

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Review Standards for

**Student Accident and Health Insurance Checklist
As of 12/11/2020**

Instructions for SERFF Checklist:

- A. For **ALL** filings, the “General Requirements for All Filings” section must be completed:
- B. For a **FORM** filing, completion of additional sections may be required as follows, depending on the type of form being submitted:
- Policy or Contract – Complete all sections.
 - Application – Complete the section entitled “Application Forms.”
 - Rider or endorsement – 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 or Contract and Certificate Provisions, Subchapter A Life, Accident and Health Insurance. All citations to New York Laws (Insurance Laws or other New York laws) link to the public LRS website. To locate the Insurance Laws, please select the link labeled “ISC”.

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

LINE OF BUSINESS: **Student Health Insurance**

TOI
H22

LINE(S) OF INSURANCE
Student Health Insurance

SUB- TOI
H22.000 Student

IF THE SUBMISSION CONTAINS INSERT PAGES, RIDERS OR ENDORSEMENTS AND THE POLICY OR CONTRACT FORM 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 or contract forms for submission and is not intended as a substitute for statute or regulation. Pursuant to Insurance Law § 4237(a)(3)(C), student health insurance is blanket insurance in New York. However, federal rules require that the more favorable of group or individual provisions apply. See Insurance Law § 3240 and 45 CFR § 147.145.</i>	Form/Page/Para Reference
Model Language Required	§ 3217-i(d) § 4306-h(d) Model Language	The use of model language is required for student health insurance and is required for all sections where model language is available.	
Complete Policy or Contract Submission or Pages/Rider/Endorsement	§ 3201(a) § 3204 § 3221(a)(1) § 4306(d), (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 policy or contract shall avoid the contract or be used in legal proceedings thereunder, unless such application or an exact copy thereof is included in or attached to such policy or contract.</p> <p>No agent or representative of such corporation and no broker, other than an officer or officers designated therein, is authorized to change the policy or contract or waive any of its provisions.</p> <p>If this submission contains insert pages, riders or endorsements, then the policy or contract form in its entirety complies with all the statutory and regulatory provisions stated below. Yes <input type="checkbox"/> No <input type="checkbox"/></p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

		(If no is checked, explain in the space provided above.) This rider, insert pages, or endorsements are being attached to a policy or contract form that was approved by the Department on _____, submission number _____.	
Electronic Delivery of Documents	State Technology Law Article III OGC Opinion No. 09-01-01 OGC Opinion No. 05-11-28	Before an insurer transmits policy forms or any other documents to an insured electronically, it must obtain the insured's consent. If the insured refuses to consent to receiving documents electronically, the insurer must send a hard copy of the policy forms or other documents to that insured.	
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 policyholder" 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.	
Filing Description in SERFF	11 NYCRR 52.33 Circular Letter No. 33 (1999) Supplement 1 to Circular Letter No. 33 (1999)	The SERFF must contain 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 form 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 	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

		<p>precisely with the previous submission; or the differences from the form submitted for preliminary review. § 52.33(e)</p> <ul style="list-style-type: none"> • If the form is other than a policy or contract, the letter must identify the form number and approval date of the policy or contract form 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 form with which it may be used in lieu of the form number and approval date. § 52.33(g) • If the form is a policy or contract, the letter must identify the form numbers and dates of approval of any applications previously approved to be used with the policy or contract form unless the application is required to be attached to the policy or contract form upon submission. § 52.33(h) • If the policy or contract form is designed to be used with insert pages, the letter must contain a statement of the insert page forms which must always be included in the policy or contract form and a list of all optional pages, together with an explanation of their use. § 52.33(i) <p><i>Note: Submission letters and or the SERFF filing description should advise as to whether the policy or contract form is intended for internet sales and should describe any proposed electronic procedures and/or the proposed use of electronic signatures associated with the sale of the policy or contract form.</i></p>	
Certificate	§ 3221(a)(6) § 4305(a)	The insurer shall issue to the institution of higher education for delivery to each student, a certificate setting forth in summary form a statement of the essential features of the insurance coverage.	
Discrimination	§ 2606 § 2607 § 2608 § 2612 § 3243 § 4330 Circular Letter No. 12 (2017) Circular Letter No. 9 (2018) Circular Letter No. 8 (2019)	No insurer or entity shall refuse to issue any insurance policy, cancel or decline to renew the policy or otherwise unfairly discriminate because of race, color, creed, national origin, disability, sex, marital status, status as a victim of domestic violence, or engage in sex stereotyping. “Sex” includes sexual orientation, gender identity or expression, and transgender status.	
Advertising/Brochures	11 NYCRR 52.21(l) 11 NYCRR 215	The premium charged to the insured may not be greater than the premium approved by the superintendent. Any additional charge added to the premium by the policyholder subjects the policyholder to the allegation of doing an insurance business without a license. Any such charges should instead be listed separately from the premium. Any brochure or certificate must include a complete statement of the premiums to be charged.	
APPLICATION FORMS			Form/Page/Para Reference

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

Authorization	11 NYCRR 420.18(b) Circular Letter No. 8 (2017) 42 USC § 290dd-2 42 CFR § 2.31	<p>If the application includes an authorization to disclose non-public personal health information, the authorization specifies the length of time the authorization will remain valid. The maximum allowable period is 24 months.</p> <p>A written authorization that consents to a disclosure of substance use disorder records must include:</p> <ol style="list-style-type: none"> (1) the specific name or general designation of the program or person permitted to make the disclosure; (2) the name or title of the individual or the name of the organization to which disclosure is to be made; (3) the name of the patient; (4) the purpose of the disclosure; (5) how much and what kind of information is to be disclosed; (6) the signature of the patient and, when required for a patient who is a minor, the signature of a person authorized to give consent under 42 C.F.R. § 2.14 or, when required for a patient who is incompetent or deceased, the signature of a person authorized to sign under 42 C.F.R. § 2.15 in lieu of the patient; (7) the date on which the consent is signed; (8) a statement that the consent is subject to revocation at any time except to the extent that the program or person that is to make the disclosure has already acted in reliance on it, where acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer; and (9) the date, event or condition upon which the consent will expire if not revoked before that date, event or condition. 	
Electronic Application	§ 3201(c)(3) 11 NYCRR 52.1(c) State Technology Law Article III	<p>If an insurer is seeking approval to use a previously approved paper application in electronic format, screen shots of the previously approved paper application must be filed for reference for informational purposes. Any drop downs, pop-ups, FAQs, or linked material that could appear in the application process must be included either within the screen shots or as a supporting document provided for informational purposes.</p> <p>If an insurer is seeking approval of an application not previously approved that will only be available in an electronic format (i.e., will be completed and signed electronically) and there is no corresponding paper application, then screen shots must be submitted for approval as the application form. In this case, the screen shots must contain a distinct form number in the lower left corner and must comply with all applicable application requirements. Reflexive material, including drop down options, must be submitted for approval in a corresponding Explanation of Variable Material. Include any pop-ups, FAQs, or linked material that could appear in the application process as a supporting document provided for informational purposes.</p> <p>If an electronic signature is used, it must comply with the Electronic Signatures and Records Act (State Technology Law Article III). The filing should describe the procedures for the use of electronic signatures</p>	
Fraud Warning Statement	§ 403(d) 11 NYCRR 86.4	<p>The application contains the prescribed fraud warning statement immediately above the insured's signature. The fraud warning statement must be placed directly above the signature line and printed in such a way that it is conspicuous to the insured such as by using bold font or larger font size.</p>	
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 	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

		<p>information, evidence of insurability (including conditions arising out of domestic violence), disability or the applicant's race.</p> <ul style="list-style-type: none"> • A provision that changes the terms of the policy or contract to which it is attached. • A statement that the applicant has not withheld any information or concealed any facts. • An agreement that an untrue or false answer material to the risk will render the policy or contract void. • An agreement that acceptance of any policy or contract issued upon the application will constitute a ratification of any changes or amendments made by the insurer and inserted in the application, except to conform to § 3204(d). 	
Verification of Compliance with Pediatric Essential Dental Health Benefit	45 CFR § 156.150	<p>In order to verify whether an individual has obtained stand-alone dental coverage through an New York State of Health ("NYSOH")-certified stand-alone dental plan offered outside the NYSOH, insurers should use the following language on their application/enrollment form:</p> <p>A. Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a NYSOH-certified stand-alone dental plan offered outside the NYSOH? Yes No</p> <p>B. If you answered "yes", please provide the name of the company issuing the stand-alone dental coverage. _____</p> <p>If you answered "no", we will provide you coverage of the pediatric dental essential health benefit.</p>	
POLICY OR CONTRACT FORM PROVISIONS			Form/Page/Para Reference
COVER PAGE	Model Language	<i>Use of the model language is required.</i>	
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).	
Free Look	§ 3216(c)(10) § 4306(h)	This policy or contract form contains a "free look" provision that is for a period of not less than 10 days and not more than 20 days.	
Brief Statement	§ 4306(m)	This policy or contract form contains a brief description of the contract on its first page.	
Table of Contents	§ 3102(c)(1)(G) Model Language	A table of contents is required.	
Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>			
DEFINITIONS	Model Language	<i>Use of the model language is required.</i>	Form/Page/Para Reference
Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Services Performed at Comprehensive Care	§ 3221(k)(14) § 4303(dd)	This policy or contract form may not exclude coverage for services covered under the policy or contract form when provided by a comprehensive care center for eating disorders pursuant to Article 27-J of the	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

Center for Eating Disorders		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		<i>Use of the model language is required.</i>	Form/Page/Para Reference
Selecting a Primary Care Provider			
<p>Selecting, Accessing and Changing Participating Providers</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3217-a(a)(9) § 3217-a(a)(10) § 4324(a)(9) § 4324(a)(10) PHL § 4408(1)(i) PHL § 4408(1)(j) Model Language</p>	Where applicable, this policy or contract form includes a description of the procedures for insureds to select, access, and change primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients.	
<p>Designation of Primary Care Provider ("PCP") & Access to Pediatricians</p> <p>Does this plan 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-e § 4306-d PHL §4403(7) 42 USC § 300gg-19a 45 CFR § 147.138(a) Model Language</p>	<p>If the 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.</p> <p>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.</p>	
<p>Direct Access to OB/GYN Services</p> <p>Does this plan 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 the policy or contract form requires the designation of a PCP, it must not limit a female insured's direct access to primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions from a qualified participating provider of such services of her choice or for any care related to pregnancy provided that:</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>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3217-g § 4306-f PHL § 2500-k PHL § 4406-f Circular Letter No. 1 (2016)</p>	If this policy or contract form requires the designation of a PCP, it must not limit a insured's direct access to screening and referral for maternal depression, as defined in Public Health Law § 2500-k, 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 policy or contract under which the insured is covered. However, if the infant is covered under a different policy than the mother and the screening and referral are performed by a	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

