NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Review Standards for Dental Insurance for Group Commercial Insurers Subject to Article 32

(As of 10/11/12)

Instructions for SERFF Checklist:

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

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

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

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

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

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

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

LINE OF BUSINESS: **Group Health - Dental** LINE(S) OF INSURANCE CODES

CODE: **H10G** **Health Dental** **H10G.000**

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

REVIEW REQUIREMENT	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD IN FILING
GENERAL REQUIREMENTS FOR ALL FILINGS	*Note: Unless otherwise noted, all references are to Insurance Law, Insurance Regulations, and Department Circular Letters and OGC opinions*	*Note: This is a checklist for dental insurance which falls under limited benefits health insurance as defined by 11 NYCRR 52.10. This checklist is intended to provide guidance in the preparation of policy forms for submission and is not intended as a substitute for statute or regulation.*	Form/Page/ Para Reference
Complete Policy Submission or Pages/Rider/Endorsement		This submission contains a complete policy form. Yes ☐ No ☐ If this submission contains insert pages, riders or endorsements, then the policy in its entirety complies with all the statutory and regulatory provisions stated below. Yes ☐ No ☐ (If no is checked, explain in the space provided above.) This rider, insert pages, or endorsements are being attached to a policy that was approved by the Department on _____, submission number _____.	
Form Requirements	11 NYCRR 52.31(b), (c), (d), (e), (f), (l)	Each form in the filing must meet the following requirements: • This form contains no strikeouts. § 52.31(b) • This form is submitted in duplicate. § 52.31(c) • This form is designated by a form number made up of numerical digits and/or letters in the lower left-hand corner of the first page. § 52.31(d) • This form is submitted in the form intended for actual use. § 52.31(e) • All blank spaces are filled in with hypothetical data. § 52.31(f) • If the form contains illustrative material, it does so only for items that may vary from case to case, such as names, dates, eligibility requirements, premiums and schedules for determining the amount of insurance for each person. § 52.31(l) • Portions of other provisions, such as insuring clauses, benefit provisions, restrictions and	

		termination of coverage provisions, may be submitted as variable, if suitably indicated by red ink, bracketing or underlining and an explanatory memorandum must be submitted that clearly indicates the nature and scope of the variations to be used. An explanatory memorandum may not use terms such as "will conform to law" or "as requested by policyholder" to describe the variable material. § 52.31(l)	
Flesch Score	§ 3102(c)	Provide Flesch score certification (the Flesch score should be at least 45). The number of words, sentences and syllables in the form should be set forth as part of the certification, which must be signed by an officer of the company.	
Letter of Submission	11 NYCRR 52.33 Circular Letter No. 33 (1999) Supplement 1 to CL No. 33 (1999)	The filing must include a letter of submission in duplicate, signed by a representative of the company authorized to submit forms for filing or approval, that contains the following: • The identifying form number of each form submitted. § 52.33(a) • If the form is a policy, the letter must indicate that the policy is submitted pursuant to 11 NYCRR 52.10. § 52.33(b) • Whether the form is new or supersedes an approved or filed form. § 52.33(c) • If the form supersedes an approved or filed form, the letter must state the form number and date of approval or filing of the superseded form and any material differences from the superseded form. § 52.33(d) • If the approval of the superseded form is still pending, the letter must include the form number, control number assigned by the Department and the submission date. § 52.33(d) • If the form had previously been submitted for preliminary review, the letter must include a reference to the previous submission and a statement setting out either that the form agrees precisely with the previous submission; or the differences from the form submitted for preliminary review. § 52.33(e) • If the form is submitted in accordance with 11 NYCRR 52.32(c), the letter must identify the prefiled group coverage. § 52.33(f) • If the form is other than a policy form, the letter must identify the form number and approval date of the policy or policies with which it will be used. If the form is for general use, the Department may accept a description of the type of policy with which it may be used in lieu of the form number and approval date. § 52.33(g) • If the form is a policy, the letter must identify the form numbers and dates of approval of any applications previously approved to be used with the policy unless the application is required to be attached to the policy upon submission. § 52.33(h) • If the policy is designed to be used with insert pages, the letter must contain a statement of the insert page forms which must always be included in the policy and a list of all optional pages, together with an explanation of their use. § 52.33(i) *Note: Submission letters should advise as to whether the policy is intended for internet sales and should describe any proposed electronic procedures and/or the proposed use of electronic signatures associated with the sale of the policy.*	
Group Status and Recognition	§ 4235 § 3201(b)(1) 11 NYCRR 59	The submission letter should include a statement that policy forms will be sold to a group specified in Insurance Law § 4235(c)(1). However, a more detailed statement must be included where discretionary group status is sought under Insurance Law § 4235(c)(1)(M). See below. The letter should indicate whether the submission is for general use or is submitted on a one case basis. If the submission is for use on a one case basis, the group must be identified along with the subpart of Insurance Law § 4235(c)(1) in which the group fits and a confirmation that the group meets all of the	

