

Guidance for Individual and Small Group Comprehensive Health Insurance Policy Forms Offered Inside and Outside the NY State of Health

Drafting Instructions

1. Form Numbers:

- Each policy form used by the insurer, health maintenance organization (HMO) or pre-paid health services plan (PHSP) shall be designated by a suitable form number which may be made up of numerical digits or letters, or both, in the lower left-hand corner of the first page of the form. The form number shall distinguish the form from all others used by the insurer, HMO or PHSP.
- The policy forms for the individual market should be separate policy forms from the small group market.

2. Use of Model Language:

- Insurers, HMOs and PHSPs should use the model contract language for all individual and small group NY State of Health (NYSOH) plans and all individual and small group plans offered outside the NYSOH.
- Insurers, HMOs and PHSPs should not add any new language to the model language other than as identified below or where specifically indicated in the model language by adding a description of:
 - How to change providers in the How Your Coverage Works section;
 - A telemedicine program in the Outpatient and Professional Services section;
 - Centers of excellence in the Inpatient Services section;
 - Wellness programs in the Wellness Benefits section; or
 - Additional covered services not addressed in the model language in the Other Covered Services section as listed in the Table of Contents.
- The model language includes drafting notes that provide guidance to insurers, HMOs and PHSPs. The drafting notes should be deleted when the model language is submitted to the Department of Financial Services (DFS).
- Model language in brackets is variable. This means either: (1) the language does not need to be included; (2) the covered visits may be increased; or (3) the benefit is optional. The drafting notes explain the permissible variability.

3. Use of Variable Material & Memorandum of Variability:

- Variable material for contract language is permissible only as provided in the model language. Variable material for cost-sharing is permissible to the extent it establishes the different metal levels required by the ACA.
- Insurers, HMOs and PHSPs should make telephone numbers and website addresses variable to enable amendments to readily be made in the event a telephone number or website address changes.
- Insurers, HMOs and PHSPs may submit a memorandum of variable material. However, plans submitting a memorandum of variable material should footnote or otherwise flag the variable contract provision so DFS can easily identify the contract provision to which each item in the memorandum of variable material relates.

4. Policy Form Submission:

- Policy forms for separately licensed entities (e.g., Article 43 corporations, Article 42 insurers and HMOs) should be submitted in separate SERFF submissions, even if the policy forms are identical.
- Insurers, HMOs and PHSPs are strongly encouraged to submit a separate individual policy or contract for catastrophic coverage.
- Insurers, HMOs and PHSPs are strongly encouraged to submit a separate child-only policy or contract.

5. Schedules of Benefits:

- Schedules of Benefits should be assigned a separate policy form number.
- Individual Schedules of Benefits for NYSOH Submissions:
 - Insurers, HMOs and PHSPs should submit one schedule per metal level for each standard plan. For non-standard NYSOH plans, insurers, HMOs and PHSPs should submit one schedule per metal level offered unless significant variable material would be needed to accommodate the variations in the plans and in such cases more than one schedule should be submitted.
 - For every standard and non-standard silver QHP offered, insurers, HMOs and PHSPs should submit a full cost silver schedule, a 73% actuarial value (AV) schedule, an 87% AV schedule, and a 94% AV schedule.
 - For Native Americans whose income is above 300% of the Federal Poverty Level (FPL), the full cost schedule may be used and a separate schedule of benefits is not required. A variable sentence on the bottom of the schedule of benefits should be used in these schedules to indicate when Native Americans do not have cost-sharing for certain services.
 - For the Native Americans whose income is at or below 300% of the FPL, a separate schedule of benefits for each metal level is not required. Insurers, HMOs and PHSPs may submit one schedule of benefits per plan with the metal level bracketed that may be used for the zero cost-sharing version.
 - A separate catastrophic schedule of benefits should be submitted.
 - Insurers, HMOs and PHSPs are strongly encouraged to use the standard versions of the schedules of benefits for child-only coverage instead of submitting separate schedules.
- Group Schedules of Benefits for NYSOH and Off NYSOH Submissions:
 - One schedule of benefits should be submitted per metal level offered unless significant variable material would be needed to accommodate the variations in the plans and in such cases more than one schedule should be submitted.

SERFF Submission Instructions

1. Insurers, HMOs and PHSPs with 2019 enrollment (existing plans) should submit forms and rates separately per market using the following Filing Types:
 - 2023 Exchange Forms (form only filings)
 - 2023 Off-Exchange Forms (form only filings)
 - 2023 Prior Approval ACA Rates (rate only filings)
2. Since the forms and rates will be submitted in separate filings, insurers, HMOs and PHSPs should include the SERFF tracking number of the corresponding form or rate filing in each filing. Enter the SERFF tracking number of the first filing in the SERFF Filing Description field of the related file.

3. Insurers, HMOs and PHSPs entering the individual or small group markets (either inside or outside the NYSOH) should use the following Filing Types:
 - Exchange Forms & Rates
 - Off Exchange NG Forms & Rates
4. Insurers, HMOs and PHSPs should also select the appropriate Type of Insurance (TOI) and Sub-TOI as listed in the appropriate [Product Checklist](#).