	Model Language	provider of pediatric services, coverage for the screening and referral shall also be provided under the policy in which the infant is covered.	
Network Adequacy	§ 3217-d(d) § 3241(a) § 4306-(c)d Model Language	If the policy or contract form uses a network of providers and is found inadequate in a specialty type in a particular county, the policy or contract form must permit the insured to see an out-of-network provider for the covered service at the in-network cost-sharing.	
Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Preauthorization			
Preauthorization Requirements	§ 3217-a(a)(2) § 3238 § 4324(a)(2) PHL § 4408(1)(b) Model Language	This policy or contract form includes a description of all preauthorization or other notification requirements for treatments and services. If the policy or contract form requires a gatekeeper, the preauthorization requirements may not be imposed on the insured for in-network services. A preauthorization or notification penalty of either 50% of the allowable amount for services rendered or \$500.00, whichever is less, is permissible. This preauthorization penalty is the only member penalty that is permitted when the obligation to request preauthorization is on the member. Plans may not impose other member penalties or deny claims in their entirety for failure to seek preauthorization or provide notification.	
Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Medical Necessity			
Definition of Medical Necessity	§ 3217-a(a)(1) § 4324(a)(1) PHL § 4408(1)(a) Model Language	This policy or contract form includes a definition of “medical necessity” used in determining whether benefits will be covered.	
Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Contact Information	§ 3217-a(a)(16) § 4324(a)(16) PHL § 4408(1)(q) Model Language	This policy or contract form includes all appropriate mailing addresses and telephone numbers to be utilized by insureds seeking information or authorization.	
Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Protection from Surprise Bills			
Protection from Surprise Bills and IDR Process	23 NYCRR 400 Art. 6 of the Financial Services Law (Chapter 60 of the Laws of 2014) Model Language	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 deductibles, copayments, and/or coinsurance if the insured assigns benefits in writing to the non-participating physician. The non-participating physician may only bill an insured for deductibles, copayments, and/or coinsurance.	
Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>		The policy or contract form also includes a description of the independent dispute resolution process.	
Delivery of Covered Services Using Telehealth			
Delivery of Covered Services Using Telehealth	§ 3217-h § 4306-g PHL § 4406-g Model Language	This policy or contract form must not exclude from coverage a service that is otherwise covered under this 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 this policy or contract form. 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.	
Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>			

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

		<p>Services delivered via telehealth may be subject to deductibles, copayments and/or coinsurance provided that they are at least as favorable to the insured as those established for the same service when not delivered via telehealth.</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>	
Early Intervention Program Services			
<p>Early Intervention Program Services</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	Model Language	<p>This policy or contract form may not exclude coverage for services covered under the policy or contract solely because they are Early Intervention Program services for infants and toddlers under three years of age who have a confirmed disability or an established developmental delay. Additionally, if Early Intervention Program services are otherwise covered under this policy or contract form, coverage for Early Intervention Program services will not be applied against any maximum annual or lifetime dollar limits if applicable. Visit limits and other terms and conditions will continue to apply to coverage for Early Intervention Program services. However, any visits used for Early Intervention Program services will not reduce the number of visits otherwise available under this policy or contract form.</p>	
Case Management			
<p>Case Management</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	Model Language	<p>Where applicable, this policy or contract form includes a description of the case management procedures for members with health care needs due to serious, complex, and/or chronic health conditions.</p>	
ACCESS TO CARE AND TRANSITIONAL CARE		<i>Use of model language is required.</i>	
<p>Referral or Authorization to Non-Participating Providers</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	§ 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	<p>If a policy or contract form is a managed care product as defined in § 4801(c) or an HMO, or an EPO or a comprehensive insurance product that uses a network of providers, it must describe how an insured may obtain a referral or authorization to a health care provider outside of the insurer’s network when the insurer does not have a health care provider with appropriate training and experience in the network to meet the health care needs of the insured and the procedure by which the insured can obtain such referral or authorization.</p>	
<p>Specialty Care Provider as PCP</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	§ 3217-a(a)(13) § 3217-d(b) § 4306-c(b) § 4324(a)(13) § 4804(c) PHL § 4403(6)(c) PHL § 4408(1)(m) Model Language	<p>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.</p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

<p>Standing Referrals or Authorizations</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3217-a(a)(12) § 3217-d(b) § 4306-c(b) § 4324(a)(12) § 4804(b) PHL § 4403(6)(b) PHL § 4408(1)(l) Model Language</p>	<p>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 or authorization to such specialist and describe the procedure for requesting and obtaining such a standing referral or authorization</p>	
<p>Specialty Care Center</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 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</p>	<p>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 or authorization 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.</p>	
<p>Transitional Care When a Provider Leaves the Network</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3217-d(c) § 4306-c(c) § 4804(e) PHL § 4403(6)(e) Model Language</p>	<p>If an insured is in an ongoing course of treatment when a provider leaves the network, then the policy or contract form must describe how an insured may continue to receive treatment 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.</p> <p>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, or authorizations, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.</p>	
<p>Transitional Care For a New Member in a Course of Treatment</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3217-d(c) § 4306-c(c) § 4804(f) PHL § 4403(6)(f) Model Language</p>	<p>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.</p> <p>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</p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

		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.	
COST-SHARING EXPENSES AND ALLOWED AMOUNT		<i>Use of model language is required.</i>	
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. 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 includes a description of the insured's financial responsibility for payment when services are provided by a health care provider who is not part of the insurer's network or by any provider without the required authorization or when a procedure, treatment or service is not a covered health care benefit.	
Reimbursement of Providers 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 includes a description of the types of methodologies the insurer uses to reimburse providers.	
WHO IS COVERED		<i>Use of model language is required.</i>	Form/Page/Para Reference
Spouse Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(a)(3) § 3216(c)(3) § 4304(d) 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 includes marriages between same-sex spouses.	
Dependents Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(a)(3) § 3216(a)(4) § 4235(f)(1)(A)(i) § 4305(c)(1)(A) § 4306(i)	Dependent coverage is optional and may include the student's spouse and/or children. If dependent coverage is selected by the policyholder or contractholder, 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</i>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

	42 USC § 300gg-14 45 CFR § 147.120 Model Language	<i>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>	
Extended Dependent Coverage Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(a)(4)(C) § 4304(d)(1)(B) § 4235(f)(1)(B) Model Language	For coverage that includes dependent children this policy or contract form must make available and if requested by the policyholder or contractholder, provide coverage for unmarried children through the age of 29 (up to age 30); regardless of financial dependence; who are not insured by or eligible for coverage under an employer-sponsored health benefit plan covering them as an employee or member, whether insured or self-insured; and who live, work or reside in New York State or the service area of the insurer. The insurer must comply with the notice requirements set forth in §§ 4235(f)(i)(B) or 4304(d)(1)(B).	
Unmarried Students on Medical Leave of Absence	§ 3237 § 4306-a 42 USC § 300gg-28	If this policy or contract form provides coverage for dependent children who are full-time students to a higher age than other dependent children, then coverage shall continue when such dependent takes a medical leave of absence from school due to illness or injury for a period of 12 months from the last day of attendance at school, provided, however, that coverage of a dependent student is not required beyond the age at which the coverage would otherwise terminate. To qualify for such coverage, the insurer may require that the medical necessity of the leave be certified to by the student's attending physician who is licensed to practice in the state of New York.	
Unmarried Disabled Children Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(a)(4)(A)(i) § 3216(c)(4)(A) § 4304(d)(1)(A)(ii) § 4304(d)(3) Model Language	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 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. <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>	
Newborn Infants Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(c)(4)(C) § 4304(d)(1)(C) Model Language 45 CFR § 155.420	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 60 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. Coverage 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. <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 are 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 60 days of the day of birth to make coverage effective from the moment of birth.</i>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

<p>Adopted Children and Step-Children</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>11 NYCRR 52.17(a)(30), (31) Model Language</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>§ 3216(a)(3) § 4304(d)(1) OGC Opinion 01-11-23 Model Language</p>	<p>If this policy or contract form covers spouses it must cover domestic partners. In order to qualify as domestic partners, the insured must demonstrate proof of economic interdependence evidenced as follows:</p> <ol style="list-style-type: none"> 1. Registration as a domestic partner, where such registry exists, or 2. If no registration is available, then: <ol style="list-style-type: none"> a. An affidavit of domestic partnership is required. The affidavit must be notarized and must contain the following: <ol style="list-style-type: none"> i. The partners are both 18 years of age or older and are mentally competent to consent to contract; ii. The partners are not related by blood in a manner that would bar marriage under laws of the State of New York; iii. The partners have been living together on a continuous basis prior to the date of the application; and iv. Neither individual has been registered as a member of another domestic partnership within the last six (6) months; b. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and c. 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 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; or other items of sufficient proof to establish economic interdependency under the circumstances of the particular case. 	
<p>Enrollment Periods</p>	<p>§ 3221(q)(5) § 4305(k)(5) 45 CFR § 147.104 45 CFR § 155.420 Model Language</p>	<p>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.</p>	
<p>MANDATORY COVERED</p>	<p>§ 3240(d)</p>	<p>Except where noted below, the following benefits must be included in the policy or contract form.</p>	<p>Form/Page/Para Reference</p>