		requirements of the identified subpart. Requests for discretionary group recognition, pursuant to Insurance Law § 4235(c)(1)(M), must be accompanied by written documentation that demonstrates that the proposed group meets each and every element stated in the named statute. The documentation must also make clear that the request for discretionary group recognition is not a subterfuge, evasion technique, or a marketing tool to avoid compliance with other statutory or regulatory requirements and recognized marketing mechanisms. This provision is not intended to allow approval of groups recognized in the various subparagraphs of § 4235(c)(1) or § 4237(a)(3), but for which the proposed discretionary group does not meet one or more of the requisites specifically required or proscribed by § 4235 or § 4237. The request for allowance of a discretionary group must be granted before it may be used. Pursuant to § 3201(b)(1) and Insurance Regulation 123, an accident and health certificate is deemed delivered in New York and subject to review and approval regardless of the actual place of delivery, if the policy is issued to certain groups. In these cases, the group certificate is reviewed for compliance with New York Law. The group policy that is delivered out-of-state is not reviewed.	
Prefiled Group Coverage	11 NYCRR 52.32	A copy of the letter of confirmation sent to the policyholder by the insurer must be submitted to the Department within 30 days after the date the insurer agrees to provide insurance and must include the following: • The effective date of coverage. § 52.32(a)(1) • The nature and extent of the benefits or change in benefits as then known. § 52.32(a)(2) • That the contractual forms may be executed and issued for delivery only after filing with or approval by the Department. § 52.32(a)(3) • That if the forms are not filed or approved or are disapproved, the parties will be returned to the status quo insofar as possible, or the coverage will be modified retroactively to meet all requirements necessary for approval. § 52.32(a)(4) *Note: At the time the insurer agrees to provide insurance, it cannot have been reasonably possible to obtain approval prior to the effective date of coverage because the policyholder requested the insurer provide immediate coverage. Also, the actual forms must be submitted for approval within six months from the date the insurer agrees to provide insurance. § 52.32(c). Failure to meet any of the conditions within the time specified shall be a violation of the Insurance Law, unless reasons for delay, including its probable extent, satisfactory to the Department are submitted to the Department within the respective times specified.*	
Table of Contents	§ 3102(c)(1)(G)	A table of contents is required for policies that are over 3,000 words or more than 3 pages regardless of the number of words.	
Discrimination	§ 2606, § 2607, & § 2608	This form does not contain any unfair discrimination provisions because of race, color, creed, national origin, disability (including treatment of mental disability), sex, and marital status.	
APPLICATION FORMS			Form/Page/Para Reference
Authorization	11 NYCRR 420.18(b)	If the application includes an authorization to disclose non-public personal health information, the authorization specifies the length of time the authorization will remain valid. The maximum allowable period is 24 months.	
Fraud Warning Statement	§ 403(d) 11 NYCRR 86.4	The application contains the prescribed fraud warning statement.	

