NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Review Standards for

Student Accident and Health Insurance Checklist
As of 2/10/16

Instructions for SERFF Checklist:

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

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

- Policy or Contract – Also complete all sections
- Rider or endorsement – Also complete all items relevant to the form being submitted in all sections.

C. For filing of initial rates, complete the section entitled "Actuarial Section for New Product Rate Filings Only" in addition to completion of the applicable form sections identified above. For filing of rate changes to existing products (increases, decreases, or change in rate calculation rules or procedures), complete the "Actuarial Section for Existing Product Rate Filings Only" section. For filing of any other changes to rate or underwriting manuals (e.g., changes in commissions or underwriting), complete the "Actuarial Section for Existing Product Rate Filings Only" section.

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

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

F. **Instructions for Citations:** All citations to Insurance regulations link to the Department of State's website and an unofficial copy of the NYCRR. Please select title 11 for Insurance regulations. Most of the pertinent form and rate regulations are located in Chapter III Policy 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	LINE(S) OF INSURANCE	SUB- TOI
H04	Health-Blanket Accident/Sickness	H04.001 Student

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

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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 of Financial Services Circular Letters and OGC opinions*	*Note: This checklist is intended to provide guidance in the preparation of policy forms for submission and is not intended as a substitute for statute or regulation.*	Form/Page/Para Reference
Complete Policy or Contract Submission or Pages/Rider/Endorsement	§3221(a)(1) § 3204 § 4306(d) § 4306(e)	This submission contains a complete policy or contract form. Yes ☐ No ☐ No statement by the individual in his application for a contract or policy shall avoid the contract or be used in legal proceedings thereunder, unless such application or an exact copy thereof is included in or attached to such contract. No agent or representative of such corporation and no broker, other than an officer or officers designated therein, is authorized to change the contract or waive any of its provisions. If this submission contains insert pages, riders or endorsements, then the policy or contract in its entirety complies with all the statutory and regulatory provisions stated below. Yes ☐ No ☐ (If no is checked, explain in the space provided above.) This rider, insert pages, or endorsements are being attached to a policy or contract that was approved by	

		the Department on __________, submission number __________.	
Form Requirements	11 NYCRR 52.31(b), (c), (d), (e), (f), (l)	Each form in the filing must meet the following requirements: • This form contains no strikeouts. § 52.31(b) • This form is designated by a form number made up of numerical digits and/or letters in the lower left-hand corner of the first page. § 52.31(d) • This form is submitted in the form intended for actual use. § 52.31(e) • All blank spaces are filled in with hypothetical data. § 52.31(f) • If the form contains illustrative material, it does so only for items that may vary from case to case, such as names, dates, eligibility requirements, premiums and schedules for determining the amount of insurance for each person. § 52.31(l) • Portions of other provisions, such as insuring clauses, benefit provisions, restrictions and termination of coverage provisions, may be submitted as variable, if suitably indicated by red ink, bracketing or underlining and an explanatory memorandum must be submitted that clearly indicates the nature and scope of the variations to be used. An explanatory memorandum may not use terms such as "will conform to law" or "as requested by group" to describe the variable material. § 52.31(l) • All policy or contract forms must be placed on the Form Schedule tab in SERFF.	
Flesch Score	§ 3102(c)	Provide Flesch score certification (the Flesch score should be at least 45). The number of words, sentences and syllables in the form should be set forth as part of the certification, which must be signed by an officer of the company.	
SERFF Filing Description or Letter of Submission	11 NYCRR 52.33 Circular Letter No. 33 (1999) Supplement 1 to CL No. 33 (1999)	The filing must include a SERFF filing description or a letter of submission that contains the following: • The identifying form number of each form submitted. § 52.33(a) • If the form is a policy or contract, the letter must indicate that the policy or contract is submitted pursuant to 11 NYCRR 52.7. § 52.33(b) • Whether the form is new or supersedes an approved or filed form. § 52.33(c) • If the form supersedes an approved or filed form, the letter must state the form number and date of approval or filing of the superseded form and any material differences from the superseded form. § 52.33(d) • If the approval of the superseded form is still pending, the letter must include the form number, control number assigned by the Department and the submission date. § 52.33(d) • If the form had previously been submitted for preliminary review, the letter must include a reference to the previous submission and a statement setting out either that the form agrees precisely with the previous submission; or the differences from the form submitted for preliminary review. § 52.33(e) • If the form is other than a policy or contract form, the letter must identify the form number and approval date of the policy or contract with which it will be used. If the form is for general use, the Department may accept a description of the type of policy or contract with 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 unless the application is required to be attached to the policy or contract upon submission. § 52.33(h)	