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

ESSENTIAL HEALTH BENEFITS		<p>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, as well as Department review.</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 Service and Devices 	
PREVENTIVE CARE		<i>Use of model language is required.</i>	
<p>Primary and Preventive Health Services</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(k)(18) § 3221(l)(8) § 4303(j) § 4303(ii) Circular Letter No. 3 (1994) Circular Letter No. 13 (2006) Required Immunizations 42 USC § 300gg-13 45 CFR § 147.130 45 CFR § 156.100 Model Language</p>	<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 medical history, complete physical examination, developmental assessment, anticipatory guidance, laboratory tests and necessary immunizations in accordance with the Advisory Committee on Immunization Practices. • Additional preventive care and screenings for infants, children and adolescents in guidelines supported by Health Resources and Services Administration (“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. This policy or contract form must provide coverage for a physical or well care visit once every year even if 365 days have not passed since the previous physical or well care visit.</i></p>	
<p>Federally Mandated Preventive Health Services and Adult Annual Physical Examination</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(l)(8) § 4303(j) 45 CFR § 156.100 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 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>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

		<p>This policy or contract form provides coverage for an adult annual physical examination. 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><i>Note: For new items or services added to the list of recommended preventive services receiving an A or B rating from the USPSTF, or new recommendations from HRSA, insurers should provide the required coverage for such items or services no later than six months from when the recommendation is made.</i></p>	
<p>Cervical Cytology Screening and Well Woman Visits</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(l)(14) § 4303(t) 42 USC § 300gg-13 45 CFR § 147.130 45 CFR § 156.100 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 includes an annual pelvic examination, collection and preparation of cervical cancer screening tests, and laboratory and diagnostic services provided in connection with examining and evaluating the cervical cancer screening tests.</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 USPSTF, or new recommendations from HRSA, insurers should provide the required coverage for such items or services no later than six months from when the recommendation is made. This policy or contract form must provide coverage for a well woman visit once every year even if 365 days have not passed since the previous well woman visit.</i></p>	
<p>Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(l)(11) § 3221(l)(19) § 4303(p) § 4303(qq) Circular Letter No. 2 (2016) Supplement No. 1 to Circular Letter No. 2 (2016) 42 USC § 300gg-13 45 CFR § 147.130 45 CFR § 156.100 Model Language HRSA Guidelines</p>	<p>This policy or contract form provides the following coverage for mammography screening for occult breast cancer:</p> <ul style="list-style-type: none"> • Upon the recommendation of a physician, a mammogram at any age for covered persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer. • A single, baseline mammogram for covered persons age 35-39, inclusive. • An annual mammogram for covered persons age 40 and older. • Screening and diagnostic imaging, including tomosynthesis (3D mammograms) diagnostic mammograms, breast ultrasounds and MRIs, for the detection of breast cancer. <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 USPSTF, or new recommendations from HRSA, insurers should provide the required coverage for such items or services no later than six months from when the recommendation is made.</i></p>	
<p>Family Planning & Reproductive Health Services</p> <p>Model Language Used?</p>	<p>§ 3216(i)(10) § 3216(i)(15) § 4303(cc) § 4328</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), patient education and counseling on use of contraceptives and related topics; follow-up services related to contraceptive methods, including management of side effects, counseling for continued adherence, and device insertion and removal; and sterilization</p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Supplement No. 1 to Circular Letter No. 1 (2003) 42 USC § 300gg-13 45 CFR § 147.130 45 CFR § 156.100 Model Language HRSA Guidelines</p>	<p>procedures for women. Such coverage shall not be subject to deductibles, copayments and/or coinsurance.</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 USPSTF, or new recommendations from HRSA, insurers should provide the required coverage for such items or services no later than six months from when the recommendation is made.</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(k)(13) § 4303(bb) 42 USC § 300gg-13 45 CFR § 147.130 45 CFR § 156.100 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 risk for osteoporosis. <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(l)(11-a) § 4303(z-1) 45 CFR § 156.100 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 shall not be subject to deductibles, copayments and/or coinsurance.</p>	
<p>AMBULANCE, EMERGENCY</p>	<p><i>Use of the model language is required.</i></p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

SERVICES AND URGENT CARE			
<p>Ambulance and Pre-Hospital Emergency Medical Services</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(l)(15) § 4303(aa) 45 CFR § 156.100 Model Language</p>	<p><u>Emergency Ambulance Transportation:</u> 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.</p> <p>“Pre-hospital emergency medical services” means the prompt evaluation and treatment of an emergency condition and/or non-airborne transportation to a hospital. The services must be provided by an ambulance service issued a certificate under the Public Health Law. Coverage will be provided for transportation to a hospital provided by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:</p> <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. <p>An insurer shall provide reimbursement for pre-hospital emergency medical services at rates negotiated between the insurer and the provider of such services. In the absence of agreed upon rates, an insurer shall pay for such services at the usual and customary charge, which shall not be excessive or unreasonable. An ambulance service must hold the insured harmless and may not charge or seek reimbursement from the insured for pre-hospital emergency medical services except for the collection of any applicable deductible, copayment, and/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 emergency services can be performed.</p> <p>This policy or contract form provides coverage for pre-hospital emergency medical services and emergency ambulance transportation worldwide.</p> <p><u>Non-Emergency Ambulance Transportation:</u> This policy or contract form covers 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 care facility to a sub-acute setting. 	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

<p>Emergency Services</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3217-a(a)(8) § 3221(k)(4) § 3221(l)(20) § 3241(c) § 4303(a)(2) § 4303(rr) § 4324(a)(8) § 4900(c) PHL § 2805-i PHL § 4408(1)(h) Article 6 of the Financial Services Law (Ch. 60 of the Laws of 2014) Circular Letter No.1 (2002) 10 NYCRR 98-1.13 42 USC § 300gg-19a(b) 45 CFR § 147.138(b) 45 CFR § 156.100 Model Language</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 co-payment or coinsurance; or (iii) the amount that would be paid under Medicare for the emergency service excluding any in-network co-payment or coinsurance. <p>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.</p> <p>This policy or contract form includes coverage for emergency services worldwide.</p> <p>Health care forensic examinations performed under Public Health Law § 2805-I are not subject to cost-sharing.</p> <p>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> <p><i>Note: The following definitions must be used:</i> “Emergency condition” means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (ii) serious impairment to such person’s bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person; or a condition described in § 1867(e)(1)(A)(i), (ii) or (iii) of the Social Security Act.</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</i></p>	
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NEW YORK DEPARTMENT OF FINANCIAL SERVICES

		<i>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>	
Urgent Care Services Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(l) § 4304(l) § 4328 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		<i>Use of the model language is required.</i>	
Advanced Imaging Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(l) § 4304(l) § 4328 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for PET scans, MRI, nuclear medicine, and CAT scans. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Allergy Testing and Treatment Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(l) § 4304(l) § 4328 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for testing and evaluations including: injections, and scratch and prick tests to determine the existence of an allergy. This policy or contract form also provides coverage for allergy treatment, including desensitization treatments, routine allergy injections and serums. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Ambulatory Surgery Center Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(l) § 4304(l) § 4328 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for surgical procedures performed at an ambulatory surgical center including services and supplies provided by the center the day the surgery is performed. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Chemotherapy Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(l) § 4304(l) § 4328 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. Chemotherapy may be administered by injection or infusion. Such coverage may be subject to deductibles, copayments and/or coinsurance.	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

<p>Chiropractic Care</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(k)(11) § 4303(y) 45 CFR § 156.100 Model Language</p>	<p>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.</p> <p>Chiropractic care and services may be subject to reasonable deductible, copayment and coinsurance amounts, reasonable fee or benefit limits, and reasonable utilization review, provided that any such amounts, limits and review: shall not function to direct treatment in a manner discriminative against chiropractic care and individually and collectively shall be no more restrictive than those applicable under the 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.</p> <p><i>Note: A policy or contract form may not subject a visit to a chiropractor or to a provider of chiropractic care to higher cost-sharing than that which applies to other specialty office visits under the policy or contract. Additionally, a policy or contract form may not impose a greater level of utilization review to chiropractic care and services than that which applies to specialty office care in general under the policy or contract. This means, for example, that a policy or contract form may not require pre-certification or preauthorization of chiropractic care and services if it does not require the same for specialty office visits in general.</i></p>	
<p>Clinical Trials</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>42 USC § 300gg-8 45 CFR § 156.100 Model Language</p>	<p>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. .</p> <p>An “approved clinical trial” means a phase I, II III, or IV clinical trial that is: (i) a federally funded or approved trial; (ii) conducted under an investigational drug application reviewed by the FDA; or (iii) a drug trial that is exempt from having to make an investigational new drug application.</p>	
<p>Dialysis Coverage</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3216(i)(27) § 3216(l) § 4303(gg) § 4304(l) § 4328 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for dialysis treatment of an acute or 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:</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 	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

		<p>permitted, provided that the insurer has a reasonable opportunity to review the travel and treatment plans of the insured;</p> <ul style="list-style-type: none"> • 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>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 this substitution or addition differs from the standard benefit in the space provided below.</p>	<p>§ 3216(l) § 4304(l) § 4328 45 CFR § 156.100 45 CFR § 156.115 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 a minimum of 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: Plans may provide more coverage than required under EHB by: (i) covering more than 60 visits or removing the visit limit; or (ii) removing the per condition limit (if increasing visit limits) and/or the limit on all therapies combined.</i></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(k)(1) § 4303(a)(3) 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 form if hospitalization or confinement in a nursing facility would otherwise be required. Home care must be provided by an agency possessing a valid certificate of approval or license issued pursuant to 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. 	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

		<ul style="list-style-type: none"> • 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><i>Note: Plans may increase the number of covered home health care visits or remove the visit limit.</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(k)(6) § 4303(s) 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 provides services for the diagnosis and treatment (surgical and medical) of infertility.</p> <p>“Infertility” is a disease or condition characterized by the incapacity to impregnate another person or to conceive, defined by the failure to establish a clinical pregnancy after 12 months of regular, unprotected sexual intercourse or therapeutic donor insemination, or after six (6) months of regular, unprotected sexual intercourse or therapeutic donor insemination for a female 35 years of age or older. Earlier evaluation and treatment may be warranted based on an insured’s medical history or physical findings.</p> <p>Basic Infertility Services. This policy or contract form provides basic infertility services, which must be provided to an insured who is an appropriate candidate for infertility treatment. In order to determine eligibility, the insurer must use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of New York. Basic fertility services include:</p> <ul style="list-style-type: none"> • Initial evaluation; • Semen analysis; • Laboratory evaluation; • Evaluation of ovulatory function; • Postcoital test; • Endometrial biopsy; • Pelvic ultra sound; • Hysterosalpingogram; • Sono-hystogram; • Testis biopsy; • Blood tests; and • Medically appropriate treatment of ovulatory dysfunction. <p>Comprehensive Infertility Services. If the basic infertility services do not result in increased fertility, this policy or contract form provides comprehensive infertility services. Comprehensive infertility services include:</p> <ul style="list-style-type: none"> • Ovulation induction and monitoring; • Pelvic ultra sound; • Artificial insemination; • Hysteroscopy; 	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