Guidance for Specific Benefits and Contract Provisions

1. Access to Care:

- HMOs, PHSPs and comprehensive insurance products that use a network of providers are required to provide the right to go out-of-network if the plan does not have an in-network provider with the appropriate training and experience.

2. Age 29 Coverage:

- **Young Adult Option.** Insurers, HMOs and PHSPs should include language in their contracts that provides an option for a young adult who has aged off his or her parent's group policy to independently purchase continuation coverage through the parent's group policy or contract through the age of 29.
- **Make Available Option.** Insurers, HMOs and PHSPs are required to offer a rider to groups and individuals that extends dependent coverage through the age of 29.

3. Ambulance Services & Pre-Hospital Emergency Medical Services:

- Coverage should be provided worldwide for ambulance services and pre-hospital emergency medical services to treat an emergency condition.
- Insurers, HMOs and PHSPs should include the name of the source of the usual and customary charge for pre-hospital emergency medical services in the contract or policy. Insurers, HMOs and PHSPs should also provide DFS with an explanation in the SERFF Filing Description of how that source is considered the usual and customary charge, in compliance with Insurance Law §§ 3216(i)(24), 3221(l)(15), and 4303(aa), if using a source other than FAIR Health.

4. Autism Spectrum Disorders:

- Applied behavioral analysis visits are unlimited.
- The cost-sharing for applied behavioral analysis treatment and assistive communication devices should be the primary care physician (PCP) copayment for standard NYSOH plans and either the PCP or the specialist cost-sharing for non-standard NYSOH plans and plans offered outside the NYSOH, if permitted under the analysis performed pursuant to the Federal Mental Health Parity and Equity Addiction Act.
- Insurers, HMOs and PHSPs may not apply any financial requirement or other quantitative treatment limitations to autism spectrum disorder benefits in any classification that is more restrictive than the predominant financial requirement of the type applied to substantially all medical/surgical benefits in the same classification. See 45 C.F.R. § 146.136(c)(2)(i).
- Insurers, HMOs and PHSPs may not impose more stringent utilization review requirements (e.g., preauthorization) or other non-quantitative treatment limitations for autism spectrum disorder benefits than imposed on medical/surgical benefits. See 45 C.F.R. § 146.136(c)(4).

5. Autologous Blood Banking:

- Under the standard benefit package design, use the Durable Medical Equipment/Medical Supplies cost-sharing.

6. Benefit Limits:

- Benefit limits may be per plan or calendar year for group coverage (as permitted by law) and should be consistent with how the coverage renews (per plan year or calendar year) unless otherwise required by law. Benefit limits should be per calendar year for individual coverage.

7. Catastrophic Coverage:

- Offered in the Individual Market only.
- Does not provide bronze, silver, gold, or platinum levels of coverage.
- Covers three primary care visits per plan year at zero cost-sharing before reaching the deductible. May not impose any cost-sharing for preventive services as required by 42 U.S.C § 300gg-13.

8. Child Only Plans:

- Offered in the Individual Market only.
- A Child Only plan should be offered for every metal level inside the NYSOH individual market, using the standard benefit package and cost-sharing amounts.
- A Child Only plan should be offered in conjunction with every metal level the insurer, HMO or PHSP offers in the individual market outside the NYSOH.
- Out-of-network coverage is permitted, but it is not required.
- To qualify for coverage, the child must be under 21 years of age as of the beginning of the plan year, defined as a calendar year.
- The insurer, HMO or PHSP cannot terminate a child who has aged to 21 until the end of the plan year.

9. Contraceptive Services:

- Insurers, HMOs and PHSPs must provide coverage for all FDA-approved contraceptive drugs, devices and other products including:
 - Over-the-counter contraceptive drugs, devices and products as prescribed or as otherwise authorized under State or Federal law that are provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) as of January 21, 2019. The HRSA Guidelines do not include contraceptives for men;
 - Voluntary sterilization procedures identified in the comprehensive guidelines supported by HRSA for women and voluntary sterilization procedures for men;
 - Patient education and counseling on contraception; and
 - Follow-up services related to the contraceptive drugs, devices, products and procedures, including management of side effects, counseling for continued adherence, and device insertion and removal.
- Where the FDA has approved one or more therapeutic and pharmaceutical equivalent versions of a contraceptive drug, device or product, the insurer, HMO or PHSP is not required to include all such therapeutic and pharmaceutical equivalent versions on its formulary so long as at least one is included and covered without cost-sharing.
- If the covered therapeutic and pharmaceutical equivalent versions of a contraceptive drug, device or product are not available or are deemed medically inadvisable, the insurer, HMO or PHSP must provide coverage for an alternative therapeutic and pharmaceutical equivalent version without cost-sharing. If the patient's attending health care provider determines that the

non-covered therapeutic and pharmaceutical equivalent version of a drug, device or product is warranted, the provider's determination shall be final.