		• If the policy or contract is designed to be used with insert pages, the letter must contain a statement of the insert page forms which must always be included in the policy or contract and a list of all optional pages, together with an explanation of their use. § 52.33(i) • Note: Submission letters and or the SERFF filing description should advise as to whether the policy or contract 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.	
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, or 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 immediately above the insured's signature.	
Prohibited Questions and Provisions	§ 3204 §3221(q) 11 NYCRR 52.51	The application does NOT contain: • Questions as to the applicant's health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of domestic violence), disability or the applicant's race. • A provision that changes the terms of the policy to which it is attached. • A statement that the applicant has not withheld any information or concealed any facts. • An agreement that an untrue or false answer material to the risk will render the policy void. • An agreement that acceptance of any policy issued upon the application will constitute a ratification of any changes or amendments made by the insurer and inserted in the application, except to conform to §3204(d).	
Verification of Compliance with Pediatric Essential Dental Health Benefit.	45 CFR § 156.150	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: 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 B. If you answered "yes", please provide the name of the company issuing the stand-alone dental coverage. ___________ If you answered "no", we will provide you coverage of the pediatric dental essential health benefit.	
POLICY OR CONTRACT FORM PROVISIONS			Form/Page/Para Reference
COVER PAGE	Model Language		

Model Language Used? Yes ☐ No ☐			
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	This contract or policy 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 contract or policy contains a brief description of the contract on its first page.	
Table of Contents Model Language Used? Yes ☐ No ☐	§ 3102(c)(1)(G) Model Language	A table of contents is required.	
DEFINITIONS Model Language Used? Yes ☐ No ☐	§ 3217 Model Language	*For a complete listing of the definitions click on the adjacent Model Language link.*	Form/Page/Para Reference
Services Performed at Comprehensive Care Center for Eating Disorders	§ 3221(k)(14) § 4303(dd)	This policy or contract form may not exclude coverage for services covered under the policy or contract when provided by a comprehensive care center for eating disorders pursuant to Article 27-J of the Public Health Law. Reimbursement for services provided through such comprehensive care centers shall, to the extent possible or practicable, be structured in a manner to facilitate the individualized, comprehensive and integrated plans of care which such centers' network of practitioners and providers are required to provide.	
HOW THIS COVERAGE WORKS			Form/Page/Para Reference
Selecting a Primary Care Provider			
Selecting, Accessing and Changing Participating Providers Model Language Used? Yes ☐ No ☐	§ 3217-a(a)(9) § 3217-a(a)(10) § 4324(a)(9); (10) PHL § 4408(1)(i) Model Language	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.	
Designation of Primary Care Provider ("PCP") & Access to Pediatricians Does this product require a PCP to be designated? Yes ☐ No ☐	§ 3217-e § 4306-d PHL §4403(7) 42 USC § 300gg-19a 45 CFR § 147.138(a) Model Language	If the policy or contract requires the designation of a primary care provider ("PCP"), this policy or contract form permits an insured to designate any participating PCP who is available to accept the insured. If designation of a PCP for a child is required, the insured is permitted to designate a physician who specializes in pediatrics as the child's PCP if the provider is in-network and available to accept the child.	

Model Language Used? Yes ☐ No ☐			
Direct Access to OB/GYN Services Does this product require a PCP to be designated? Yes ☐ No ☐ Model Language Used? Yes ☐ No ☐	§ 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	If the policy or contract requires the designation of a PCP, it must provide a female insured direct access to primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions from a qualified participating provider of such services of her choice or for any care related to pregnancy provided that: • 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.	
Direct Access to Maternal Depression Screenings	§ 3217-g § 4306-f § 4406-f PHL § 2500-k	To the extent a policy or contract provides coverage for maternal depression screening, no insurer may limit a insured's direct access to screening and referral for maternal depression, as defined in subdivision one of section twenty-five hundred-l of the public health law, from a provider of obstetrical, gynecologic, or pediatric services of her choice; provided that the insured's access to such services, coverage and choice of provider is otherwise subject to the terms and conditions of the contract or policy under which the insured is covered.	
Preauthorization			
Preauthorization Requirements Model Language Used? Yes ☐ No ☐	§ 3217-a(a)(2) § 3238 § 4324(a)(1) 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.	
Medical Necessity			
Definition of Medical Necessity Model Language Used? Yes ☐ No ☐	§ 3217-a(a)(1) § 4324(a)(1) § 4408(1)(a) Model Language	This policy or contract form includes a definition of "medical necessity" used in determining whether benefits will be covered.	
Contact Information Model Language Used? Yes ☐ No ☐	§ 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.	
Protection from Surprise Bills Model Language Used? Yes ☐ No ☐	Art. 6 of the Financial Services Law, Chapter 60 of the Laws of 2014 Model Language	For services received on or after April 1, 2015, the policy or contract form shall provide that the insured will be held harmless for any non-participating physician charges for a surprise bill that exceeds an insured's copayment, coinsurance or deductible if the insured assigns benefits in writing to the non-participating physician. The non-participating physician may only bill an insured for a copayment, coinsurance or deductible.	
Case Management		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	