		<ul style="list-style-type: none"> • Laparoscopy; and • Laparotomy. <p>Fertility Preservation Services. This policy or contract form provides standard fertility preservation services when a medical treatment will directly or indirectly lead to iatrogenic infertility. Standard fertility preservation services include the collecting, preserving, and storing of ova or sperm. “Iatrogenic infertility” means an impairment of the insured’s fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes.</p> <p>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.</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; • Cryopreservation and storage of sperm or ova, except when performed as fertility preservation services; • 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><i>Note: These are the only infertility treatments that may be expressly excluded in the policy or contract form. The exclusions listed above may be removed.</i></p>	
<p>Infusion Therapy</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3216(l) § 4304(l) § 4328 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>§ 3216(l) § 4304(l) § 4328 11 NYCRR 52.16(o) 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for medically necessary abortions including abortions in cases of rape, incest or fetal malformation. Elective abortions are covered for one (1) procedure per member, per year.</p> <p>In-network medically necessary abortion coverage must be provided with no cost-sharing, unless the plan is a high deductible health plan as defined in section 223(c)(2) of the Internal Revenue Code in which case coverage for medically necessary abortions may be subject to the deductible.</p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

		<i>Note: Plans may provide coverage for elective abortions that is more favorable. Coverage for elective abortions may be removed for any policy or contract.</i>	
Laboratory Procedures, Diagnostic Testing and Radiology Services Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(l) § 4304(l) § 4328 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Office Visits Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(l) § 4304(l) § 4328 45 CFR § 156.100 Model Language	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 contract form may also, if applicable, provide 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. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Outpatient Hospital Services Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(i)(5) § 3216(l) § 4304(l) § 4328 45 CFR § 156.100 Model Language	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. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Preadmission Testing Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(i)(7) § 4303(a)(1) 45 CFR § 156.100 Model Language	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. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Prescription Drugs for Use in the Office Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(l) § 4304(l) § 4328 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for medications and injectables (excluding self-injectables) used by the provider in the provider's office for preventive and therapeutic purposes. This benefit applies when the insured's provider orders the prescription drug and administers it to the insured. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Outpatient Rehabilitative Services Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(l) § 4304(l) § 4328 45 CFR § 156.100 Model Language	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 a minimum of 60 visits per condition, per plan year. The visit limit applies to all therapies combined.	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

<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 this substitution or addition differs from the standard benefit in the space provided below.</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 includes 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: Plans may provide more coverage than required under EHB by: (i) covering more than 60 visits or removing the visit limit; or (ii) removing the per condition limit (if increasing visit limits) and/or the limit on all therapies combined.</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(k)(9) § 4303(w) 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 includes coverage for a second medical opinion from a non-participating specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer when the attending physician provides a written referral to the non-participating specialist, at no additional cost to the insured beyond what such insured would have paid for services from a participating specialist. • This benefit also includes coverage for a second medical opinion by a non-participating specialist where there is no referral from the attending physician and where the insurer has not pre-authorized the service. In such cases, the insurer is responsible for covering the medically necessary services at a usual, customary and reasonable rate. <p>Such coverage may be subject to 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?</p>	<p>§ 3221(k)(3) § 4303(b)</p>	<p>This policy or contract form provides coverage for a second surgical opinion by a qualified physician on the need for surgery.</p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

Yes <input type="checkbox"/> No <input type="checkbox"/>	Circular Letter No. 29 (1979) 45 CFR § 156.100 Model Language	Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Mandatory Second Surgical Opinion Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3221(k)(3) § 4303(b) Circular Letter No. 29 (1979) 45 CFR § 156.100 Model Language	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). Such coverage may not be subject to deductibles, copayments and/or coinsurance.	
Second Opinion in Other Cases Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(l) § 4304(l) § 4328 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for a second opinion in cases when an insured disagrees with a provider's recommended course of treatment. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Surgical Services Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(l) § 4304(l) § 4328 11 NYCRR 52.6 45 CFR § 156.100 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"/>	§ 3216(l) § 4304(l) § 4328 11 NYCRR 52.16(c)(9) 45 CFR § 156.100 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	§ 3216(i)(20) § 3221(k)(10)	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	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

<p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 4303(x) 45 CFR § 156.100 Women's Health and Cancer Rights Act of 1998, 29 USC 1185b Model Language</p>	<p>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 form.</p>	
<p>Transplants</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3216(l) § 4304(l) § 4328 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for transplants determined to be non-experimental 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.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Autism Spectrum Disorder</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3216(i)(25) § 3221(l)(17) § 4303(ee) § 4328 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for the screening, diagnosis and treatment of autism spectrum disorder, including the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist:</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 form provides coverage for prescription drugs. <p>This policy or contract form includes a definition of "autism spectrum disorder" which means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.</p> <p>The policy or contract form includes a definition of "behavioral health treatment" which means counseling and treatment programs, when provided by a licensed or certified provider and applied behavior analysis, when provided or supervised by a licensed or certified behavior analysis health care professional, 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>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

		<p>The policy or contract form includes a definition of “assistive communication devices” which at a minimum includes dedicated devices which are specifically designed to aid in communication and are not generally useful to a person in the absence of a communication impairment and software applications that enable a non-covered device to function as a communication device.</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 and in accordance with the federal Mental Health Parity Addiction Equity Act (“MHPAEA”).</p> <p><i>Note: Under MHPAEA, a health policy or contract that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (e.g., cost-sharing) and treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policy or contract form from imposing separate cost-sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law. These requirements apply to behavioral health treatment.</i></p>	
<p>Diabetes Equipment, Supplies and Self-Management Education</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3216(i)(15-a) § 3216(l) § 4303(u) § 4304(l) § 4328 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 §§ 3216(i)(15-a) 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: Plans may apply prescription drug cost-sharing to the benefit if the cost-sharing is more favorable to the insured than when treated as a medical benefit. Since the statute refers to equipment, supplies and self-management education that are prescribed by a physician “or other licensed health care provider legally authorized to prescribe under title eight of the education law...,” 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>§ 3216(l) § 4304(l) § 4328 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 replacements that are the result of misuse or abuse.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>External Hearing Aids</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3216(l) § 4304(l) § 4328 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 at least once every three (3) years.</p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

		<p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p> <p><i>Note: Plans may remove or modify the three-year limit on hearing aids so that coverage is more favorable.</i></p>	
<p>Cochlear Implants</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3216(l) § 4304(l) § 4328 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form provides coverage for bone anchored hearing aids (i.e., cochlear implants) when they are Medically Necessary to correct a hearing impairment.</p> <p>Examples of when bone anchored hearing aids are Medically Necessary include 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: Plans may remove or modify the limit on bone anchored hearing aids so that coverage is more favorable.</i></p>	
<p>Hospice Care</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3216(l) § 4304(l) § 4328 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form must provide coverage for hospice care to members who have been certified by a primary attending physician as having a life expectancy of six (6) months or less and 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 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 within this policy or contract form.</p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

		<i>Note: Plans may use 6 months or 12 months for the life expectancy timeframe. Plans may cover more than 210 days or remove the limit.</i>	
Medical Supplies Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3221(k)(19) § 4303(u-1) 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for medical supplies required for the treatment of a disease or injury, including maintenance supplies.	
Prosthetics Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(l) § 4304(l) § 4328 45 CFR § 156.100 Model Language	<p>External Prosthetic Devices: 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: Plans may increase or remove the one external prosthetic limit so that coverage is more favorable.</i></p> <p>Internal Prosthetic Devices: 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 includes 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 includes 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>	
Hospital Services Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(l) § 4304(l) § 4328 11 NYCRR 52.5 45 CFR § 156.100 Model Language	<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 plaster casts; • Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, x-ray examinations and radiation therapy, laboratory and pathological examinations; 	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

		<ul style="list-style-type: none"> 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(k)(5) § 3221(l)(20) § 4303(c) § 4303(oo) 45 CFR § 156.100 29 USC § 1185 42 USC § 300gg Circular Letter No. 5 (2018) 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 form. Such coverage, other than for perinatal complications, includes inpatient hospital coverage for mother and newborn for at least 48 hours after childbirth for any delivery other than a caesarean section, and for at least 96 hours following a caesarean section. Such coverage may be subject to deductibles, copayments and/or coinsurance.</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 includes parent education, training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments. Comprehensive lactation support services, including breastfeeding equipment and supplies, must be provided without cost-sharing through the duration of breast feeding. The coverage includes the cost of renting or purchasing one (1) breast pump per pregnancy in conjunction with childbirth.</p> <p>This policy or contract form also provides coverage for the inpatient use of pasteurized donor human milk, which may include fortifiers as medically necessary, for which a Health Care Professional has issued an order for an infant who is medically or physically unable to receive maternal breast milk, participate in breast feeding, or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breast feeding despite optimal lactation support. Such infant must have a documented birth weight of less than one thousand five hundred grams, or a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.</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>	
Mastectomy Care	<p>§ 3221(k)(8) § 4303(v)</p>	<p>This policy or contract form provides coverage for a period of inpatient hospital care as is determined by the attending physician in consultation with the patient to be medically appropriate for a person</p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