Pre-Existing Conditions	11 NYCRR 52.51(j)	If the application is used with a policy that contains a "pre-existing conditions" provision, the application must include a statement describing the provision.	
Prohibited Questions and Provisions	§ 3204 11 NYCRR 52.51	The application does NOT contain: Questions about the applicant's race. A provision that changes the terms of the policy to which it is attached. A statement that the applicant has not withheld any information or concealed any facts. An agreement that an untrue or false answer material to the risk will render the policy void. An agreement that acceptance of any policy issued upon the application will constitute a ratification of any changes or amendments made by the insurer and inserted in the application, except to conform to § 3204(d).	
POLICY FORM PROVISIONS			Form/Page/Para Reference
COVER PAGE			
Insurer name		This policy contains the name and full address of the issuing insurer on the front or back cover.	
Signature of Company Officer		The signature of company officer(s) appears prominently on the policy (such as on the cover).	
ELIGIBILITY			
Spouse Model Language Used? Yes ☐ No ☐	§ 4235(f)(1)(A) Circular Letter No. 27 (2008) Model Language	If dependent coverage is selected by the policyholder, this policy provides coverage for the lawful spouse, unless there is a divorce or annulment of the marriage. This includes the recognition of marriages between same-sex partners legally performed in this state and in other jurisdictions.	
Dependents	§4235(f)(1)(A) §3221(a)(7)	If dependent coverage is selected by the policyholder, this policy provides coverage of dependents, and states the age restrictions for the insurance provided. *Note: Pursuant to § 2608-a, an insurer may not deny enrollment to a child under the health coverage of the child's parent on the ground that the child was born out of wedlock, the child is not claimed as a dependent on the parent's federal income tax return, or the child does not reside with the parent or in the insurer's service area.*	
Unmarried Disabled Children Model Language Used? Yes ☐ No ☐	§ 4235(f)(1)(A)(ii) Model Language	If dependent coverage is selected by the policyholder, this policy provides coverage for unmarried disabled children, regardless of age, who are incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap, and who became so incapable prior to attainment of the age at which dependent coverage would otherwise terminate. *Note: Such coverage shall not terminate while the policy remains in effect and the dependent remains in such condition and is chiefly dependent on the insured for support and maintenance, if the insured has within 31 days of such dependent's attainment of the limiting age submitted proof of such dependent's incapacity.*	
Newborn Infants	§ 4235(f)(2)	If dependent coverage is selected by the policyholder, this policy provides coverage of newborn infants, including newly born infants adopted by the insured if the insured takes physical custody of the infant upon the infant's release from the hospital and files a petition pursuant to § 115-c of the domestic relations law within 30 days of birth; and provided further that no notice of revocation to the adoption has been filed and consent to the adoption has not been revoked, shall be effective from the moment of birth, except that in cases of adoption, coverage of the initial hospital stay shall not be	

		required where a birth parent has insurance coverage available for the infant's care. *Note: In the case of individual or two-person coverage, the insurer must permit the insured to elect such coverage of newborn infants from the moment of birth. If notification and/or payment of an additional premium is required to make coverage effective for a newborn infant, the coverage may provide that such notice and/or payment be made within no less than 30 days of the day of birth to make coverage effective from the moment of birth.*	
Adopted Children and Step-Children	11NYCRR52.18(e)(2); (3)	If dependent coverage is selected by the policyholder, this policy provides that adopted children and stepchildren dependent upon the insured are eligible for coverage on the same basis as natural children. Further, a family policy covering a proposed adoptive parent, on whom the child is dependent, shall provide that such child be eligible for coverage on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption.	
Domestic Partners Model Language Used? Yes ☐ No ☐	§4235(f)(1)(A) OGC Opinion 01-11-23 Model Language	This policy may cover domestic partners, who are financially interdependent on the employee or member, but such coverage is not required. If such coverage is provided, the policy shall require the applicant to provide the following: • Registration as a domestic partner or an affidavit of domestic partnership • Proof of cohabitation • Proof of financial interdependency by evidence of two or more of the following: joint bank account; joint credit or charge card; joint obligation on a loan; status as authorized signatory on the partner's bank account, credit card or charge card; joint ownership or holding of investments; joint ownership of residence; joint ownership of real estate other than residence; listing of both partners as tenants on lease; shared rental payments; shared household expenses; shared household budget for purposes of receiving government benefits; joint ownership of major items of personal property; joint ownership of a motor vehicle; joint responsibility for child care; shared child-care expenses; execution of wills naming each other as executor and/or beneficiary; designation as beneficiary under the other's life insurance policy or retirement benefits account; mutual grant of durable power of attorney; mutual grant of authority to make health care decisions; affidavit by creditor or other individual able to testify to partners' financial interdependence; other items of sufficient proof to establish economic interdependency under the circumstances of the particular case.	
New Family Members		The policy describes the requirements to add new family members to the policy.	
New Employees	§3221(a)(3)	New employees or members of the class must be added to the class for which they are eligible.	
DENTAL BENEFITS		*The following benefits must be included in the policy.*	
Alternative Service	Article 49	If this policy has a provision which states that the insurer will review certain services before they are performed and, if determined by the insurer, will pay benefits for a lower cost alternative service, then the denial of the requested service is treated as an adverse determination subject to internal and external appeal rights contained in Article 49 of the Insurance Law.	
Experimental/Investigational Services Recommended by an External Appeal Agent	§ 3221(k)(12) Article 49	This policy shall not exclude coverage of a health care service on the basis that it is experimental or investigational, or rendered as part of a clinical trial, if coverage of the service has been recommended by an external appeal agent pursuant to an external appeal performed according to Title II of Article 49.	
Temporomandibular Joint Disfunction (TMJ) Exclusion	OCG Opinions 92-49 & 06-08-08	If the policy contains an exclusion for the treatment of temporomandibular joint dysfunction, then it may not exclude the treatment of temporomandibular joint dysfunction where the treatment is dental in nature, unless a medical necessity determination is made and the insured receives all utilization review and external appeal rights under Article 49.	