- Insurers, HMOs and PHSPs must allow for the dispensing of the entire 12-month supply of the contraceptive at the same time.
- Emergency contraception is covered without cost-sharing when provided pursuant to a prescription, an order under Education Law § 6831, or when lawfully provided over-the-counter.
- Insurers, HMOs and PHSPs must not impose any cost-sharing requirements, restrictions, or delays on all covered contraceptive drugs, devices, products, and procedures.

10. Cost-Sharing:

- The cost-sharing for benefits cannot vary for standard plans inside the NYSOH and should comply with the standard benefit package design.
- The cost-sharing for benefits may vary for non-standard NYSOH plans and plans offered outside the NYSOH.
- If the cost of the service is less than the copayment for the service, the insured is only responsible for the lesser amount.
- The insured's coinsurance may not exceed 50%.

11. Deductibles:

- For standard NYSOH plans, insurers, HMOs and PHSPs should comply with the standard benefit package design.
- For non-standard NYSOH plans and plans offered outside the NYSOH, the deductibles, in total, cannot exceed the out-of-pocket limit.

12. Diabetic Equipment, Supplies, & Self-Management Education:

- Insurers, HMOs and PHSPs should cover diabetic supplies under the medical benefit for the standard NYSOH plan. For non-standard NYSOH plans and plans offered outside the NYSOH, diabetic supplies may be covered under the prescription drug benefit if the cost-sharing is more favorable to the insured than the medical benefit.
- The cost-sharing for diabetic equipment, supplies, and self-management education should be the PCP copayment for standard NYSOH plans and the PCP or the specialist cost-sharing for non-standard NYSOH plans and plans offered outside the NYSOH. However, if more favorable, the cost-sharing may be the prescription drug cost-sharing for non-standard NYSOH plans and plans offered outside the NYSOH.
- An insured's out-of-pocket costs for prescription insulin drugs should not exceed \$100 per 30-day supply, regardless of the amount or type of insulin that is needed to fill the insured's prescription. This limit on out-of-pocket costs applies to each prescription insulin drug.

13. Dialysis:

- Home dialysis is covered as part of the dialysis benefit. Visits are not counted against the home health care benefit. The cost-sharing will be the same as the dialysis benefit.
- Dialysis benefits in individual health insurance contracts cannot be reduced because an insured is eligible for but not enrolled in Medicare.
- EPOs, HMOs and PHSPs are required to cover dialysis when performed by a non-participating provider located outside their service area, subject to any applicable cost-sharing that applies to dialysis treatments by a participating provider. The out-of-network coverage may be limited to 10 visits per calendar year. 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.

14. Durable Medical Equipment:

- Repairs and replacements of durable medical equipment that result from misuse or abuse are not covered. Repairs and replacements are covered when necessary due to normal wear and tear.

15. Domestic Partner Coverage:

- Insurers, HMOs and PHSPs should offer groups the option for domestic partner coverage in the NYSOH.
- Insurers, HMOs and PHSPs should cover domestic partners in all individual direct payment contracts.
- Coverage for domestic partners should include both same and opposite sex domestic partners.

16. Emergency Care:

- Coverage should be provided worldwide for an emergency condition in hospital facilities.
- Insurers, HMOs and PHSPs are required to hold insureds harmless for any non-participating provider charges for emergency services in hospital facilities that exceed the in-network copayment, coinsurance, or deductible.

17. Extension of Benefits:

- The extension of benefits provision for group coverage in 11 NYCRR § 52.18(b)(4) provides that if an insured is totally disabled on the day the coverage ends, the insurer will continue to pay for an insured's hospital confinement or surgery performed in the next 31 days for injury, sickness or pregnancy causing the total disability.
- The extension of benefits provision for group coverage in 11 NYCRR § 52.18(b)(5) also provides that if an insured is totally disabled on the day the coverage ends due to the termination of active employment, the insurer will continue to pay for the insured's care during an uninterrupted period of disability until the insured is either no longer disabled or 12 months from the date the policy is terminated.
- The extension of benefits provision for individual coverage in 11 NYCRR § 52.17(a)(15) provides that if an insured is totally disabled on the day the coverage ends, the insurer will continue to pay for the insured's care during an uninterrupted period of disability until the insured is either no longer disabled or 12 months from the date the policy is terminated.
- It is reasonable to conclude that an insured is "totally disabled" if the insured is an inpatient in the hospital because the definition of "totally disabled" is that the person is prevented because of injury or disease from engaging in any work or other gainful activity. As such, if an insured is hospitalized at the time the policy is terminated, the previous insurer should continue to pay for the hospital stay until such time that the insured is no longer totally disabled or until the end of the 12-month period.

18. External Appeal Rights for Out-of-Network Denials:

- **Out-of-network service denial.** HMOs, PHSPs, and comprehensive insurance products that use a network of providers (e.g., EPOs and PPOs) are required to provide external appeal rights if the plan is unable to provide a requested service in-network and the plan recommends an in-network service that the plan asserts is not materially different from the requested service.