<p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Women's Health and Cancer Rights Act of 1998, 29 USC 1185b 45 CFR § 156.100 Model Language</p>	<p>undergoing a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered under the policy or contract form, and any physical complications arising from the mastectomy, including lymphedema.</p> <p>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.</p>	
<p>Autologous Blood Banking Services</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3216(l) § 4304(l) § 4328 45 CFR § 156.100 Model Language</p>	<p>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.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
<p>Inpatient Habilitation Services</p> <p>Model Language Used? 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 this substitution or addition differs from the standard benefit in the space provided below.</p>	<p>§ 3216(l) § 4304(l) § 4328 45 CFR § 156.100 45 CFR § 156.115 Model Language</p>	<p>This policy or contract form provides coverage for inpatient habilitation services, including physical therapy, speech therapy, and occupational therapy for 60 days per plan year. The day limit applies to all therapies combined.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p> <p><i>Note: Plans may: (i) cover 60 or more visits or remove the visit limit; or (ii) remove the limit on all therapies combined.</i></p>	
<p><u>Benefit explanation:</u></p>			
<p>Inpatient Rehabilitative Services</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3216(l) § 4304(l) § 4328 45 CFR § 156.100 Model Language</p>	<p>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 day limit applies to all therapies combined.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

<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 this substitution or addition differs from the Model Language in the space provided below.</p>		<p><i>Note: Plans may (i) cover 60 or more days or remove the day limit; or (ii) remove the limit on all therapies combined.</i></p>	
<p><u>Benefit explanation:</u></p>			
<p>Skilled Nursing Facility</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3216(l) § 4304(l) § 4328 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 a minimum of 200 days, per plan 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: Plans may increase the number of days covered or remove the day limit.</i></p>	
<p>End of Life Care</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3216(l) § 4304(l) § 4328 § 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 insured 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><i>Use of model language is required.</i></p>	
<p>Inpatient Mental Health Care Services</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(l)(5) § 4303(g) Circular Letter No. 5 (2014)</p>	<p>This policy or contract form provides coverage for inpatient mental health care services relating to the diagnosis and treatment of mental health conditions. Coverage for inpatient services for mental health care is limited to facilities as defined in Mental Hygiene Law § 1.03(10) and, in other states, to similarly licensed or certified facilities.</p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

	Circular Letter No. 4 (2016) Circular Letter No. 13 (2019) Federal Mental Health Parity Addition Equity Act of 2008 (MHPAEA) 29 USC § 1185a 45 CFR § 146.136 45 CFR § 156.100 Model Language	<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>For the purposes of this benefit, “mental health condition” means any mental health disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders or another source which must be a generally recognized independent standard of current medical practice, such as the International Classification of Diseases.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent, that are consistent with other benefits within the policy or contract form, and in accordance with MHPAEA.</p> <p><i>Note: Under MHPAEA, individual 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 the treatment of mental health conditions and substance use disorder consistent with the federal law.</i></p>	
Outpatient Mental Health Care Services Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(i)(4) § 3221(l)(5) § 4303(g) § 4303(h) Circular Letter No. 5 (2014) Circular Letter No. 4 (2016) Circular Letter No. 13 (2019) Federal Mental Health Parity Addition Equity Act of 2008 (MHPAEA) 29 USC § 1185a 45 CFR § 146.136 45 CFR § 156.100 Model Language	<p>This policy or contract form provides coverage for outpatient mental health care services relating to the diagnosis and treatment of mental health conditions, including, but not limited to, partial hospitalization program and intensive outpatient program services. Such coverage is limited to facilities that have been issued an operating certificate pursuant to Article 31 of the Mental Hygiene Law; a facility operated by the New York State Office of Mental Health and, in other states, to similarly licensed or certified facilities; and; services provided by a psychiatrist or psychologist licensed to practice in this state; a licensed clinical social worker who meets the requirements of Insurance Law §§ 3216(i)(4) and 4303(h)(1); a nurse practitioner licensed to practice in this state; or a professional corporation or a university faculty practice corporation thereof.</p> <p>For purposes of this benefit, “mental health condition” means any mental health condition as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders or another source which must be a generally recognized independent standard of current medical practice, such as the International Classification of Diseases.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent, that are consistent with other benefits within the policy or contract form, and in accordance with MHPAEA. An insurer shall not impose a copayment or coinsurance for outpatient mental health services provided in a facility licensed, certified, or otherwise authorized by OMH that</p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

		<p>exceeds the copayment or coinsurance imposed for a primary care office visit under the policy or contract.</p> <p><i>Under MHPAEA, individual 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>§ 3221(l)(6) § 4303(k) Circular Letter No. 5 (2014) Circular Letter No. 4 (2016) Circular Letter No. 6 (2016) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) 29 USC § 1185a 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 disorders, including detoxification and rehabilitation services. Inpatient substance use services are limited to facilities in New York which are licensed, certified, or otherwise authorized by the Office of Addiction Services and Supports (“OASAS”), and in other states, to those facilities that are licensed, certified, or otherwise authorized by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.</p> <p>Coverage for inpatient substance use services also includes services received at residential treatment facilities, including room and board charges. Coverage for residential treatment services is limited to facilities that are licensed, certified or otherwise authorized by OASAS; and, in other states, to those facilities that are licensed, certified, or otherwise by a similar state agency and accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.</p> <p>For purposes of this benefit, “substance use disorder” means any substance use disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders or another source which must be a generally recognized independent standard of current medical practice, such as the International Classification of Diseases.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent, that are consistent with other benefits within the policy or contract form, and in accordance with MHPAEA.</p> <p><i>Under MHPAEA, individual 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</i></p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

		<i>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>Outpatient Substance Use Services</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(1)(7) § 4303(1) Circular Letter No. 5 (2014) Circular Letter No. 4 (2016) Circular Letter No. 6 (2016) Federal Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) 29 USC § 1185a 45 CFR § 146.136 45 CFR § 156.100 Model Language</p>	<p>This policy form provides coverage for outpatient substance use services relating to the diagnosis and treatment of substance use disorder, including but not limited to partial hospitalization program services, intensive outpatient program services, counseling and medication-assisted treatment. Such coverage is limited to facilities in New York State that are licensed, certified or otherwise authorized by OASAS to provide outpatient substance use disorder services and, in other states, to those facilities that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence programs. Coverage is also available in a professional office setting for outpatient substance use disorder services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe schedule III, IV and V narcotic medication for the treatment of opioid addiction during the acute detoxification stage of treatment or during stages of rehabilitation.</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 as deemed appropriate by the Superintendent, that are consistent with other benefits within the policy or contract form, and 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 includes treatment as a family member pursuant to such family member's own policy or contract provided such family member does not exceed the allowable number of family visits and is otherwise entitled to the coverage pursuant to this mandate.</i></p> <p><i>Note: Under MHPAEA, individual 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.</i></p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

		<i>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>	
PRESCRIPTION DRUGS		<i>Use of the model language is required.</i>	
Prescription Drugs Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(l) § 4304(l) § 4328 45 CFR § 156.100 45 CFR § 156.122 Model Language	<p>This policy or contract form covers 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>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
Enteral Formulas Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3221(k)(11) § 4303(y) OGC Opinion 10-12-03 45 CFR § 156.100 Model Language	<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 has issued a written order. The order must state that the formula is medically necessary and has been proven effective as a disease-specific treatment regimen. Specific diseases and disorders include but are not limited to: inherited amino-acid or organic acid metabolism; Crohn’s Disease; gastroesophageal reflux; gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies. Multiple food allergies include, but are not limited to: immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders and impaired absorption of nutrients cause by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract.</p> <p>This policy or contract form provides coverage for modified solid food products that are low in protein, contain modified protein, or are amino acid based to treat certain inherited diseases of amino acid and organic acid metabolism and severe protein allergic conditions.</p> <p>Such coverage may be subject to deductibles, copayments and/or coinsurance.</p>	
Off-Label Cancer Drug Usage Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(i)(12) § 4303(q) Model Language	<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 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>	
Usual and Customary Cost of Prescribed Drugs Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 4325(h) PHL § 4406-c(6) Circular Letter No. 7 (2019)	<p>Copayments relating to prescription drugs shall not exceed the usual and customary cost of such prescribed drug.</p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

	Model Language		
Prohibition for Tier IV Drugs	§ 3216(i)(27) § 4303(jj) PHL § 4406-c(7)	The policy or contract form shall not impose cost-sharing (deductible, copayment, and/or coinsurance) 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). This policy or contract form may have up to three tiers of cost-sharing. Tier placement should be determined using an evidence-based process that analyzes the safety and effectiveness of a drug or device in addition to its economic value relative to alternative therapies. Determinations on tier placement may not be based on the cost of the drug alone.	
Eye Drops Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(i)(28) § 4303(hh) Model Language	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.	
Orally Administered Anticancer Medications Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(i)(12-a) § 4303(q-1) 45 CFR § 156.100 Model Language	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. The insurer shall not achieve compliance with the law by imposing an increase in cost-sharing for IV anti-cancer medications. Therefore, an increase in cost-sharing for IV anti-cancer medications may not be applied to oral anti-cancer medications.	
Mail Order Drugs for Policies or Contracts With a Provider Network Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3221(l)(18) § 4303(kk) Model Language	If this policy or contract form provides coverage for mail order drugs, then this policy or contract shall permit an insured to fill any prescription that may be obtained at a network participating mail order or other non-retail pharmacy, at the insured's option, at a network participating non-mail order retail pharmacy provided that the network participating non-mail order retail pharmacy agrees 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.	
Contraceptive Drugs and Devices Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3221(l)(16) § 4303(cc) Supplement No. 1 to Circular Letter No. 1 (2003) 42 USC § 300gg-13 45 CFR § 147.130 45 CFR § 156.100 Model Language HRSA Guidelines	This policy or contract form provides coverage for contraceptive drugs, devices and other products, including over-the-counter contraceptive drugs, devices, and other products approved by the FDA and as prescribed or otherwise authorized under State or Federal Law. "Over-the counter contraceptive products" means those products provided for in the comprehensive guidelines supported by HRSA. Coverage also includes emergency contraception when provided pursuant to a prescription or order or when lawfully provided over-the-counter. The insured may request coverage for an alternative version of a contraceptive drug, device and other product if the covered contraceptive drug, device and other product is not available or is deemed medically inadvisable, as determined by the insured's attending health care provider. Contraceptive coverage must be provided with no cost-sharing. <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 form may not limit coverage to contraceptive drug and devices prescribed by a physician.</i>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