MANDATORY STANDARD PROVISIONS		*Note: These provisions MUST be included in each policy. The provision must be no less favorable to the insured than the statutory provision.*	
Cost of Service	§ 3201(c)(3) 11NYCRR52.1(c)	If the cost of the service is less than the copayment for the service, the patient is responsible for the lesser amount.	
Renewal	§ 3221(a)(5) 11NYCRR52.18(c)	The policy must specify the conditions under which the insurer may refuse to renew the policy.	
Continuation Coverage	COBRA, Title X of Public Law 99-272	If the policy subject to COBRA, then it must a provision regarding continuation coverage in accordance with COBRA. An employee or member who wishes continuation of coverage must request continuation in writing and remit the first premium payment within the 60-day period following the later of: the date of termination or the date the employee is sent notice by first class mail of the right to continuation by the group policyholder. The continuation benefits terminate: • 18 months after the date the employee or member's benefits would otherwise have terminated because of termination of employment or membership. • In the case of an eligible dependent, 36 months after the date such person's benefits would otherwise have terminated by reason of the death of the employee or member, divorce or legal separation of the employee or member from his or her spouse, the employee or member becoming eligible for Medicare, or a dependent child ceasing to be a dependent child under the generally applicable requirements of the policy. • On the date which the employee or member becomes entitled to coverage under Medicare. • On the date which the employee or member becomes covered by an insured or uninsured arrangement which provides hospital, surgical or medical coverage for individuals in a group which does not contain any exclusion or limitation with respect to any pre-existing condition. • The end of the period for which premiums were made if the employee or member fails to make timely payment.	
Suspension of Coverage	USERRA, 38 USC § 4317	This policy provides that: • Any covered persons who are also members of a reserve component of the armed forces of the United States, including the National Guard, shall be entitled, upon request, to have their coverage suspended during a period of active duty. • The insurer will refund any unearned premiums for the period of the suspension. • Persons covered by this policy shall be entitled to resumption of coverage, upon written application and payment of the required premium within 60 days after the date of termination of the period of active duty. • Coverage shall be retroactive to the date of termination of the period of active duty. • No exclusion or waiting period may be imposed for any condition unless the condition arose during the period of active duty and the condition has been determined by the secretary of veterans affairs to be a condition incurred in the line of duty or a waiting period had been imposed and was not completed at the time of suspension.	
Extension of Benefits	§3201(c)	Upon termination of insurance, whether due to termination of employment, termination of eligibility or termination of the policy, an extension of benefits shall be provided for a period of no less than 30 days for completion of a dental procedure that was started before the covered person's coverage ended.	
Misstatement	§3221(a)(1)	The policy must provide that statements by the insured must be in writing and signed in order to be used to reduce benefits or avoid the insurance.	