- **Out-of-network referral denial.** HMOs, PHSPs and comprehensive insurance products that use a network of providers (e.g., EPOs and PPOs) are required to provide external appeal rights if the plan denies a referral or authorization to a non-participating provider because a participating provider with the appropriate training and experience to meet an insured's health care needs is able to provide the requested service.

19. Group Contract/Policy:

- The model language should be used for the certificate of coverage.
- There is no model language for the contract between the group and the insurer, HMO or PHSP. However, if the group contract/policy covers any of the items addressed in the certificate, the same model language/provisions should be used in the contract/policy as are in the certificate.
- Insurers, HMOs and PHSPs may attach the group contract/policy to the certificate or use a separate document for the contract with the group.

20. Guaranteed Availability:

- Pursuant to the guaranteed availability requirements in 45 CFR § 147.104, a plan offered inside the NYSOH must also be available to individuals and groups who apply for the same plan outside of the NYSOH.

21. Habilitation Services:

- **Outpatient.** For the standard NYSOH plan, coverage should be provided for habilitative therapy, including physical therapy, speech therapy, and occupational therapy, in the outpatient department of a facility or in a professional provider's office for up to 60 visits combined for all therapies per condition, per plan year. Prior hospitalization or surgery is not required. For non-standard NYSOH plans and plans offered outside the NYSOH, more coverage may be provided by: (i) covering more than 60 visits or removing the visit limit; (ii) removing the per condition limit; or (iii) removing the limit on all therapies combined. Substitution is permitted for non-standard NYSOH plans and plans offered outside the NYSOH.
- **Inpatient.** For the standard NYSOH plan, coverage should be provided for inpatient habilitative therapy including physical therapy, speech therapy and occupational therapy for 60 days per plan year. For non-standard NYSOH plans and plans offered outside the NYSOH, coverage may be provided for more than 60 days or 60 or more days per therapy. Substitutions are permitted for the non-standard NYSOH plans and plans offered outside the NYSOH.

22. Hearing Aids & Cochlear Implants:

- **Hearing Aids.** Coverage should be provided for the purchase of hearing aids every three years for both hearing impaired ears combined. The single purchase could be for hearing aids for one or both hearing impaired ears. Non-standard NYSOH plans and plans offered outside the NYSOH may remove the three-year limit.
- **Cochlear Implants.** Coverage for cochlear implants is a per ear benefit. Only one implant per ear is covered during the time the insured is enrolled under the contract, certificate, or policy. Non-standard NYSOH plans and plans offered outside the NYSOH may cover more than one implant per ear.

23. HMO Look Alike: (EPO coverage that does not meet the definition of a managed care plan.)

- EPOs may use a gatekeeper and, when doing so, should adhere to all HMO protections.

24. Home Health Care:

- **Standard NYSOH plan.** Insurers, HMOs and PHSPs should cover 40 home health care visits.
- **Non-standard NYSOH plan.** Insurers, HMOs and PHSPs may cover 40 or more home health care visits for non-standard NYSOH plans and plans offered outside the NYSOH.

25. Hospice:

- **Standard NYSOH plan.** Insurers, HMOs and PHSPs should cover 210 hospice days.
- **Non-standard NYSOH plan.** Insurers, HMOs and PHSPs may cover 210 or more hospice days for non-standard NYSOH plans and plans offered outside the NYSOH.

26. Mammography, Screening and Diagnostic Imaging for the Detection of Breast Cancer (Including Diagnostic Mammograms, Breast Ultrasounds, and MRIs):

- Screening and diagnostic imaging for the detection of breast cancer (including diagnostic mammograms, breast ultrasounds, and MRIs) are required to be covered at no cost-sharing.
- **High Deductible Health Plans (HDHPs).** To be used with a Health Savings Account (HSA), federal requirements provide that HDHPs should include a deductible that is applied to all benefits under the policy, except preventive care. Internal Revenue Bulletin 2004-15 (Notice 2004-23) Health Savings Accounts—Preventive Care, provides a list of services that are considered preventive care and thus may be exempt from the deductible in a HDHP. The Bulletin specifically provides that preventive care is not limited to the list (the list is illustrative, not exhaustive). Further, the list specifically recognizes diagnostic procedures ordered in connection with routine examinations and separately lists breast cancer screenings as preventive services. As such, HDHPs that exempt screening and diagnostic imaging for breast cancer from the deductible for compliance with Chapter 74 of the Laws of 2016 should be qualified to be used with an HSA.
- **Tomosynthesis (3D mammograms).** Tomosynthesis (3D mammograms) fall under the definition of mammography screening and are required to be covered at no cost-sharing when medically necessary.

27. Maternal Depression Screening:

- Insurers, HMOs and PHSPs may not limit an insured's direct access to screening and referral for maternal depression from a provider of obstetrical, gynecologic or pediatric services.
- If the infant is covered under a different policy or contract than the mother and the screening and referral are performed by a provider of pediatric services, coverage for the screening and referral should also be provided under the policy or contract in which the infant is covered.