<p>Prohibition on Prior Authorization for Prescription Drugs for Substance Use Disorder</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3221(l)(7-b) § 4303(l-1) § 4303(l-2) Circular Letter No. 6 (2016) Model Language</p>	<p>This policy or contract form provides coverage for immediate access, without preauthorization, to the formulary forms of a prescription drug otherwise covered under the policy for the treatment of a substance use disorder, including a prescription drug to manage opioid withdrawal and/or stabilization and for the formulary forms of medication for opioid overdose reversal otherwise covered under the policy prescribed or dispensed to an individual covered by the policy.</p>	
<p>Initial Limited Supply of Prescription Opioid Drugs</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3216(i)(33) § 4303(qq) Circular Letter No. 6 (2016) Model Language</p>	<p>If this policy or contract form provides coverage for prescription drugs subject to a copayment, coverage shall be provided for an initial limited prescription for a seven (7) day supply or less of any schedule II, III, or IV opioid prescribed for Acute pain with a copayment that is either proportional between the copayment for a thirty (30) day supply and the amount of drugs the patient was prescribed or equivalent to the copayment for a full thirty (30) day supply, provided that no additional copayments may be charged for any additional prescriptions for the remainder of the thirty (30) day supply.</p>	
<p>Formulary Exceptions</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3242(b) § 4329(b) 45 CFR § 156.122(c) Model Language</p>	<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. The insurer must notify the insured in writing within 72 hours or three (3) business days of receipt of the insured's request. If the insurer approves the request, the insurer must cover the prescription drug while the insured is taking the prescription drug, including any refills.</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. The insurer must notify the insured within 72 hours or three (3) business days of receipt of the insured's request. If the insurer approves the request, the insurer must cover the prescription drug while the insured suffers from the health condition that may seriously jeopardize the insured's health, life or ability to regain maximum function or for the duration of the insured's current course of treatment using the non-formulary prescription drug.</p> <p>If an insurer denies the formulary exception request, the denial is considered a final adverse determination for purposes of Insurance Law and Public Health Law Articles 49 and the insured, insured's designee or the insured's prescribing health care provider shall have the right to request that such denial be reviewed by an external appeal agent certified pursuant to Insurance Law § 4911.</p>	
<p>Disclosure of Formulary</p>	<p>§ 3242(b) § 4329(b) 45 CFR § 156.122(d)(1)</p>	<p>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</p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

		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. The formulary drug list shall clearly identify the preventive prescription drugs that are available without annual deductibles or coinsurance, including co-payments.	
WELLNESS		<i>Use of the model language is required.</i>	
<p>Exercise Facility Reimbursement/Other Wellness Benefits</p> <p>Model Language Used? 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><i>Note: If an insurer is substituting for this benefit, the benefit that is substituted must comply with §3239.</i></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 this substitution or addition differs from the Model Language in the space provided below.</p>	<p>§ 3216(l) § 3239 § 4224 § 4304(l) § 4328 45 CFR § 146.121 45 CFR § 156.100 Model Language</p>	<p>This policy or contract form partially reimburses the student and the student's covered spouse or each covered dependent for certain exercise facility fees or membership fees. All wellness benefits must comply with Insurance Law § 3239.</p> <p>This policy or contract form should provide a detailed description of the wellness program and/or reward being offered as part of the wellness program. All wellness programs and any rewards must have a nexus to accident and health insurance.</p> <p>Participation in the wellness program must be voluntary on the part of the member.</p>	
<u>Benefit explanation:</u>			
VISION CARE		<i>Use of the model language is required.</i>	
<p>Pediatric Vision Care</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3216(l) § 4304(l) § 4328 45 CFR § 156.100 Model Language</p>	<p>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 & frames; and contact lenses.</p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

		Such coverage may be subject to deductibles, copayments and/or coinsurance.	
DENTAL CARE		<i>Use of the model language is required.</i>	
Pediatric Dental Care Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/> Is dental coverage being provided by this filing? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, please explain how the insurer is meeting the requirement to offer the pediatric essential health benefit in the space provided below.	§ 3216(l) § 4304(l) § 4328 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 up to age 19: 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. <i>Note: Insurers are required to offer the pediatric dental essential health benefit as either an embedded benefit (coverage provided by the insurer) or bundled benefit (coverage provided through an arrangement with another insurer).</i> <i>Note: The cosmetic orthodontics benefit is optional. Plans may impose no longer than a 12-month waiting period on the cosmetic orthodontics benefit.</i>	
<u>Benefit explanation:</u>			
ADDITIONAL BENEFITS		The benefits below are optional additional benefits. <i>Use of the model language is required.</i>	
Acupuncture Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	Model Language	This policy or contract form provides coverage for acupuncture.	
Adult Dental Care Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	Model Language	This policy or contract form provides coverage for adult dental care including the following dental care services: emergency dental care; preventive dental care; routine dental care; endodontics; periodontics; prosthodontics; oral surgery; and orthodontics. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Adult Vision Care 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 or 24-month period; one (1) time per plan year, or every other plan year unless more frequent examinations are medically necessary as evidenced by appropriate documentation; prescribed lenses and frames; and contact lenses.	
Advanced Infertility Services Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	Model Language	This policy or contract form provides coverage for advanced infertility services.	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

Retail Health Clinics Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	Model Language	This policy or contract form provides coverage for basic health care services provided on a “walk-in” basis at retail health clinics, normally found in major pharmacies or retail stores. Covered services are typically provided by a physician’s assistant or nurse practitioner. Covered services available at retail health clinics are limited to routine care and treatment of common illnesses.	
Shoe Inserts Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	Model Language	This policy or contract form covers 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 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>			
MAKE AVAILABLE BENEFITS			
Care in a Nursing Home or Skilled Nursing Facility	§ 3221(l)(2) § 4303(d)	This policy or contract form must make available coverage for care in a nursing home, as defined by Public Health Law § 2801, or a skilled nursing facility as defined in 42 USC § 1395, when such services are preceded by a hospital stay of at least three days and further hospitalization would otherwise be necessary.	
Licensed Clinical Social Worker	§ 3221(l)(4) § 4303(i)	If this policy or contract form provides reimbursement for psychiatric or psychological services or for the diagnosis and treatment of mental, nervous or emotional disorders and ailments by physicians, psychiatrists or psychologists, the policy or contract form must make available and if requested by the policyholder or contractholder, provide the same coverage to insureds for the such services when performed by a licensed clinical social worker, within the lawful scope of his or her practice, who is licensed pursuant to Article 154 of the Education Law (Education Law § 7700 et seq.).	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

PERMISSIBLE EXCLUSIONS AND LIMITATIONS		<p><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></p> <p><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, use of the model language is required.</i></p>	Form/Page/Para Reference
Aviation Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	11 NYCRR 52.16(c)(4)(iii) Model Language	This policy or contract form excludes coverage for services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.	
Convalescent and Custodial Care Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	11 NYCRR 52.16(c)(11) Model Language	This policy or contract form excludes coverage for services related to rest cures, custodial care or transportation. Custodial care means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include covered services determined to be medically necessary.	
Conversion Therapy Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	11 NYCRR 52.16(n) Model Language	<p>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 any 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.</p> <p><i>Note: This exclusion is required.</i></p>	
Cosmetic Services Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	11 NYCRR 52.16(c)(5) 11 NYCRR 56 Model Language	This policy or contract form excludes coverage for cosmetic services, prescription drugs, or surgery, except that cosmetic surgery does not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect. Cosmetic surgery does not include surgery determined to be medically necessary. If a claim for a procedure listed in 11 NYCRR 56 is submitted retrospectively and without medical information, any denial will not be subject to utilization review unless medical information is submitted.	
Coverage Inside the United States	§ 3240(a)(1)(B)(iv)	<p>This policy or contract form excludes coverage for care or treatment inside the United States or its possessions except for emergency services, pre-hospital emergency medical services and ambulance services to treat an emergency condition.</p> <p><i>Note: This exclusion may only be included for study abroad coverage issued pursuant to Insurance Law § 3240(a)(1)(B)(iv).</i></p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

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 you to receive the treatment, the costs of managing the research, or costs that would not be covered under the policy or contract form for non-investigational treatments.	
Felony Participation Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(d)(2)(J) § 3221(c) 11 NYCRR 52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for any illness, treatment or medical condition due to participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of a medical condition, including both physical and mental health conditions.	
Foot Care Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	11 NYCRR 52.16(c)(6) Model Language	This policy or contract form excludes coverage for routine foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, this policy or contract form provides coverage for foot care for a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in a covered person's legs or feet.	
Government Facility 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 care or treatment provided in a hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.	
Medically Necessary Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3201(c)(3) Article 49 Model Language	This policy or contract form generally excludes coverage for any health care service, procedure, treatment, test, device or prescription drug that is determined to not be medically necessary; however, coverage will be provided when the denial of services is overturned by an external appeal agent certified by the State. 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 this policy or contract form.	
Medicare or Other Governmental Program	11 NYCRR 52.16(c)(8)	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).	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	11 NYCRR 52.26(c) Model Language	This policy or contract form may exclude Medicare benefits when coverage continues beyond the members eligibility for Medicare, provided appropriate adjustment is made to the premium.	
Military Service Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	11 NYCRR 52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.	
No-Fault Automobile Insurance 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 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.	
Services Separately Billed by Hospital Employees 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 rendered and separately billed by employees of hospitals, laboratories or other institutions.	
Services Provided by a Family Member 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 performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister, or brother of the insured or the insured's spouse.	
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 the policy 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.	
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.	
Workers' Compensation Model Language Used?	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.	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

Yes <input type="checkbox"/> No <input type="checkbox"/>			
CLAIM DETERMINATIONS		<i>Use of the model language is required.</i>	Form/Page/Para Reference
Notice of Claim	§ 3221(a)(8) § 3224-a 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	§ 3221(a)(9) § 4305(m) Model Language	The policy or contract form 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.	
Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>			
GRIEVANCE, UTILIZATION REVIEW AND EXTERNAL APPEAL		<i>Use of the model language is required.</i>	Form/Page/Para Reference
Grievance Procedures	§ 3217-a(a)(7) § 3217-d(a) § 4306-c(a) § 4324(a)(7) § 4802 PHL § 4408(1)(g) PHL § 4408-a 10 NYCRR 98-1.14 42 USC § 300gg-19 29 CFR § 2560.503-1 45 CFR § 147.136 Model Language	A policy or contract form that is a managed care product as defined in § 4801(c), a comprehensive policy that utilizes a network of providers, or an HMO, includes a description of the grievance procedure to be used to resolve disputes between the insurer and the insured, including: <ul style="list-style-type: none"> • The right to file a grievance regarding any dispute between an insured and the insurer; • The right to file a grievance orally when the dispute is about referrals or covered benefits; • The toll-free telephone number which insureds may use to file an oral grievance; • The timeframes and circumstances for expedited and standard grievances; • The right to 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. 	
Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Utilization Review Policies and Procedures	§ 3217-a(a)(3) § 3217-d(d) § 4306-c(d) § 4324(a)(3) Article 49 PHL § 4408(1)(c) 42 USC § 300gg-19 29 CFR § 2560.503-1 45 CFR § 147.136 Model Language	This policy or contract form includes a description of the utilization review policies and procedures, including: <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; 	
Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>			