Changes	§3221(a)(2)	The policy must provide that no agent has the authority to change the policy or waive any provisions and that no change shall be valid unless approved by an officer of the insurer and evidenced by endorsement on the policy, or by amendment to the policy signed by the policyholder and insurer.	
Premiums	§3221(a)(4)	The policy must provide that premiums are to be paid to the insurer by the employer or such other person designated, by the due date, with a grace period as specified.	
Certificate	§3221(a)(6)	The insurer shall issue either to the employer or person in whose name the policy is issued, for delivery to each member of the insured group, a certificate setting forth in summary form a statement of the essential features of the insurance coverage.	
Notice of Claim	§3221(a)(8)	The policy must provide that the insured has a minimum of 20 days to provide the insurer with written notice of claim. However, failure to give notice within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such notice and the notice was provided as soon as reasonably possible.	
Proof of Loss	§ 3221(a)(9)	The policy must provide that the insured has a minimum of 120 days to provide the insurer with proof of loss after the date of such loss. However, failure to give proof within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such proof and the proof was provided as soon as reasonably possible	
Filing Proof of Loss	§ 3221(a)(10)	The policy must provide that the insurer will furnish the insured or the policyholder such forms as are usually furnished for filing proof of loss. If such forms are not furnished before the expiration of fifteen days after the insurer receives notice of the claim, the insured shall be deemed to have complied with the proof of loss requirements upon submitting within the time fixed written proof covering the occurrence, character and extent of the loss for which the claim is made.	
Examination	§3221(a)(11)	The insurer shall have the right and opportunity to examine the insured making a claim as required during the pendency of the claim and the right and opportunity to conduct an autopsy in the case of death unless prohibited by law.	
Action in Law or Equity	§3221(a)(14)	The policy must provide that no action in law or equity shall be brought to recover on the policy prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy and that no such action shall be brought after the expiration of two years following the time such proof of loss is required by the policy.	
Prompt Payment of Claims	§3224-a	This policy must pay claims to the policyholder, covered person or health care provider according to §3224-a.	
Notice of Termination	11 NYCRR 52.18(c)	Unless otherwise specified under the Insurance Law, notices of nonrenewal or termination shall provide at least 30 days prior written notice.	
OPTIONAL STANDARD PROVISIONS		*If optional standard provisions are included in the policy, they must comply with the following.*	
Pre-Existing Condition Exclusion	11NYCRR52.18(a)(5)	The policy may not exclude, limit or reduce coverage for a loss due to a preexisting condition for a period greater than 12 months following the effective date of an insured's coverage. Where a policy is delivered or issued for delivery to a group which includes persons aged 65 or older, such policy shall not contain any provision which excludes, limits or reduces coverage for a loss due to a preexisting condition for those aged 65 or older for a period greater than six months following the effective date of the insured's coverage. A preexisting condition is defined as one for which medical advice was given, treatment was recommended by or received from a physician, within six months before the effective date of an insured's coverage. *Note: Waiting periods for benefits are viewed as preexisting condition exclusions. Waiting periods for benefits or "phase in" of full benefits cannot be longer than one year.*	

Wellness Programs	§ 3239	Wellness programs are permitted and are defined as programs designed to promote health and prevent disease that may contain rewards and incentives for participation. A wellness program may include but is not limited to: the use of a health risk assessment tool; a smoking cessation program; a weight management program; a stress management program; a worker injury prevention program; a nutrition education program; and a health or fitness incentive program. A wellness program may use rewards and incentives for participation provided that where the group health insurance policy or subscriber contract is required to be community-rated, the rewards and incentives shall not include a discounted premium rate or a rebate or refund of premium. Permissible rewards and incentives include: full or partial reimbursement of the cost of participating in smoking cessation or weight management programs; full or partial reimbursement of the cost of membership in a health club or fitness center; the waiver or reduction of copayments, coinsurance and deductibles for preventive services covered under the group policy or subscriber contract; and monetary rewards in the form of gift cards or gift certificates, so long as the recipient of the reward is encouraged to use the reward for a product or a service that **promotes good health**, such as healthy cook books, over the counter vitamins or exercise equipment. Participation in the wellness program must be available to similarly situated members of the group and must be voluntary on the part of the member. The terms of the wellness program must be set forth in the policy or contract.	
Subrogation	General Obligations Law § 5-335 Civil Practice Law and Rules § 4545(a)	If a subrogation provision is included in this policy or certificate, it must comply with NYS General Obligations Law § 5-335 and Civil Practice Law and Rules § 4545(a).	
Coordination of Benefits Model Language Used? Yes ☐ No ☐	11NYCRR52.23 Model Language	If this policy contains a coordination of benefits provision, then it must comply with 11 NYCRR 52.23.	
Prior Authorization Requirements	§ 3217-a(a)(2) § 3238	This policy includes a description of all prior authorization or other requirements for treatments and services. If the policy requires pre-authorization for health care services, it will do so in compliance with Section 3238 of the Insurance Law. The Department will not approve a penalty greater than 50% for failure to obtain pre-authorization of health care services.	
Utilization Review Policies and Procedures Model Language Used? Yes ☐ No ☐	Article 49 29 CFR 2560.503-1 Model Language	If the insurer is performing utilization review of dental services, then this policy includes a description, consistent with Article 49, of the utilization review policies and procedures including: • The circumstances under which utilization review will be undertaken; • the toll-free telephone number of the utilization review agent; • the timeframes under which utilization review decisions must be made for prospective, retrospective and concurrent decisions; • the right to reconsideration; • the right to appeal, including the expedited and standard appeals processes and the timeframes for such appeals; • the right to designate a representative; • a notice that all denials of claims will be made by qualified clinical personnel and that all notices of denials will include information about the basis of the decision; • a notice of the right to an external appeal, together with a description, jointly promulgated by the	