28. Maternity:

- Maternity care coverage, other than for perinatal complications, includes inpatient hospital coverage for mother and newborn for at least 48 hours after childbirth for any delivery other than a caesarean section, and for at least 96 hours following a caesarean section. Coverage also includes parent education, training and assistance in breast or bottle feeding, and any maternal or newborn clinical assessments.
- Coverage is provided for one home care visit (not counting against the insured's home health care visit limit) if the mother is discharged prior to 48 hours after childbirth for any delivery other than a caesarean section, and for at least 96 hours following a caesarean section. The home care visit is not subject to cost-sharing.
- Coverage includes the services of a midwife.

- Coverage includes breastfeeding support, counseling, and supplies, including the cost of renting or purchasing one (1) breast pump per pregnancy for the duration of breast feeding and coverage for nursing bras, with no cost-sharing.
- Coverage includes the inpatient use of pasteurized donor human milk, which may include fortifiers as medically necessary, for which a health care professional has issued an order for an infant who is medically or physically unable to receive maternal breast milk, participate in breast feeding, or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breast feeding despite optimal lactation support. Such infant must have a documented birth weight of less than 1,500 grams, or a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.
- Maternity and newborn care includes one visit for genetic testing.

29. Medicare:

- Individuals who are eligible for, but not enrolled in, Medicare Parts A and B (due to age, disability, or end stage renal disease) are eligible to purchase individual health insurance coverage inside and outside the NYSOH pursuant to federal and state guaranteed availability requirements.
- Individual health insurance coverage cannot be terminated because an insured enrolls in Medicare.

30. Mental Health Care and Substance Use:

- Outpatient mental health services and substance use services include but are not limited to partial hospitalization program services and intensive outpatient program services.
- Insurers, HMOs and PHSPs should provide coverage in a professional office setting for outpatient substance use services relating to the diagnosis and treatment of substance use disorder.
- Coverage for medication-assisted treatment (including methadone treatment) is provided as part of the outpatient substance use services benefit. Coverage is based on the site of service and includes coverage in the acute phase or subsequent phases on a maintenance basis.
- Coverage for naloxone, suboxone and subutex are provided as part of the prescription drug benefit.
- Residential treatment facilities, including comprehensive care centers for eating disorders, are required to be covered if a policy covers similar intermediate levels of care for treatment of medical or surgical conditions. Similar intermediate levels of care may include coverage of skilled nursing facilities or inpatient rehabilitation benefits.
- Services that are otherwise covered under a policy may not be excluded when provided by a comprehensive care center for eating disorders identified pursuant to Mental Hygiene Law Article 30.
- Counseling for a family member of an individual with a substance use disorder is covered for 20 visits under the outpatient substance use services benefit when the family member seeks counseling without the individual with the substance use disorder. If an individual with a substance use disorder seeks counseling, whether in an individual or family setting, it is covered as outpatient substance use disorder treatment and not subject to visit limits.
- Insurers, HMOs and PHSPs may not apply any financial requirement or other quantitative treatment limitations to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement of the type applied to substantially all medical/surgical benefits in the same classification. See 45 C.F.R. § 146.136(c)(2)(i).

- Insurers, HMOs and PHSPs may not impose more stringent utilization review requirements (e.g., preauthorization) or other non-quantitative treatment limitations for mental health or substance use disorder benefits than imposed on medical/surgical benefits. See 45 C.F.R. § 146.136(c)(4).
- Insurers, HMOs and PHSPs may not impose a copayment or coinsurance for outpatient mental health services provided in a facility licensed, certified, or otherwise authorized by OMH that exceeds the copayment or coinsurance imposed for a primary care office visit under the policy or contract.

31. Native American Cost-Sharing Reductions (Individual Market Only):

- For Native Americans whose income is over 300% of the FPL, the cost-sharing is the same as the associated metal level.
- There is no cost-sharing for services rendered at Indian Health Services and any other providers required by Federal law.
- For Native Americans whose income is at or under 300% of the FPL, the cost-sharing is zero for all essential health benefits. If any benefits are added beyond the required essential health benefits, then the cost-sharing for those benefits should be the same as what is in the full cost metal level plan.

32. Networks:

- Insurers, HMOs and PHSPs may only use preferred or two-tier networks in non-standard NYSOH plans and plans offered outside the NYSOH. Insurers, HMOs and PHSPs may use a preferred network for some or all benefits. However, many benefits mandated by Insurance Law §§ 3216, 3221 and 4303 include requirements that the cost-sharing be consistent with other benefits within the policy. Insurers, HMOs and PHSPs with preferred networks should comply with the consistent cost-sharing requirement for those benefits in both tiers.
- Insurers, HMOs and PHSPs should explain in the filing how the tiered network is developed and describe the criteria used to determine how providers are placed into each tier.

33. Other Covered Services:

- For non-standard plans on the NYSOH and for plans outside the NYSOH, additional benefits (that are not essential health benefits) are permitted.
- If the model language does not contain a provision for the additional benefit, then the insurer, HMO or PHSP may add language in the Other Covered Services section.