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

		<ul style="list-style-type: none"> • A notice of the right to an external appeal, together with a description, jointly promulgated by the Commissioner of Health and Superintendent, of the external appeal process and the timeframes for such appeals; and • Further appeal rights, if any. 	
<p>Step Therapy Override Determinations</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 4903(c-1), (c-2), (c-3) Model Language</p>	<p>If the insurer uses step therapy protocols for prescription drugs, the insured, the insured's designee or health care professional may request a step therapy protocol override determination for coverage of a prescription drug selected by the insured's health care professional.</p> <p>A step therapy protocol override determination request must include supporting rationale and documentation from a health care professional, demonstrating that:</p> <ul style="list-style-type: none"> • The required prescription drug(s) is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured; • The required prescription drug(s) is expected to be ineffective based on the insured's known clinical history, condition, and prescription drug regimen; • The insured has tried the required prescription drug(s) while covered by the insurer or under a previous health insurance coverage, or another prescription drug in the same pharmacologic class or with the same mechanism of action, and that prescription drug(s) was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event; • The insured is stable on a prescription drug(s) selected by their health care professional, provided this does not prevent the insurer from requiring the insured to try an AB-rated generic equivalent; or • The required prescription drug(s) is not the insured's best interest because it will likely cause a significant barrier to the insured's adherence to or compliance with the insured's plan of care, will likely worsen a comorbid condition, or will likely decrease the insured's ability to achieve or maintain reasonable functional ability in performing daily activities. <p>Standard Review. The insurer will make a step therapy protocol override determination and provide notification to the insured or the insured's designee and, where appropriate, the insured's health care professional, within 72 hours of receipt of the supporting rationale and documentation.</p> <p>Expedited Review. If the insured has a medical condition that places the insured's health in serious jeopardy without the prescription drug, the insurer will make a step therapy protocol override determination and provide notification to the insured or the insured's designee and the insured's health care professional, within 24 hours of receipt of the supporting rationale and documentation.</p> <p>If the insurer does not make a determination within 72 hours (or 24 hours for expedited reviews) of receipt of the supporting rationale and documentation, the step therapy protocol override request will be approved.</p> <p>If the insurer determines that the step therapy protocol should be overridden, the insurer will authorize immediate coverage for the Prescription Drug. An adverse step therapy override</p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

		determination is eligible for an internal and external appeal pursuant to Article 49 of the Insurance Law. <i>Note: A “step therapy protocol” means a policy, protocol or program that establishes the sequence in which the insurer will approve prescription drugs for a medical condition. When establishing a step therapy protocol, the insurer will use recognized evidence-based and peer reviewed clinical review criteria that also takes into account the needs of atypical patient populations and diagnoses.</i>	
External Appeal Procedures Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	Article 49 PHL Article 49 45 CFR § 147.136 45 CFR § 156.122(c)(3) 42 USC § 300gg-19 Model Language	This policy or contract form includes a description of the external appeal procedures, including: <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. 	
TERMINATION OF COVERAGE		<i>The following are the only termination provisions permissible under the Insurance Law. Use of the model language is required.</i>	Form/Page/Para Reference
Termination for Failure to Pay Premiums Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3221(a)(4) § 3221(p)(2)(A) § 4305(j)(2)(A) § 4306(a) § 4306(g) Model Language	This policy or contract form provides a provision permitting the insurer to terminate coverage if the insured has failed to pay premiums or contributions to the insurer within 30 days of when premiums are due in accordance with the terms of the policy or contract form.	
Termination for Fraud Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3105 § 3221(p)(2)(B) § 4305(j)(2)(B) Model Language	This policy or contract form includes a provision permitting the insurer to terminate the policy or contract if the student has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in writing on an enrollment application or in order to obtain coverage for a service.	
Discontinuation of a Class of Coverage Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3221(p)(2)(D) § 3221(p)(3)(A) § 4305(j)(2)(D) § 4305(j)(3)(A) Model Language	This policy or contract form includes a provision permitting the insurer to discontinue this class of policy or contract upon written notice to each policyholder or contractholder, participant, and beneficiary not less than 90 days prior to the date of discontinuance.	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

Discontinuation of all Policies or Contracts in the Student Market Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3221(p)(2)(D) § 3221(p)(3)(E) § 4305(j)(2)(D) § 4305(j)(3)(E) Model Language	This policy or contract form includes a provision permitting the insurer to discontinue all hospital, surgical and medical expense coverage in the student market upon written notice to the superintendent and to each policyholder or contractholder, participant, and beneficiary at least 180 days prior to the date of discontinuance.	
Termination for Spouses in Cases of Divorce Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(g)(1)(F) § 4304(c)(2)(F) Model Language	If this policy or contract form provides coverage for spouses, 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 Student Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(g)(1)(F) § 4304(c)(2)(F) Model Language	This policy or contract form provides that upon the student's death, the coverage will terminate unless there are dependents covered. If there is coverage for dependents, then coverage will terminate as of the last day of the month for which the premium has been paid.	
Termination by Student Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	Model Language	This policy or contract form provides that termination will occur at the end of the month during which the student 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 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 student makes an intentional misrepresentation of material fact in writing upon his/her enrollment application, coverage may be rescinded if the facts misrepresented would have lead the insurer to refuse to issue the coverage.	
Notice of Termination Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	11 NYCRR 52.18(c) Model Language	Unless otherwise specified under the Insurance Law, notices of nonrenewal and termination shall provide at least 30 days prior written notice.	
Renewal Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(g) § 4304(b)(2) 11 NYCRR 52.17(a)(2) Model Language	Renewal is optional. If renewal is available, the insurer must renew or continue in force such coverage at the option of the student. The policy or contract form must specify the conditions under which the insurer may refuse to renew the policy or contract.	
LOSS OF COVERAGE		<i>Use of the model language is required.</i>	Form/Page/Para Reference
Extension of Benefits Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	11 NYCRR 52.17(a)(15) Model Language	If a covered person is totally disabled on the date that coverage terminates, continued benefits may be available for the treatment of the injury or sickness that has caused the total disability. If a covered person is pregnant on the date that coverage terminates, continued benefits may be available for maternity care.	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

		<p>In the instance of total disability on the date that coverage terminates, the insurer will pay for the care of a covered person during an uninterrupted period of total disability until the first of the following:</p> <ul style="list-style-type: none"> • The date the covered person is no longer totally disabled; or • 90 days from the date the extended benefits began (if benefits are extended based on termination of student status. <p>In the instance of pregnancy on the date that coverage terminates, the insurer will continue to pay for maternity care through delivery and post-partum services directly related to the delivery.</p> <p>The insurer will not pay extended benefits:</p> <ul style="list-style-type: none"> • For any member who is not totally disabled or pregnant on the date coverage ends; or • Beyond the extent to which the insurer would have paid benefits if coverage had not ended. 	
<p>Temporary Suspension Rights for Armed Forces' Members Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3216(a)(13) § 4304(i) 11 NYCRR 52.17(a)(9) Circular Letter No. 7 (2003) USERRA, 38 USC § 4317 Model Language</p>	<p>This policy or contract form provides that:</p> <p>If the student is a member of a reserve component for the armed forces of the United States, including the National Guard, the student may have the right to temporary suspension of coverage during active duty and reinstatement coverage at the end of active duty if:</p> <ul style="list-style-type: none"> • The student's active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided the additional active duty is at the request and for the convenience of the federal government; and • The student's service ends during the Plan Year for which the Certificate/ Policy/Contract is effective. <p>The student must make a written request to have his or her coverage suspended during a period of active duty. Unearned premiums will be refunded during the suspension period. Upon completion of active duty, the student may resume coverage as long as a written application is provided to the insurer and the premium is remitted within 60 days of the termination of active duty.</p>	
<p>Continuation of Coverage</p>	<p>45 CFR§ 147.145(a) Model Language</p>	<p>This policy or contract form contains an optional continuation of coverage provision for up to 90 days.</p> <p>A covered Student, his or her spouse, or his or her child may be able to temporarily continue coverage when any of the following qualifying events occurs:</p> <ul style="list-style-type: none"> • A student may be able to continue coverage if his or her coverage ends due to the termination of the Student's status. • A covered spouse may continue coverage if coverage ends due to termination of the Student's status as a student, divorce or legal separation from the Student, or death of the Student. • A covered child may continue coverage if coverage ends due to termination of the Student's status as a Student, loss of covered child status under the plan rules, or death of the student. <p>Continued coverage will terminate at the earliest of the following applicable events:</p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

		<ul style="list-style-type: none"> • 90 days after the Student's coverage would have terminated because of termination of student status. • If you are a covered spouse or child, the date 90 days after coverage would have terminated due to the death of a Student, divorce or legal separation, the Student's eligibility for Medicare, or the failure to qualify under the definition of "children". • The date a student became covered by an insured or uninsured arrangement that provides hospital, surgical or medical coverage. • The date a student becomes entitled to Medicare. <p>The date the policy or contract terminates. Please Note, if the policy or contract is replaced with similar coverage, the student has the right to become covered under the new policy or contract for the balance of the period remaining for the student's continued coverage.</p>	
GENERAL PROVISIONS			Form/Page/Para Reference
Assignment	23 NYCRR 400 Article 6 of the Financial Services Law; (Chapter 60 of the Laws of 2014) Model Language	The policy or contract form states whether or not assignment is permitted. This policy or contract form must allow assignment of monies due to the insured's health care provider resulting from a surprise bill for covered services or for a bill for emergency services and inpatient services which follow an emergency room visit.	
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) § 4306(e) 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 policyholder or contractholder and insurer.	
Action in Law or Equity Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(d)(1)(K) PHL § 4406-a Model Language	The policy or contract form 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 three (3) years following the time such proof of loss is required by the policy or contract.	
Subrogation Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	General Obligations Law § 5-335 Civil Practice Law and Rules § 4545(a) Model Language	Although not required, if a subrogation provision is included in this policy or contract form, it must comply with General Obligations Law § 5-335 and Civil Practice Law and Rules § 4545(a).	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