		commissioner of health and superintendent of insurance, of the external appeal process and the timeframes for such appeals; and • further appeal rights, if any.	
External Appeal Procedures Model Language Used? Yes ☐ No ☐	Article 49 Model Language	If the insurer is performing utilization review of dental services, then this policy includes a description of the external appeal procedures, including: • Instructions on how to request an external appeal; • The circumstances under which an external appeal may be pursued (service denied as not medically necessary or experimental/investigational, including clinical trials and treatment for rare diseases; and for managed care health insurance contracts as defined as §4801(c), out-of-network denials when the service is not available in-network and the insurer recommends an alternate treatment); and • The timeframe for submitting an external appeal.	
Grievance Procedures	29 CFR §2560.503-1	If this policy is issued to an employer group, then this policy contains grievance procedures consistent with the federal Department of Labor Claims Payment regulation.	
Unilateral Modification	11NYCRR52.18(a)(8)	Unilateral modifications by an insurer to an existing policy must be made with at least 30 days prior written notice to the policyholder. If the policy requires the policy holder to provide written notice to terminate coverage, the notice of the unilateral modification by the insurer must be provided to such policy holder no less than 14 days prior to the date by which the policy holder is required to provide notice to terminate coverage.	
PERMISSIBLE EXCLUSIONS AND LIMITATIONS		*No policy shall limit or exclude coverage by type of illness, accident, treatment or medical condition, with an exception for the following exclusions which may, but are not required to be included in the policy.*	
War or Act of War, Participation in Felony, Riot or Insurrection, Service in the Armed Forces	11NYCRR52.16(c)(4)(i)	This policy excludes coverage for illness, accident, treatment or medical condition arising out of war or act of war (whether declared or undeclared), participation in a felony, riot or insurrection and service in the Armed Forces or units auxiliary thereto. Exclusions for terrorism are not included in this permissible exclusion.	
Suicide, Attempted Suicide, Intentionally Self-Inflicted Injury	11NYCRR52.16(c)(4)(ii)	This policy excludes coverage for illness, accident, treatment or medical condition arising out of suicide, attempted suicide or intentionally self-inflicted injury.	
Aviation	11NYCRR52.16(c)(4)(iii)	This policy excludes coverage for illness, accident, treatment or medical condition arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.	
Cosmetic Surgery	11NYCRR52.16(c)(5) 11NYCRR56	This policy excludes coverage for cosmetic surgery, except that cosmetic surgery does not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect. *Note: All exclusions for cosmetic surgery must be based on medical necessity, with the insured receiving all utilization review and external appeal rights under Article 49, except as otherwise provided in 11NYCRR56.*	
Foot Care	11NYCRR52.16(c)(6)	This policy excludes coverage for foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet.	
Mandatory No-Fault Recovered or Recoverable	11NYCRR52.16(c)(8)	This policy excludes benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable.	