Model Language Used? Yes ☐ No ☐		conditions.	
ACCESS TO CARE AND TRANSITIONAL CARE			
Referral to Non-Participating Providers Model Language Used? Yes ☐ No ☐	§ 3217-a(a)(11) § 3217-d(d) § 4306-c(d) § 4324(a)(11) PHL § 4408(1)(k) § 4403(6)(a) § 4804(a) Model Language	A policy or contract must describe how an insured may obtain a referral 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.	
Specialty Care Provider as PCP Model Language Used? Yes ☐ No ☐	§ 3217-a(a)(13) § 3217-d(b) § 4324(a)(13) § 4306-C(b) PHL § 4408(1)(m) PHL § 4403(6)(c) § 4804(b) Model Language	If this policy or contract form requires (i) the designation of a PCP, and (ii) that specialty care must be provided pursuant to a referral from a PCP, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, is permitted to request that a specialist be designated as their PCP to provide or coordinate the insured's medical care and describe the procedure for requesting and obtaining a specialist as a PCP.	
Standing Referrals or Authorizations Model Language Used? Yes ☐ No ☐	§ 3217-a(a)(12) § 3217-d(b) § 4324(a)(12) § 4306-C(b) PHL § 4408(1)(l) § 4804(c) Model Language	If this policy or contract form requires (i) the designation of a PCP, and (ii) that specialty care must be provided pursuant to a referral from a PCP, 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	
Specialty Care Center Model Language Used? Yes ☐ No ☐	§ 3217-a(a)(14) § 3217-d(b) § 4324(a)(14) § 4306-C(b) PHL § 4408(1)(n) PHL § 4403(6)(d) § 4804(d) Model Language	If this policy or contract form requires (i) the designation of a PCP, and (ii) that specialty care must be provided pursuant to a referral 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.	
Transitional Care When a Provider Leaves the Network Model Language Used? Yes ☐ No ☐	§ 3217-d(c) § 4306-C(c) § 4804(e) PHL § 4403(6)(e) Model Language	If an insured is in an ongoing course of treatment when a provider leaves the network, then the policy or contract form must describe how an insured may to continue to receive treatment for the ongoing treatment from the former participating provider for up to 90 days from the date the provider's contractual obligation to provide services terminated. If the insured is pregnant and in the second or third trimester, the insured may be able to continue care with a former participating provider through delivery and any postpartum care directly related to the delivery.	

		In order for the insured to continue to receive care for up to 90 days or through a pregnancy with a former participating provider, the provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of the insurer's contractual agreement with the provider and must also agree to provide the insurer with the necessary medical information related to the insured's care and adhere to the insurer's policies and procedures, including those for assuring quality of care, obtaining preauthorization, referrals, 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.	
Transitional Care For a New Member in a Course of Treatment Model Language Used? Yes ☐ No ☐	§ 3217-d(c) § 4306-C(c) § 4804(f) PHL § 4403(6)(f) Model Language	If an insured is in an ongoing course of treatment with a non-participating provider when the insured's coverage becomes effective for (i) a life-threatening disease or condition or a degenerative and disabling condition or disease, or (ii) for care for pregnancy if the insured is in the second or third trimester, then this policy or contract form must describe how the insured may continue to receive care for the ongoing course of treatment from the non-participating provider for up to 60 days from the effective date of the insured's coverage. The insured may continue care through delivery and any post-partum services directly related to the delivery. In order for the insured to continue to receive care for up to 60 days or through pregnancy, the non-participating provider must agree to accept as payment the insurer's fees for such services. The provider must also agree to provide the insurer with necessary medical information related to the insured's care and to adhere to the insurer's policies and procedures including those for assuring quality of care, obtaining preauthorization, referrals, and a treatment plan approved by the insurer. If the provider agrees to the conditions, the care is treated as if being received from a participating provider.	
COST-SHARING EXPENSES AND ALLOWED AMOUNT			
Cost of Service Model Language Used? Yes ☐ No ☐	§ 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 ☐ No ☐	IRC § 223(c)(2)(A)(ii) 42 U.S.C. § 300gg-6 45 C.F.R. § 155.20 45 C.F.R. § 156.20 Model Language	The cost-sharing for in-network services may not exceed the dollar amounts in effect under § 223(c)(2)(A)(ii) of the Internal Revenue Code. For 2015, the amounts are $6,600 for individual coverage and $13,200 for other than individual coverage (e.g., individual/spouse, parent and child/children and family).	
Non-Participating Providers and Non-Authorized Services Model Language Used? Yes ☐ No ☐	§ 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 ☐ No ☐	§ 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.	
Protection from Surprise Bills and IDR Process (Recommended) Model Language Used? Yes ☐ No ☐	Article 6 of the Financial Services Law (Chapter 60 of the Laws of 2014) Model Language	The policy form shall provide that the insured will be held harmless for any non-participating physician charges for a surprise bill that exceeds an insured's copayment, coinsurance or deductible if the insured assigns benefits in writing to the non-participating physician. The non-participating physician may only bill an insured for a copayment, coinsurance or deductible. The policy or contract form also includes a description of the independent dispute resolution process.	
WHO IS COVERED Model Language Used? Yes ☐ No ☐	Model Language		Form/Page/Para Reference
Person to Whom Contract is Issued	§ 4304(d)	This policy or contract provides coverage for the person to whom the contract is issued.	
Spouse	§ 4304(d) Circular Letter No. 27 (2008) Model Language	For individual, 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 legally performed in this state and in other jurisdictions.	
Dependents	§ 3221(a)(7) § 4235(f)(1)(A)(i) § 4305(c)(1) 42 USC § 300gg-14 26 CFR §§ 144.101, 146.101, 147.100 and 147.120 Model Language	Dependent coverage is optional and may include the student's spouse and/or children. If dependent coverage is selected by the group, this policy or contract form provides coverage of children until the age of 26. *Note: Pursuant to § 2608-a of the Insurance Law, an insurer may not deny enrollment to a child under the health coverage of the child's parent on the ground that the child was born out of wedlock, the child is not claimed as a dependent on the parent's federal income tax return, or the child does not reside with the parent or in the insurer's service area*	
Unmarried Disabled Children	§ 4304(d) § 3216(a)(4)(C) 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. *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.	
Newborn Infants	§ 4304(d) § 3216(c)(4)(C) Model Language 45 CFR § 155.420 45 CFR § 155.725	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, 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 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.*	
Adopted Children and Step-Children	11 NYCRR 52.17(a)(30), (31)	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.	
Domestic Partners	§ 4304(d)(1) OGC Opinion 01-11-23 Model Language	This policy or contract form may cover domestic partners, who are financially interdependent on the employee, but such coverage is not required. If such coverage is provided, the policy or contract form shall require the applicant to provide the following: • Registration as a domestic partner, where such registry exists, or an affidavit of domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six (6) months; • Proof of cohabitation; and • Proof of financial interdependency by evidence of two (2) or more of the following: joint bank account; joint credit or charge card; joint obligation on a loan; status as authorized signatory on the partner's bank account, credit card or charge card; joint ownership or holding of investments; joint ownership of residence; joint ownership of real estate other than residence; listing of both partners as tenants on lease; shared rental payments; shared household expenses; shared household budget for purposes of receiving government 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.	
Enrollment Periods	45 CFR § 155.410 45 CFR § 155.420	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.	