34. Out-of-Pocket Limit:

- The cost-sharing may not exceed the dollar amounts in effect under Internal Revenue Code § 223(c)(2)(A)(ii). For 2023, the proposed amounts are \$9,100 for individual coverage and \$18,200 for other than individual coverage (e.g., individual/spouse, parent and child/children and family). See Public Health Service Act § 2707(b), 42 U.S.C. § 300gg-6, and Insurance Law §§ 3217-i and 4306-h.
- The individual maximum out-of-pocket limit permitted by Federal and State law applies to each individual regardless of whether the individual is covered by a plan providing individual coverage or coverage other than individual coverage.

35. Pediatric Dental:

- Pediatric dental benefits may be included in NYSOH plans but are not required at this time as determined by the NYSOH based upon the availability of stand-alone dental coverage.

- Plans offered outside the NYSOH are required to provide coverage of all 10 categories of essential health benefits but may exclude coverage for pediatric dental benefits when the insurer, HMO or PHSP is reasonably assured that the applicant (even an adult-only applicant) has obtained NYSOH-certified stand-alone dental coverage outside the NYSOH. If an insurer, HMO or PHSP is not reasonably assured that each applicant has obtained NYSOH-certified stand-alone dental coverage outside the NYSOH, the pediatric essential health benefit should be included (even in adult-only policies).
- Pediatric dental benefits are required to be covered through the end of the month in which the child turns 19 years of age.

36. Pediatric Vision:

- Pediatric vision benefits are required to be covered through the end of the month in which the child turns 19 years of age.

37. Prescription Drug Coverage:

- **Ancillary Charge.** Insurers, HMOs and PHSPs may include a provision in non-standard plans or plans offered outside NYSOH that permits the insurer, HMO or PHSP to charge an additional amount (“ancillary charge”) when a prescription drug covered under the policy or contract on a higher tier is dispensed at the insured’s or provider’s request when a chemically equivalent prescription drug is available on a lower tier, unless the prescription drug on a higher tier is medically necessary.
 - The insured, the insured’s designee, or provider may request coverage for the prescription drug at the higher tier. A denial of coverage of the prescription drug at the higher tier (e.g., imposition of the ancillary charge) is subject to the utilization review and external appeal process described in Insurance Law and Public Health Law Articles 49.
 - If a prescription drug that requires preauthorization is subject to the ancillary charge, and a request for preauthorization is made, the insurer, HMO or PHSP should review the request for the prescription drug at the higher tier. If a chemically equivalent prescription drug is available on a lower tier and the ancillary charge will be applied, the health plan should issue a utilization review denial in accordance with the requirements of Insurance Law § 4903 and Public Health Law § 4903.
 - Insurers, HMOs and PHSPs should include a description of the ancillary charge process, including how the insured or the insured’s provider may request coverage of the higher tier prescription drug, along with the list of prescription drugs subject to the charge, on their websites.
- **Designated Pharmacies.** Insurers, HMOs and PHSPs may require insureds to use designated pharmacies for certain prescription drugs to treat certain conditions and may add to or subtract from the list of designated pharmacy prescription drugs in the model language.
- **Formularies.**
 - Plans are required to cover at least the greater of one drug in every United States Pharmacopeia (USP) category and class; or the same number of prescription drugs in each category and class as the Oxford benchmark plan. To avoid the scrutiny required by 45 CFR § 156.125 which prohibits discriminatory benefit designs, plans should not place all prescription drugs to treat a specific condition on the highest cost tier. Determinations on tier placement may not be based on the cost of the drug alone.
 - Insurers, HMOs and PHSPs are required to publish an up-to-date, accurate, and complete list of all covered drugs on their formulary, including any tiering structure that they have 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, the NYSOH, the U.S.

Department of Health and Human Services, the U.S. Office of Personnel Management, and the general public. The website cannot require the individual to create or access an account or enter a policy number to view the formulary. If an insurer, HMO or PHSP offers more than one plan, its website should easily identify which formulary drug list applies to which plan. The formulary drug list must clearly identify preventive prescription drugs that are available without cost-sharing. See Insurance Law §§ 3242(a) and 4329(a).