Medicare, Other Governmental Programs and Workers' Compensation	11NYCRR52.16(c)(8)	This policy excludes coverage for treatment provided in a government hospital; benefits provided under Medicare or other governmental programs (except Medicaid); any state or federal workers' compensation, employers' liability or occupational disease law, unless where otherwise provided in State or Federal statute.	
Hospital Employees	11NYCRR52.16(c)(8)	This policy excludes coverage for services rendered and separately billed by employees of hospitals, laboratories or other institutions.	
Immediate Family	11NYCRR52.16(c)(8)	This policy excludes coverage for services performed by a member of the insured's immediate family.	
Services For Which No Charge Normally Made	11NYCRR52.16(c)(8)	This policy excludes coverage for services for which no charge is normally made.	
Eyeglasses and Hearing Aids	11NYCRR52.16(c)(10)	This policy excludes coverage for eyeglasses, hearing aids and examination for the prescription or fitting thereof. *Note: It is impermissible to exclude lasik and other surgeries or treatments to the eyes, unless a medical necessity determination is made and the insured receives all utilization review and external appeal rights under Article 49.*	
Custodial Care and Transportation	11NYCRR52.16(c)(11)	This policy excludes coverage for custodial care as defined in 11NYCRR52.16(l) and for transportation. *Note: All exclusions for custodial care that exceed the definition contained in 11NYCRR52.16(l) must be based on medical necessity, with the insured receiving all utilization review and external appeal rights.*	
Rest Cures	11NYCRR52.16(c)(11)	This policy excludes coverage for rest cures.	
Outside the U.S.	11NYCRR52.16(c)(12)	This policy excludes coverage while the insured is outside the United States, its possessions or the countries of Canada or Mexico.	
Illegal Occupation	§ 3221(c) § 3216(d)(2)(J)	The policy excludes losses to which a contributing cause was the insured's participation in a felony or attempted felony. If included, the exclusion can be no more restrictive than to provide that the insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.	
Intoxicants and Narcotics	§ 3221(c) § 3216(d)(2)(K)	The policy excludes losses in consequence of the insured's being intoxicated or under the influence of a narcotic. If included, the exclusion can be no more restrictive than to provide that the insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.	
PROVISIONS THAT MUST BE INCLUDED IN THE POLICY OR WRITTEN DISCLOSURE STATEMENT		*Insurers shall provide insureds and the following written disclosure information, which may be incorporated into or accompany the certificate. In the event of any inconsistency between any separate written disclosure statement and the policy, the terms of the policy shall be controlling.*	
Benefits and Exclusions	11NYCRR52.54	This certificate includes a description of coverage provisions; health care benefits; benefit maximums, including benefit limitations; and exclusions of coverage.	
Disclosure Statement	11NYCRR52.54(c)(2)(viii)	The certificate contains the following disclosure statement: The insurance evidenced by this certificate provides DENTAL insurance only.	

PROVIDER NETWORKS	§ 3201(c)	If the policy will be used in conjunction with a provider network, then the following items or information must be submitted: • Participating provider directory; • Whether the provider network is capitated; • Provider selection criteria; • Quality assurance procedures; • Breakdown of geographic service area by county; • The underlying assumptions for the network regarding ratios of providers to insureds, the travel times and distances to participating providers; • Sample participating provider agreement; and, • Listing of providers by specialty type. The Department will not approve more than a 30% differential between in-network and out-of-network coverage unless supported by scholarly literature or actual claims experience of the insurer.	
ACTUARIAL SECTION FOR NEW PRODUCT RATE FILINGS ONLY		*Complete this section for all new product forms filings except those filings where a rate filing is unnecessary because: (**select one**)* ☐ *The submission contains only application forms, disclosure statements, and/or advertising, OR* ☐ *The submission is an out-of-state filing pursuant to Section 3201(b)(2), OR* ☐ *The form submission has no premium rate implications and a letter or actuarial memorandum is enclosed that states and justifies this as appropriate.* *For rate changes to existing products, do NOT complete this section – complete the Existing Products-Rate Requirements section below.*	Form/Page/ Para Reference
ACTUARIAL MEMORANDUM	11NYCRR52.40(a)(1)	Actuarial qualifications: a. Member of the Society of Actuaries; and b. Meet the "Qualification Standards of Actuarial Opinion" as adopted by the American Academy of Actuaries.	
Justification of Rates	§3103 & §3221 11NYCRR52.40(e) 11NYCRR52.40(f) 11NYCRR360.10 11NYCRR360.11 11NYCRR52.45(f) 11NYCRR59.5(b)	Small Group: a. Provide community rated rating methodology and assumptions used in calculating rates. b. Provide rating methodology and assumptions used in rate calculation for mental health coverage provided pursuant to §3221(l)(5). c. Actuarial justification for the use of claim costs and other assumptions. d. Non-claim expense components as a percentage of gross premium. e. Expected loss ratio(s). Large Group: a. Development of manual rates including actuarial assumptions used and justification thereof. b. Provide rating methodology including experience rating formula. c. Provide all elements of the formula, such as claims run-off, credibility and trend factors. d. Provide actuarial justification of all assumptions used. e. Provide rating methodology and assumptions used in rate calculation for mental health coverage provided pursuant to §3221(l)(5). f. Non-claim expense components as a percentage of gross premium. g. Expected loss ratio(s).	