	45 CFR § 155.305 Model Language		
MANDATORY COVERED ESSENTIAL HEALTH BENEFITS	§ 3240(d)	**Except where noted below, the following benefits must be included in the policy or contract form.** 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. The categories of benefits that may be substituted are: • Preventive/Wellness/Chronic Disease Management • Rehabilitative and Habilitative	Form/Page/Para Reference
Benefits and Exclusions	§ 4306	This contract or policy includes a statement of the nature of the benefits to be furnished and the period during which they will be furnished and a detailed statement of any excluded or excepted benefits. The excepted benefits in this contract or policy appear with the same prominence as the benefits to which they apply.	
PREVENTIVE CARE			
Primary and Preventive Health Services Model Language Used? Yes ☐ No ☐	§ 3221(l)(8) § 4303(j), Circular Letter No. 3 (1994) Circular Letter No. 13 (2006) Required Immunizations 42 USC § 300gg-13 45 CFR §147.130 45 CFR § 156.100	This policy or contract form includes the following coverage for primary and preventive health services for a covered child from the date of birth through the age of 19: • 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. Such coverage shall not be subject to deductibles, copayments and/or coinsurance. *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.*	
Federally Mandated Preventive Health Services Model Language Used? Yes ☐ No ☐	§ 3221(l)(8) 45 CFR § 156.100 Model Language HRSA Guidelines	This policy or contract form includes coverage for the following preventive care and screenings for children and adults with no cost-sharing: • Evidence-based items or services for children and adults with a rating of “A” or “B” by the U.S. Preventive Services Task Force (“USPSTF”). • Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. • Preventive care and screenings for infants, children and adolescents in guidelines supported by the Health Resources and Services Administration (“HRSA”).	

		• Preventive care and screenings for women in guidelines supported by the HRSA. Such coverage shall not be subject to deductibles, copayments and/or coinsurance. *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.*	
Cervical Cytology Screening Model Language Used? Yes ☐ No ☐	§ 3221(l)(14) § 4303(t) 42 USC § 300gg-13 45 CFR § 147.130 Model Language HRSA Guidelines	This policy or contract form includes 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 a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines.	
Mammography Screening Model Language Used? Yes ☐ No ☐	§ 3221(l)(11) § 4303(p) 42 USC § 300gg-13 45 CFR §147.130 Model Language HRSA Guidelines	This policy or contract form includes the following coverage for mammography screening for occult breast cancer: • Upon the recommendation of a physician, a mammogram at any age for covered persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer. • A single, baseline mammogram for covered persons age 35-39, inclusive. • An annual mammogram for covered persons age 40 and older. • Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are covered whenever they are medically necessary. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with HRSA guidelines. *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.*	
Family Planning & Reproductive Health Services Model Language Used? Yes ☐ No ☐	§ 3216(i)(10) § 3216(l) § 4328 45 CFR § 156.100 Model Language 42 USC § 300gg-13 HRSA Guidelines	This policy or contract form includes coverage for family planning services which consist of federal Food and Drug Administration ("FDA") approved contraceptive methods prescribed by a provider (not covered under the prescription drug benefits), counseling on use of contraceptives, related topics and sterilization procedures for women. Such coverage shall not be subject to deductibles, copayments and/or coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. This policy or contract form includes coverage for vasectomies. Such coverage may be subject to deductibles, copayments and/or coinsurance.	