- Insurers, HMOs and PHSPs should use a pharmacy and therapeutics (P&T) committee that meets the standards set forth in 45 C.F.R. § 156.122(a)(3). Pursuant to the P&T committee requirements, insurers, HMOs and PHSPs should review new drugs within 90 days and make a decision about each drug within 180 days of its release on the market.
- **Formulary Changes.** Prescription drugs must not be removed from the formulary during the plan year, except when the FDA determines that such prescription drug should be removed from the market. Before insurers, HMOs or PHSPs remove a prescription drug from their formulary at the beginning of the upcoming plan year, they must provide at least 90 days' notice prior to the start of the plan year and post the notice on their website. See Insurance Law §§ 3242(c) and 4329(c).
- **Utilization Management Restrictions.** Insurers, HMOs and PHSPs must not add utilization management restrictions (e.g., step therapy or Preauthorization requirements) to a prescription drug on their formulary during a plan year unless the requirements are added pursuant to FDA safety concerns. See Insurance Law §§ 3242(c) and 4329(c).
- **Tier Status Changes.** Prescription drugs must not be moved to a tier with a higher cost-sharing during the plan year, except a Brand-Name Drug may be moved to a tier with higher cost-sharing if an AB-rated generic equivalent or interchangeable biological product for that prescription drug is added to the formulary at the same time. A prescription drug may also be moved to a tier with a higher copayment during the plan year, although the change will not apply to an insured already taking the prescription drug or an insured that has been diagnosed or presented with a condition on or prior to the start of the plan year which is treated by such prescription drug for which the prescription drug is or would be part of the insured's treatment regimen. See Insurance Law §§ 3242(c) and 4329(c).
- **Notice of Tier Status Changes.** Before moving a prescription drug to a higher tier, insurers, HMOs and PHSPs must provide at least 90 days' notice prior to the start of the plan year and post the notice on their website. If a prescription drug is moved to a different tier during the plan year for one of the permitted reasons, insurers, HMOs and PHSPs must provide at least 30 days' notice before the change is effective. See Insurance Law §§ 3242(c) and 4329(c).
- **Formulary Exceptions.** Insurers, HMOs and PHSPs are required to provide a standard and expedited formulary exception process for the insured or the insured's designee and the insured's prescribing health care professional to request a formulary exception for a clinically-appropriate prescription drug that is not on the formulary. For standard formulary exception requests, the insurer, HMO or PHSP is required to make a decision and notify the insured or the insured's designee and the prescribing health care professional by telephone no later than 72 hours after receipt of the request. For expedited requests, the insurer, HMO or PHSP is required to make a decision and notify the insured or the insured's designee and the prescribing health care professional by telephone no later than 24 hours after receipt of the request. The insurer, HMO or PHSP must notify the insured in writing no later than three (3) business days from receipt of the exception request. The written notice is considered a final adverse determination under Insurance Law and Public Health Law Articles 49. The written notice must also include the name or names of the clinically appropriate prescription drugs covered by the insurer, HMO or PHSP to treat the insured's condition.

- **Mail Order Drugs.** A mail order drug program is optional for the standard and non-standard NYSOH plans.
- **Maintenance Drugs.**
 - Insurers, HMOs and PHSPs may cover a 90-day supply of maintenance drugs at retail pharmacies. For standard plan designs, a 90-day supply of maintenance drugs at a retail pharmacy would be three cost-sharing amounts (e.g., copayments).
 - Maintenance drugs are generally defined in the model contract language. However, insurers, HMOs and PHSPs have flexibility in determining what drugs are considered maintenance drugs.
- **Retail Pharmacies.** Insurers, HMOs and PHSPs should allow insureds to access prescription drug benefits at in-network retail pharmacies unless the drug: (1) is subject to restricted distribution by the U.S. Food and Drug Administration; or (2) requires special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy.
- **Standard Plan Design.**
 - The standard NYSOH plan should have a three-tier prescription drug option. Non-standard NYSOH plans may have one, two, or three tier prescription drug options.
 - The standard NYSOH plan should use the prescription drug cost-sharing for enteral formulas.

38. Preventive Services:

- For new items or services added to the list of recommended preventive services receiving an A or B rating from the United States Preventive Services Task Force (“USPSTF”), insurers, HMOs and PHSPs should provide the coverage for such items or services no later than six months from when the recommendation is made.

39. Prosthetic Devices:

- **Standard NYSOH plan.** Coverage is for the cost of one prosthetic device, per limb, per lifetime. The cost of repair and replacement due to normal wear and tear or if the previous device has been outgrown is covered.
- **Non-Standard NYSOH plans.** Insurers, HMOs and PHSPs may provide coverage for more than one device or may remove the limit for non-standard NYSOH plans and plans offered outside the NYSOH.

40. Prostate Cancer Screening:

- Prostate cancer screening is required to be covered without cost-sharing.
- **High Deductible Health Plans (HDHPs).** To be used with a Health Savings Account (HSA), federal requirements provide that HDHPs should include a deductible that is applied to all benefits under the policy, except preventive care. Internal Revenue Bulletin 2004-15 (Notice 2004-23) Health Savings Accounts—Preventive Care, provides a list of services that are considered preventive care and thus may be exempt from the deductible in a HDHP. The Bulletin specifically provides that preventive care is not limited to the list (the list is illustrative, not exhaustive). Further, the list specifically recognizes diagnostic procedures ordered in connection with routine examinations and separately lists prostate cancer screening as a preventive service. As such, HDHPs that exempt prostate cancer screening from the deductible for compliance with Chapter 74 of the Laws of 2016 should be qualified to be used with an HSA.

