, copayments and/or coinsurance, and any other charges, annual limits on an insured’s financial responsibility, caps on payments for covered services and financial responsibility for non-covered health care procedures, treatment or services.	
ADDITIONAL RIDERS			
Out-of-Network Coverage Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> If out-of-network coverage	§ 3241(b) Model Language	If out-of-network coverage has been selected, this policy or contract form provides benefits for covered services that are received from out-of-network providers and have not been approved by the insurer to be covered on an in-network basis. Out-of-network coverage may be provided in the base policy or contract, or by rider. <i>Note: The Department will not approve more than a 30% differential between in-network and out-</i>	

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<p>is offered, please answer the following:</p> <p>Out-of-network coverage in the base policy/contract or by rider? <input type="checkbox"/> Policy/Contract <input type="checkbox"/> Rider</p>		<p><i>of-network coverage unless supported by scholarly literature or actual claims experience of the insurer.</i></p>	
<p>Extended Dependent Coverage</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 4235(f)(1)(B) § 4305(c)(1) Model Language</p>	<p>For parent and child/children and/or family coverage, this policy or contract form must make available and if requested by the group, provide coverage for unmarried children through the age of 29 (up to age 30); regardless of financial dependence; who are not insured by or eligible for coverage under an employer-sponsored health benefit plan covering them as an employee or member, whether insured or self-insured; and who live, work or reside in New York State or the service area of the insurer. The company must comply with the notice requirements set forth in §§ 4235(f)(1)(B) or 4305(c)(1).</p>	
<p>Rider for Contraceptive Drugs and Devices and Family Planning Services for Employees of Religious Employers</p>	<p>§ 3221(l)(16)(A) § 4303(cc)(1)(A)</p>	<p>This policy or contract form provides a rider for situations when a group has elected not to purchase coverage for contraceptive drugs or devices pursuant to the religious employer exemption pursuant to §§ 3221(l)(16)(A) and 4303(cc)(1)(A). In accordance with law, if elected by an insured, this rider amends the policy or contract and provides coverage for contraceptive drugs or devices or generic equivalents approved as substitutes by the FDA and provides coverage for family planning services.</p>	
<p>PROVIDER NETWORKS</p>	<p>§ 3241</p>	<p>The provider network must be submitted to the Department of Health through the Health Commerce System. Also, upon submission of a QHP filing through SERFF, please provide the network information in both the Service Area and Network Templates.</p>	
<p>ACTUARIAL SECTION FOR NEW PRODUCT RATE FILINGS ONLY</p>		<p>NOTE: A new and detailed set of instructions “2017 Rate Filing Instructions” is posted on the Department website and on SERFF.</p> <p><i>Complete this section for all new product forms filings except those filings where a rate filing is unnecessary because: (select one)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> <i>The submission contains only application forms, disclosure statements, and/or advertising, OR</i> <input type="checkbox"/> <i>The submission is an out-of-state filing pursuant to Section 3201(b)(2), OR</i> <input type="checkbox"/> <i>The form submission has no premium rate implications and a letter or actuarial memorandum is enclosed that states and justifies this as appropriate.</i> <p><i>Note: For rate changes to existing products, do NOT complete this section – complete the Existing Products-Rate Requirements section below.</i></p>	
<p>ACTUARIAL MEMORANDUM</p>	<p>11 NYCRR 52.40(a)(1)</p>	<p>Actuarial qualifications:</p> <ul style="list-style-type: none"> • Member of the Society of Actuaries or Member of the American Academy of Actuaries; and • Meet the “Qualification Standards of Actuarial Opinion” as adopted by the American Academy of Actuaries. 	
<p>Justification of Rates</p>	<p>§ 3221</p>	<p>Small Group:</p>	