		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.	
Bone Mineral Density Measurements or Tests, Drugs and Devices Model Language Used? Yes ☐ No ☐	§ 3221(k)(13) § 4303(bb) 42 USC § 300gg-13 45 CFR § 147.130 Model Language	This policy or contract form includes 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: • 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. 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. *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.*	
Prostate Cancer Screening Model Language Used? Yes ☐ No ☐	§ 3221(l)(11-a) § 4303(z-1) Model Language	This policy or contract form includes coverage for the diagnostic screening for prostate cancer including: • 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. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent of the New York State Department of Financial Services ("Superintendent") and as are consistent with other benefits within the policy or contract form.	
AMBULANCE, EMERGENCY SERVICES AND URGENT CARE			
Ambulance and Pre-	§ 3221(l)(15)	**Emergency Ambulance Transportation:**	

Hospital Emergency Medical Services Model Language Used? Yes ☐ No ☐	§ 4303(aa) Model Language	This policy or contract form includes coverage for pre-hospital emergency medical services for the treatment of an emergency condition when such services are provided by an ambulance service. "Pre-hospital emergency medical services" means the prompt evaluation and treatment of an emergency condition and/or non-airborne transportation to a hospital. The services must be provided by an ambulance service issued a certificate under the Public Health Law. 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: • 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. An ambulance service may not charge or seek reimbursement from the insured for pre-hospital emergency medical services except for the collection of any applicable copayment, deductible or coinsurance. This policy or contract form includes 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. This policy or contract form includes coverage for pre-hospital emergency medical services and emergency ambulance transportation worldwide. **Non-Emergency Ambulance Transportation:** 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: • 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.	
Emergency Services Model Language Used? Yes ☐ No ☐	§ 3217-a(a)(8) §3221(k)(4) § 4303(a)(2) § 4900(c) Circular Letter No.1 (2002) PHL § 4408(1)(h)	This policy or contract form includes coverage for the treatment of an emergency condition in a hospital: • 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;	

	10 NYCRR § 98-1.13 42 USC § 300gg-19a 45 CFR § 147.138(b) 45 CFR § 156.100 Model Language	• The cost-sharing (copayment 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. • . *Note: The following definitions must be used:* *"Emergency condition" means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the person afflicted with such condition 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.* *With respect to an emergency condition, "emergency services" means: (i) a medical screening examination as required under 42 USC § 1395dd, which is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and (ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under 42 USC § 1395dd to stabilize the patient. For purposes of this paragraph" to stabilize" means, with respect to an emergency condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the insured from a facility or to deliver a newborn child (including the placenta).*	
Urgent Care Services Model Language Used? Yes ☐ No ☐	§ 3216(l) 45 CFR § 156.100	This policy or contract form includes coverage for urgent care. Urgent care is medical care for an illness, injury or condition that is serious enough for a reasonable person to seek care right away, but not so severe as to require emergency care.	
OUTPATIENT SERVICES, INPATIENT SERVICES, EQUIPMENT AND DEVICES			
Advanced Imaging	§ 3216(l)	This policy or contract form provides coverage for PET scans, MRI, nuclear medicine, and CAT scans.	

Model Language Used? Yes ☐ No ☐	45 CFR § 156.100 Model Language	Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Allergy Testing and Treatment Model Language Used? Yes ☐ No ☐	§ 3216(l) 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 ☐ No ☐	§ 3216(l) 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 ☐ No ☐	§ 3216(l) 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for chemotherapy in an outpatient facility or in a professional provider office. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Chiropractic Care Model Language Used? Yes ☐ No ☐	§ 3221(k)11 § 4303(y) Model Language	This policy or contract form includes coverage for chiropractic care in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment, or subluxation in the vertebral column. Chiropractic care and services may be subject to reasonable deductible, copayment and coinsurance amounts, reasonable fee or benefit limits, and reasonable utilization review, provided that any such amounts, limits and review: shall not function to direct treatment in a manner discriminative against chiropractic care and individually and collectively shall be no more restrictive than those applicable under the coverage to care or services provided by other health care professionals in the diagnosis, treatment and management of the same or similar conditions, injuries, complaints, disorders or ailments even if differing nomenclature is used to describe the condition, injury, complaint, disorder or ailment. *Note: The Department interprets this mandate to mean that policy or contract forms may not subject a visit to a chiropractor or to a provider of chiropractic care to higher cost-sharing than that which applies to other specialty office visits under the policy or contract. Additionally, a policy or contract may not impose a greater level of utilization review to chiropractic care and services than that which applies to specialty office care in general under the policy or contract. This means, for example, that a policy or contract may not require pre-certification or preauthorization of chiropractic care and services if it does not require the same for specialty office visits in general.*	
Clinical Trials Model Language Used?	42 USC § 300gg-8 Model Language	This policy or contract form provides coverage for the routine patient costs for participation in an “approved clinical trial” and such coverage shall not be subject to utilization review if the insured is: (i) eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease	