41. Rehabilitation Services:

- **Outpatient.** For the standard NYSOH plan, coverage should be provided for rehabilitation therapy, including physical therapy and speech therapy (following hospitalization or surgery for the illness or injury) and occupational therapy, in the outpatient department of a facility or in a provider's office for up to 60 visits combined for all therapies per condition, per plan year. For non-standard NYSOH plans and plans offered outside the NYSOH, more coverage may be provided by: (i) covering more than 60 visits or removing the visit limit; (ii) removing the per condition limit; (iii) removing the limit on all therapies combined; or (iv) removing the requirement for a prior hospitalization or surgery for coverage of physical or speech therapy. Substitutions are permitted for non-standard NYSOH plans or plans offered outside the NYSOH.
- **Inpatient.** For the standard NYSOH plan, coverage should be provided for rehabilitative therapy including physical therapy and speech therapy (following hospitalization or surgery for the illness or injury) and occupational therapy for 60 days per plan year. For non-standard NYSOH plans and plans offered outside the NYSOH, coverage may be provided for more than 60 days; 60 or more days per therapy; and the requirement for a prior hospitalization or surgery for coverage of physical or speech therapy may be removed. Substitutions are permitted for the non-standard NYSOH plans and plans offered outside the NYSOH.

42. Service Areas:

- Insurers, HMOs and PHSPs should offer all plans across their entire service area (the geographical area where they provide health insurance coverage) unless otherwise approved by the Superintendent, or for coverage offered inside the NYSOH, unless otherwise approved by the Superintendent and the NYSOH. Insurers, HMOs and PHSPs seeking to offer a limited network plan should submit a written proposal to the Superintendent. For coverage offered inside the NYSOH, the written proposal should also be submitted to the NYSOH. HMOs and PHSPs should also submit such proposals to the Department of Health.

43. Skilled Nursing Facility – Inpatient Care:

- **Standard NYSOH plan.** Insurers, HMOs and PHSPs should cover 200 days.
- **Non-standard NYSOH plan.** Insurers, HMOs and PHSPs may cover more than 200 days for non-standard NYSOH plans and plans offered outside the NYSOH.
- **Make Available Benefit.** Plans offered outside the NYSOH should make available (which may be done by rider) unlimited coverage for care in a nursing home, as defined by Public Health Law § 2801, or a skilled nursing facility as defined in 42 USC § 1395, when such services are preceded by a hospital stay of at least three days and further hospitalization would otherwise be necessary.

44. Special Enrollment Periods:

- Insurers, HMOs and PHSPs may include items on their applications used outside the NYSOH to elicit information regarding the applicability of special enrollment periods, including having the applicant attest to his or her eligibility for the special enrollment period.

45. Surgical Services:

- Exclusions for specific types of surgeries (e.g., Bariatric Surgery, Reconstructive, etc.) are not permitted.
- Insurers, HMOs and PHSPs may impose a medical necessity review for covered surgical services.

46. Telemedicine Programs:

- Telemedicine programs are permitted in the standard NYSOH plan, non-standard NYSOH plans and plans offered outside the NYSOH.

47. Termination:

- For group contracts, a 30-day grace period should be provided for payment of premiums.
- For group contracts, coverage will terminate as of the last day premiums were paid.
- For individual contracts, a 30-day grace period should be provided or, in the case of an insured receiving advance payments of the premium tax credit who has paid at least one full month's premium, three consecutive months. Coverage will terminate as of the date premiums were due. However, for insureds who are receiving advance payments of the premium tax credit, a plan may only retroactively terminate for up to 61 days.

48. Tobacco Use Screening, Counseling & Medications:

- The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. Insurers, HMOs and PHSPs should cover screening for tobacco use and at least two tobacco cessation attempts per year with no cost-sharing. A tobacco cessation attempt includes:
 - Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group or individual counseling) without prior authorization; and
 - All FDA-approved tobacco cessation medications (including prescription and over-the-counter medications) for a 90-day treatment when prescribed by a health care provider without prior authorization.
- Insurers, HMOs and PHSPs should provide coverage for vaping cessation using the same treatments recommended for smoking cessation, including behavioral interventions and FDA-approved pharmacotherapy for adults and behavioral interventions for school-aged children and adolescents.

49. Vasectomies:

- The standard NYSOH plan should apply the surgical services cost-sharing based on the site of the service for vasectomies.

50. Wellness:

- Insurers, HMOs and PHSPs should cover exercise facility reimbursement of the lesser of \$200 for the subscriber and \$100 for the subscriber's spouse or dependents per six-month period in the standard NYSOH plan, non-standard NYSOH plans and plans offered outside the NYSOH. Substitution of the exercise facility reimbursement benefit is permitted for the standard NYSOH plan, non-standard NYSOH plans and plans offered outside the NYSOH.
- Insurers, HMOs and PHSPs may cover other wellness activities in the standard NYSOH plan, non-standard NYSOH plans and plans offered outside the NYSOH.
- Insurers, HMOs, and PHSPs should provide a detailed description of the wellness program and any reward being offered as part of the wellness program. The description should include how the insured accesses and participates in the wellness program, a description of the wellness activities, and the rewards. All wellness programs and any rewards should have a nexus to accident and health insurance.