Loss Ratios	11NYCRR52.45(f) 11NYCRR59.5(b)	Expected loss ratio(s) – with actuarial justification	
Reserve Basis	11NYCRR94	Description of bases for unpaid claim liabilities and extra reserves (if any).	
Actuarial Certification	11NYCRR52.40(a)(1)	a. The filing is in compliance with all applicable laws and regulations of the State of New York. b. The filing is in compliance with Actuarial Standard of Practice No. 8 "Regulatory Filings for Rates and Financial Projections for Health Plans" as adopted by the Actuarial Standards Board. c. The expected loss ratio meets the minimum requirements of the State of New York. d. The benefits are reasonable in relation to the premiums charged. e. The rates are not unfairly discriminatory.	
Expected Loss Ratio Certification		The expected loss ratio is:	
GROUP RATE MANUAL	11NYCRR52.40(e)(2) 11NYCRR52.40(e)(3) 11NYCRR52.45(f) 11NYCRR59.5(b)	a. Table of contents. b. Rate pages. c. Insurer name on each consecutively numbered rate page. d. Identification by form number of each policy, rider, or endorsement to which the rates apply. e. Brief description of benefits, types of coverage, limitations, exclusions, and issue limits. f. Description of rating classes, factors and premium discounts. g. Examples of rate calculations. h. Commission schedule(s) and fees. i. Underwriting guidelines and/or underwriting manual. j. Expected loss ratio(s).	
ACTUARIAL SECTION FOR EXISTING PRODUCT RATE FILINGS ONLY		*Complete this section for all filings of changes in rates (e.g., rate increases/decreases or changes in rate calculation rules or procedures), commissions or underwriting to existing products.* *(For new products, do NOT complete this section – complete the New Products-Rate Requirements section above instead.)*	
ACTUARIAL MEMORANDUM	11NYCRR52.40(a)(1)	Actuarial qualifications: a. Member of the Society of Actuaries; and b. Meet the "Qualification Standards of Actuarial Opinion" as adopted by the American Academy of Actuaries.	
Justification of Rates	11NYCRR52.40(e) 11NYCRR52.40(g)(3) 11NYCRR52.45 11NYCRR59.5(b)	a. Description of proposed changes in coverage, rates, commissions, underwriting rules, etc. b. History of previous New York rate revisions. c. Provide New York and nationwide claims experience respectively, including: (i) Earned premium; (ii) Paid and incurred claims; and (iii) Incurred loss ratios. d. Actuarial justification of proposed rates revision (increase/decrease). e. Non-claim expense components as a percentage of gross premium. f. Impact on rates as a result of each of the changes with actuarial justification. g. Expected loss ratio(s) after the proposed changes.	
Actuarial Certification	11NYCRR52.40(a)(1)	a. The filing is in compliance with all applicable laws and regulations of the State of New York. b. The filing is in compliance with Actuarial Standard of Practice No. 8 "Regulatory Filings for Rates and Financial Projections for Health Plans". c. The expected loss ratio meets the minimum requirements of the State of New York. d. The benefits are reasonable in relation to the premiums charged. e. The rates are not unfairly discriminatory.	

Expected Loss Ratio Certification		The expected loss ratio is:	
REVISED RATE MANUAL PAGES	11NYCRR52.40(e)(2) 11NYCRR52.45(f) 11NYCRR59.5(b)	a. Table of contents. b. Rate pages. c. Insurer name on each consecutively numbered rate page. d. Identification by form number of each policy, rider, or endorsement to which the rates apply. e. Brief description of benefits, types of coverage, limitations, exclusions, and issue limits. f. Description of revised rating classes, factors and discounts. g. Examples of rate calculations. h. Commission schedule(s) and fees. i. Underwriting guidelines and/or underwriting manual. j. Expected loss ratio(s).	