Yes ☐ No ☐		or condition; and (ii) referred by a participating provider who has concluded that the insured's participation in the approved clinical trial would be appropriate. . An "approved clinical trial" means a phase I, II III, or IV clinical trial that is: (i) a federally funded or approved trial; (ii) conducted under an investigational drug application reviewed by the FDA; or (iii) a drug trial that is exempt from having to make an investigational new drug application.	
Dialysis Coverage Model Language Used? Yes ☐ No ☐	§ 3216(l) § 4303(gg) 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for dialysis treatment of an acute of chronic kidney ailment. If the policy or contract form does not otherwise cover out-of-network services, dialysis treatment or services provided by a non-participating provider must be covered if the following conditions are met: • The out-of-network provider is duly licensed to practice and authorized to provide such treatment; • The out-of-network provider is located outside the service area of the insurer; • The in-network provider treating the insured for the condition issues a written order stating that the dialysis treatment is necessary; • The insured notifies the insurer in writing 30 days in advance of the proposed date(s) of the out-of-network dialysis treatment and attaches the written order of the in-network provider. If the insured must travel on sudden notice due to family or other emergency, shorter notice may be permitted, provided that the insurer has a reasonable opportunity to review the travel and treatment plans of the insured; • The insurer has the right to pre-approve the dialysis treatment schedule; and • Such coverage may be limited to 10 out-of-network treatments in a calendar year. 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.	
Outpatient Habilitative Services Model Language Used? Yes ☐ No ☐ Is this benefit being substituted? Yes ☐ No ☐ Are additional benefits being added to this EHB category? Yes ☐ No ☐	§ 3216(l) 45 CFR § 156.100 Model Language	This policy or contract form includes 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 lifetime. Such coverage may be subject to deductibles, copayments and/or coinsurance.	

If yes, please explain how this substitution or addition differs from the standard benefit in the space provided below.			
Benefit explanation:			
Home Health Services Model Language Used? Yes ☐ No ☐	§ 3221(k)(1) § 4303(a)(3) Model Language	This policy or contract form includes coverage of home care for not less than 40 visits in a plan year for each person covered under the policy or contract if hospitalization or confinement in a nursing facility would otherwise be required. Home care must be provided by an agency possessing a valid certificate of approval or license issued pursuant to Article 36 of the Public Health Law and shall consist of one (1) or more of the following: • Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse. • Part-time or intermittent home health aide services which consist primarily of caring for the patient. • Physical, occupational or speech therapy if provided by the home health service or agency. • Medical supplies, prescription drugs and medications prescribed by a physician and laboratory services by or on behalf of a certified or licensed home health agency. • Each visit by a member of a home care team shall be considered as one (1) home care visit. • Four (4) hours of home health aide service shall be considered as one (1) home care visit	
Treatment of Correctable Medical Conditions that Cause Infertility/Infertility Treatments Model Language Used? Yes ☐ No ☐	§ 3221(k)(6) § 4303(s) Definition of Infertility OGC Opinion 05-11-10 Model Language	This policy or contract form shall not exclude coverage for hospital, surgical or medical care for the diagnosis and treatment of correctable medical conditions otherwise covered under the policy or contract solely because the medical condition results in infertility. • Coverage shall not exclude surgical or medical procedures which would correct malformation, disease or dysfunction resulting in infertility. • Coverage shall not exclude diagnostic tests and procedures including hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysterogram, post coital tests, testis biopsy, semen analysis, blood tests, ultrasound and artificial insemination, or prescription drugs if prescription drug coverage is otherwise provided under the policy or contract. • Coverage shall be provided for persons aged 21-44 years; however, coverage beyond this age range is not precluded. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract. This mandate does not require coverage of the following treatments in connection with infertility: • In vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers; • The reversal of elective sterilizations; • The cost for an ovum donor or donor sperm;	

		• Sperm storage costs; • Cryopreservation and storage of embryos; • Ovulation predictor kits; • Reversal of tubal ligations; • Sex change procedures; • Cloning; or • Medical or surgical services or procedures determined to be experimental. These are the only infertility treatments that may be expressly excluded in the policy or contract form.	
Infusion Therapy Model Language Used? Yes ☐ No ☐	45 CFR § 156.100 § 3216(i)(15-a)(A) § 3216(l) Model Language	This policy or contract form includes coverage for infusion therapy which is the administration of drugs using specialized delivery systems which otherwise would have required hospitalization. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Interruption of Pregnancy Model Language Used? Yes ☐ No ☐	§3216(l) 45 CFR § 156.100 Model Language	This policy or contract form includes coverage for therapeutic abortions. Non-therapeutic abortions in cases of rape, incest or fetal malformation are also covered. Elective abortions are covered for one (1) procedure per member, per year. *Note: Plans must include the one procedure limit and may provide coverage that is more favorable.*	
Laboratory Procedures, Diagnostic Testing and Radiology Services Model Language Used? Yes ☐ No ☐	§ 3216(l) 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.	
Medications for Use in the Office Model Language Used? Yes ☐ No ☐	45 CFR § 156.100 Model Language	This policy or contract form provides coverage for medications and injectables (excluding self-injectables) used by an insured's 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.	
Office Visits Model Language Used? Yes ☐ No ☐	§ 3216(l) 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 ☐ No ☐	§ 3216(i)(5) § 3216(l) 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	§ 3221(k)(2)	This policy or contract form includes coverage for preadmission testing ordered by a physician	