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	11 NYCRR 52.40(e) 11 NYCRR 360.10 11 NYCRR 360.11 § 3201(e)(1)(B) § 4308(c)(3)(A)	<ul style="list-style-type: none"> • Provide community rated rating methodology and assumptions used in calculating rates. • Provide rating methodology and assumptions used in rate calculation for mental health coverage provided pursuant to § 3221(l)(5). • Actuarial justification for the use of claim costs and other assumptions. • Non-claim expense components as a percentage of gross premium. • The expected loss ratio is: <input type="text"/> %. 	
Loss Ratios	§ 3231(e)(1)(B) § 4308(c)(3)(A)	Expected loss ratio(s) – with actuarial justification.	
Reserve Basis	11 NYCRR 94	Description of bases for unpaid claim liabilities and extra reserves (if any).	
Actuarial Certification	11 NYCRR 52.40(a)(1)	<ul style="list-style-type: none"> • The filing is in compliance with all applicable laws and regulations of the State of New York. • 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. • The expected loss ratio meets the minimum requirements of the State of New York. • The benefits are reasonable in relation to the premiums charged. • The rates are not unfairly discriminatory. 	
Expected Loss Ratio Certification	§ 3231(e)(1)(B) § 4308(c)(3)(A)	The expected loss ratio is: <input type="text"/> %.	
GROUP RATE MANUAL	11 NYCRR 52.40(e)(2) § 3231(e)(1)(B) § 4308(c)(3)(A)	<ul style="list-style-type: none"> • Table of contents. • Rate pages. • Insurer name on each consecutively numbered rate page. • Identification by form number of each policy, rider, or endorsement to which the rates apply. • Brief description of benefits, types of coverage, limitations, exclusions, and issue limits. • Description of rating classes, factors and premium discounts. • Examples of rate calculations. • Commission schedule(s) and fees. • Underwriting guidelines and/or underwriting manual. • Expected loss ratio(s). 	
ACTUARIAL SECTION FOR EXISTING PRODUCT RATE FILINGS ONLY		<p>NOTE: An updated set of instructions entitled “2017 Rate Filing Instructions” is posted on the Department website and on SERFF.</p> <p><i>Complete this section for all filings of changes in rates (e.g., rate increases/decreases or changes in rate calculation rules or procedures), commissions or underwriting to existing products.</i></p> <p><i>Note: For new products, do NOT complete this section – complete the New Products-Rate Requirements section above instead.</i></p>	
ACTUARIAL MEMORANDUM	11 NYCRR 52.40(a)(1)	<p>Actuarial qualifications:</p> <ul style="list-style-type: none"> • Member of the Society of Actuaries or Member of the American Academy of Actuaries; and • Meet the “Qualification Standards of Actuarial Opinion” as adopted by the American Academy of Actuaries. 	

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Justification of Rates	11 NYCRR 52.40(e)	<ul style="list-style-type: none"> • Description of proposed changes in coverage, rates, commissions, underwriting rules, etc. • History of previous New York rate revisions. • Provide New York and nationwide claims experience respectively, including: <ul style="list-style-type: none"> ○ Earned premium; ○ Paid and incurred claims; and ○ Incurred loss ratios. • Actuarial justification of proposed rates revision (increase/decrease). • Non-claim expense components as a percentage of gross premium. • Impact on rates as a result of each of the changes with actuarial justification. • Expected loss ratio(s) after the proposed changes. 	
Actuarial Certification	11 NYCRR 52.40(a)(1)	<ul style="list-style-type: none"> • The filing is in compliance with all applicable laws and regulations of the State of New York. • The filing is in compliance with Actuarial Standard of Practice No. 8 “Regulatory Filings for Rates and Financial Projections for Health Plans”. • The expected loss ratio meets the minimum requirements of the State of New York. • The benefits are reasonable in relation to the premiums charged. • The rates are not unfairly discriminatory. 	
Expected Loss Ratio Certification	§ 3201(e)(1)(B) § 4308(c)(3)(A)	The expected loss ratio is: <input type="text"/> %.	
REVISED RATE MANUAL PAGES	11 NYCRR 52.40(e)(2)	<ul style="list-style-type: none"> • Table of contents. • Rate pages. • Insurer name on each consecutively numbered rate page. • Identification by form number of each policy, rider, or endorsement to which the rates apply. • Brief description of benefits, types of coverage, limitations, exclusions, and issue limits. • Description of revised rating classes, factors and discounts. • Examples of rate calculations. • Commission schedule(s) and fees. • Underwriting guidelines and/or underwriting manual. • Expected loss ratio(s). 	