<p>Unilateral Modification</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>11 NYCRR 52.17(a)(25) Model Language</p>	<p>Unilateral modifications by an insurer to an existing policy or contract must be made with at least 45 days prior written notice to the policyholder or contractholder. Unilateral modification by the insurer may be made only at the time of renewal. If the policy or contract form requires the policyholder or contractholder to provide written notice to terminate coverage, the notice of the unilateral modification by the insurer must be provided to the policyholder or contractholder no less than 14 days prior to the date by which the policyholder or contractholder is required to provide notice to terminate coverage.</p>	
<p>Non-English Speaking Insureds</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3217-a(a)(15) § 4324(a)(15) PHL § 4408(1)(p) Model Language</p>	<p>This policy or contract form includes a description of how the insurer addresses the needs of non-English speaking insureds.</p>	
<p>Reinstatement After Default</p>	<p>§ 3216(d)(1)(D) § 4306(f) Model Language</p>	<p>This policy or contract form must provide that if the insured defaults in making any payment under the policy or contract, the subsequent acceptance of payment by the insurer or by one of the insurer's authorized agents or brokers shall reinstate the policy or contract.</p>	
<p>SCHEDULE OF BENEFITS</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>		<p><i>Use of the model language is required.</i> This policy or contract form <u>must</u> contain a Schedule of Benefits. All services subject to preauthorization and/or referral requirements <u>must</u> be clearly indicated in the Schedule of Benefits.</p>	<p>Form/Page/Para Reference</p>
<p>Prohibition on Annual or Lifetime Dollar Limits</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3217-f § 4306-e 42 USC § 300gg-11 45 CFR § 147.126 45 CFR § 147.145 Model Language</p>	<p>The policy or contract form may not include an annual or lifetime limit on essential health benefits. Essential health benefits are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorders, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.</p>	
<p>Insured's Financial Responsibility for Payment</p>	<p>§ 3217-a(a)(5) § 4324(a)(5) PHL § 4408(1)(e)</p>	<p>This policy or contract form includes a description of the insured's financial responsibility for payment of premiums, deductibles, copayments and/or coinsurance, and any other charges, annual limits on an insured's financial responsibility, caps on payments for covered services and financial responsibility for non-covered health care procedures, treatment or services.</p> <p>Coinsurance values imposed on an insured should not exceed 50%.</p>	
<p>ADDITIONAL RIDERS</p>			
<p>Out-of-Network Coverage</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If out-of-network coverage is offered, please answer the following:</p>	<p>Model Language</p>	<p>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.</p> <p><i>Note: The Department will not approve more than a 30% differential between in-network and out-of-network coverage unless supported by scholarly literature or actual claims experience of the insurer.</i></p>	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

Out-of-network coverage in the base policy/contract or by rider? Policy/Contract <input type="checkbox"/> Rider <input type="checkbox"/>			
Provider Networks	§ 3241	If the policy or contract uses a network of providers, the insurer must ensure that the network is adequate to meet the health needs of the insureds and provide an appropriate choice of providers sufficient to render the services covered under the policy or contract. The network must be filed in PNDS. If the network has not been filed in PNDS, it must be filed within 60 days of approval. See the Department of Financial Services' website for additional instructions and guidance relating to the submission of networks for review.	
ACTUARIAL SECTION FOR NEW PRODUCT RATE FILINGS ONLY		<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> <p><input type="checkbox"/> The submission contains only application forms, disclosure statements, and/or advertising, OR</p> <p><input type="checkbox"/> The submission is an out-of-state filing pursuant to Section 3201(b)(2), OR</p> <p><input type="checkbox"/> The form submission has no premium rate implications and a letter or actuarial memorandum is enclosed that states and justifies this as appropriate.</p> <p><i>Note: For rate changes to existing products, do NOT complete this section – complete the Existing Products-Rate Requirements section below.</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. 	
Justification of Rates to be included in Actuarial Memorandum	§ 3201 § 3240(h) 11 NYCRR 52.40(e)	<ul style="list-style-type: none"> • Expected claim costs. • Actuarial justification for claim costs and other assumptions. Issuers may establish one or more separate risk pools for an institution of higher education if the distinction between or among groups of students (or dependents of students) who form the risk pool is based on a bona fide school-related classification and not based on health status. The rates must reflect the claims experience of the individuals who comprise the risk pool. Any adjustments to rates within a risk pool must be explicitly shown and actuarially justified. • Experience of a preceding issuer or issuers may be relied on to the extent available and credible. • Describe rating methodology including experience rating formula. • Provide all elements of the formula, such as claims run-off, credibility and trend factors. The formula should be sufficiently clear such that two different individuals evaluating a particular case will arrive at the same premium for that case. • Provide the range of commission rates and other fees. Include the criteria used to determine the actual commission amount paid including any applicable fees for a particular case. • Non-claim expense components as a percentage of gross premium, including but not limited to administrative expenses, commissions, brokerage fees, taxes and fees, risk and profit margins. • Include support for the Actuarial Value for all plan designs. 	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

		<ul style="list-style-type: none"> Expected loss ratio(s) – with actuarial justification. The manner of calculation of the loss ratio as determined by the superintendent is the ratio of incurred claims plus quality improvements to earned premium minus taxes. 	
Experience Pooling Options	§ 3240(g)	<p>The issuer may choose to pool the student accident and health experience in a manner including</p> <ul style="list-style-type: none"> By policy form for all policyholders; By policyholder; or <p>By all policy forms for all policy holders.</p>	
Reserve Basis	11 NYCRR 94	<ul style="list-style-type: none"> 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	§ 3240(i)	<p>The expected loss ratio is: _____ %.</p> <p>A MLR rebate calculation report is due to HHS by August 31st of each year following the year to be reported upon. Submitting a copy of the federal HHS Medical Loss Ratio Annual reporting form to the superintendent by August 31st satisfies the reporting requirement of Insurance Law Section 3240(i).</p> <ul style="list-style-type: none"> For companies that submitted policy data aggregated nationally, an additional report showing New York only experience must also be submitted to the superintendent along with the HHS reporting form. 	
RATE MANUAL	11 NYCRR 52.40(e)	<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, issue limits, and renewal conditions. Description of rating classes, factors and premium discounts. Experience rating formula, including all elements of the formula such as credibility factors, completion factors and applicable rating adjustments. The formula should be sufficiently clear such that two different individuals evaluating a particular case will arrive at the same premium for that case. Examples of rate calculations. Outline of marketing rules and methods. Commission schedule. Non-claim expenses as a percent of premium. Underwriting guidelines. Expected loss ratio(s). 	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

ACTUARIAL SECTION FOR EXISTING PRODUCT RATE FILINGS ONLY		<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> <ul style="list-style-type: none"> <i>Note: For new products, do NOT complete this section – complete the New Products-Rate Requirements section above instead.</i> 	
ACTUARIAL MEMORANDUM	11NYCRR52.40(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. 	
Justification of Rates to be included in Actuarial Memorandum	11 NYCRR 52.40(e) § 3240(h)	<ul style="list-style-type: none"> Description of proposed changes in coverage, rates, commissions, underwriting rules, etc. History of previous New York rate revisions. Description, in detail, of policy benefits. Provide complete annual and total New York and nationwide claims experience respectively, since inception, including: <ul style="list-style-type: none"> Earned premium; Paid and incurred claims; and Incurred loss ratios. Derivation of the proposed rate revision in detail, including: <ul style="list-style-type: none"> Demonstration that the expected future loss ratio and expected lifetime loss ratio are at least as large as the disclosed loss ratio Actuarial justification of proposed rates revision (increase/decrease). Issuers may establish one or more separate risk pools for an institution of higher education if the distinction between or among groups of students (or dependents of students) who form the risk pool is based on a bona fide school-related classification and not based on a health status. The rates must reflect the claims experience of the individuals who comprise the risk pool. Any adjustments to rates within a risk pool must be explicitly shown and actuarially justified. Non-claim expense components as a percentage of gross premium, including administrative expenses, commissions, brokerage fees, taxes and fees, risk and profit margins. Impact on rates as a result of each of the changes with actuarial justification. Include support for the Actuarial Value for all plan designs. Expected loss ratio(s) after the proposed changes. The manner of calculation of the loss ratio as determined by the superintendent is the ratio of incurred claims plus quality improvements to earned premium minus taxes and fees. 	
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. 	

NEW YORK DEPARTMENT OF FINANCIAL SERVICES

		<ul style="list-style-type: none"> • The rates are not unfairly discriminatory. 	
Expected Loss Ratio Certification	§ 3240(i)	<p>The expected loss ratio is: _____ %.</p> <p>A MLR rebate calculation report is due to HHS by August 31st of each year following the year to be reported upon. Submitting a copy of the federal HHS Medical Loss Ratio Annual reporting form to the superintendent by August 31st satisfies the reporting requirement of Insurance Law Section 3240(i).</p> <ul style="list-style-type: none"> • For companies that submitted policy data aggregated nationally, an additional report showing New York only experience must also be submitted to the superintendent along with the HHS reporting form. 	
REVISED RATE MANUAL PAGES	11 NYCRR 52.40(e)	<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, issue limits, and renewal conditions. • Description of revised rating classes, factors and discounts. • Experience rating formula, including all elements of the formula such as credibility factors, completion factors and applicable rating adjustments. The formula should be sufficiently clear such that two different individuals evaluating a particular case will arrive at the same premium for that case. • Examples of rate calculations. • Outline of marketing rules and methods. • Commission schedule. • Non-claim expenses as a percent of premium. • Underwriting guidelines. • Expected loss ratio(s). 	