Model Language Used? Yes ☐ No ☐	§ 4303(a)(1) Model Language	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 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.	
Outpatient Rehabilitative Services Model Language Used? Yes ☐ No ☐ Is this benefit being substituted? Yes ☐ No ☐ Are additional benefits being added to this EHB category? Yes ☐ No ☐ If yes, please explain how this substitution or addition differs from the standard benefit in the space provided below.	§ 3216(l) 45 CFR § 156.100 Model Language	This policy or contract form includes 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 lifetime. For purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy. 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. Speech, physical and occupational therapy services must begin within six (6) months of the later to occur: • 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. In no event will the therapy continue beyond 365 days after such event. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Benefit explanation:			
Second Medical Opinion for Cancer Diagnosis Model Language Used? Yes ☐ No ☐	§ 3221(k)(9) § 4303(w) Model Language	This policy or contract form includes 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. • 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. 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.	
Second Surgical Opinion Model Language Used? Yes ☐ No ☐	§ 3221(k)(3) § 4303(b) Circular Letter No. 29 (1979) Model Language	This policy or contract form includes coverage for a second surgical opinion by a qualified physician on the need for surgery. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Mandatory Second Surgical Opinion Model Language Used? Yes ☐ No ☐	§ 4303(b) Circular Letter No. 29 (1979) 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 ☐ No ☐	45 CFR § 156.100 Model Language	This policy or contract form includes coverage for a second opinion in cases when a subscriber 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 ☐ No ☐	§ 3216(l) 11 NYCRR § 52.6 45 CFR § 156.100 Model Language	This policy or contract form includes 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 ☐ No ☐	§ 3216(l) 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: • 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.	
Mastectomy Care Model Language Used? Yes ☐ No ☐	§ 3221(k)(8) § 4303(v) Women's Health and Cancer Rights Act of 1998, 29 USC 1185(b) Model Language	This policy or contract form includes coverage for a period of inpatient hospital care as is determined by the attending physician in consultation with the patient to be medically appropriate for a person undergoing a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered under the policy or contract, and any physical complications arising from the mastectomy, including lymphedema. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
Post Mastectomy Reconstruction Model Language Used? Yes ☐ No ☐	§ 3216(i)(20) § 3221(k)(10) § 4303(x) Women's Health and Cancer Rights Act of 1998, 29 USC 1185(b) Model Language	This policy or contract form includes coverage for breast reconstruction surgery after a mastectomy or partial mastectomy including all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of mastectomy including lymphedemas in the manner determined by the attending physician and the patient to be appropriate. Such coverage may be subject to deductibles, copayments and/or coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract.	
Transplants Model Language Used? Yes ☐ No ☐	§ 3215(l) 45 CFR § 156.100 Model Language	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. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Autism Spectrum Disorder Model Language Used? Yes ☐ No ☐	§ 3221(l)(17) 11 NYCRR 440 Model Language	This policy or contract form includes coverage for the screening, diagnosis and treatment of autism spectrum disorder, including the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist: • Behavioral health treatment; • Psychiatric care; • Psychological care; • Medical care provided by a licensed health care provider; • Therapeutic care, including therapeutic care which is deemed habilitative or nonrestorative, in the event that the policy provides coverage for therapeutic care; and • Pharmacy care in the event that the policy or contract provides coverage for prescription drugs. 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. 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 behavior analysis provider as defined and	

		described in 11 NYCRR 440, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. The policy or contract form includes 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. 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. 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.	
Diabetes Equipment, Supplies and Self-Management Education Model Language Used? Yes ☐ No ☐	§3221(k)(7) § 4303(u) 10 NYCRR 60-3.1 Model Language	This policy or contract form includes 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. *Note: Plans may apply either a medical or a prescription benefit, may apply whichever will provide a more generous benefit.* *Note: Since the statute refers to equipment, supplies and self-management education that are prescribed by a physician "or other licensed health care provider legally authorized to prescribe under title eight of the education law…," the policy or contract form may not limit coverage to care prescribed by a physician.*	
Durable Medical Equipment and Braces Model Language Used? Yes ☐ No ☐	§ 3216(l) 45 CFR § 156.100 Model Language	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. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Hearing Aids Model Language Used? Yes ☐ No ☐	§ 3216(l) 45 CFR § 156.100 Model Language	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. 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.	

		Bone anchored hearing aids must be covered only if an insured has either of the following: • 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. Coverage must be provided for one (1) 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. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Medical Supplies Model Language Used? Yes ☐ No ☐	§ 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 ☐ No ☐	§ 3216(l) 45 CFR § 156.100 Model Language	**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 must be provided for one (1) external prosthetic device per limb per lifetime/per plan year, but may be modified so that coverage is more favorable. Replacements are covered for children for devices that have been outgrown. Coverage is for standard equipment only. **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. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Hospital Services Model Language Used? Yes ☐ No ☐	§ 3216(l) 11NYCRR § 52.5 45 CFR § 156.100 Model Language	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: • Semiprivate room and board; • General, special, and critical nursing care; • Meals and special diets; • The use of operating, recovery, and cystocopic 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; • 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. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Maternity Care Model Language Used? Yes ☐ No ☐	§ 3221(k)(5) § 4303(c) Model Language	This policy or contract form includes coverage for maternity care, to the same extent as coverage is provided for illness or disease under the policy or contract. Such coverage, other than for perinatal complications, 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. 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 § 3216(i)(10) or 4303(a)(3). Such home care is not subject to deductibles, copayments and/or coinsurance. Maternity coverage also includes coverage of the services of a midwife licensed pursuant to Article 140 of the Education Law, practicing consistent with a collaborative relationship with a physician or a hospital licensed pursuant to Article 28 of the Public Health Law, consistent with the requirements Education Law § 6951. Maternity coverage also includes parent education, training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments. The cost of renting one (1) breast pump per pregnancy in conjunction with childbirth is covered in full. Such coverage may be subject to deductibles, copayments and/or coinsurance as deemed appropriate by the Superintendent and as are consistent with other benefits within the policy or contract form.	
Autologous Blood Banking Services Model Language Used? Yes ☐ No ☐	§ 3216(l) 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for autologous blood banking services when they are being provided in connection with a scheduled, covered inpatient procedure for the treatment of a disease or injury. In such instances, this policy or contract form will cover storage fees for what are determined to be a reasonable storage period that is appropriate for having the blood available when it is needed. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Inpatient Rehabilitative Services	§ 3216(l) 45 CFR § 156.100	This policy or contract form includes coverage for rehabilitation services including physical therapy, speech therapy, and occupational therapy for a minimum of one consecutive 60-day period, per	

Model Language Used? Yes ☐ No ☐ Is this benefit being substituted? Yes ☐ No ☐ Are additional benefits being added to this EHB category? Yes ☐ No ☐ If yes, please explain how this substitution or addition differs from the Model Language in the space provided below.	Model Language	condition, per lifetime in a rehabilitation facility. Such coverage may be subject to deductibles, copayments and/or coinsurance. For purposes of this benefit, "per condition" means the disease or injury causing the need for the therapy.	
Benefit explanation:			
Skilled Nursing Facility Model Language Used? Yes ☐ No ☐	§ 3216(i)(6) § 4303(d) 45 CFR § 156.100 Model Language	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 calendar year, for non-custodial care. Custodial, convalescent or domiciliary care is not covered. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
End of Life Care Model Language Used? Yes ☐ No ☐	§ 4805 PHL § 4406-e 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for acute care provided in a licensed Article 28 facility or acute care facility that specializes in the care of terminally ill patients if the subscriber is diagnosed with advanced cancer and has fewer than 60 days to live.	
Centers of Excellence	§ 3201(c)	This policy or contract form may provide coverage for centers of excellence which are hospitals approved and designated for certain services.	
MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES			
Inpatient Mental Health Care Services Model Language Used? Yes ☐ No ☐	§ 3221(l)(5) § 4303(g) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20	This policy or contract form provides coverage for inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders at least equal to the coverage provided for other health conditions under this policy or contract. Coverage for inpatient services for mental health care is limited to facilities as defined in New York Mental Hygiene Law § 1.03(10) and, in other states, to similarly licensed or certified facilities.	

	(2009) Federal Mental Health Parity Addiction Equity Act of 2008 (“MHPAEA”) Public Law 110-343 45 CFR § 146.136 45 CFR § 156.100 Model Language	Coverage for inpatient mental health care also includes 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 Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with the federal Mental Health Parity Addiction Equity Act (“MHPAEA”). *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.*	
Outpatient Mental Health Care Services Model Language Used? Yes ☐ No ☐	§ 3216(i)(4) § 3221(l)(5) § 4303(g) § 4303(h) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 (“MHPAEA”) Public Law 110-343 45 CFR § 146.136 45 CFR § 156.100 Model Language	This policy or contract form provides coverage for outpatient mental health care services including, but not limited to, partial hospitalization program and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Such coverage is limited to facilities that have been issued an operating certificate pursuant to Article 31 of the Mental Hygiene Law; 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); or a professional corporation or a university faculty practice corporation thereof. Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *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.*	
Inpatient Substance Use	§ 3221(l)(7)	This policy or contract form provides coverage for inpatient substance use services relating to the	

Services Model Language Used? Yes ☐ No ☐	§ 4303(k) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 ("MHPAEA") Public Law 110-343 45 CFR § 146.136 45 CFR § 156.100 Model Language	diagnosis and treatment substance use disorder. This includes coverage for detoxification and/or rehabilitation services as a consequence of chemical use and/or substance use. Inpatient substance use services are limited to facilities in New York which are certified by the Office of Alcoholism and Substance Abuse Services ("OASAS"), and in other states, to those facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. Coverage for inpatient substance use services also includes services received at residential treatment facilities (which include room and board charges). Coverage for residential treatment services is limited to facilities certified by OASAS; and, in other states, to those facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Under MHPAEA, group health policy or contract forms that provide both medical and surgical benefits and mental health or substance use disorder benefits shall ensure that the financial requirements (cost-sharing) and treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy or contract form. The MHPAEA also prohibits such policies or contracts from imposing separate cost-sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the policy or contract form provides coverage for out-of-network services, such policy or contract must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorder consistent with the federal law.*	
Outpatient Substance Use Services Model Language Used? Yes ☐ No ☐	§ 3216(l) § 4303(l) Circular Letter No. 20 (2009) Supplement No. 1 to Circular Letter No. 20 (2009) Federal Mental Health Parity Addiction Equity Act of 2008 ("MHPAEA") Public Law 110-343 45 CFR § 146.136 45 CFR § 156.100 Model Language	This policy form provides coverage for outpatient substance use services relating to the diagnosis and treatment of substance use disorder. Such coverage is limited to facilities in New York State, certified by the OASAS or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs or by physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the acute detoxification stage of treatment or during stages of rehabilitation, and, in other states, to those facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use disorder services related to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. 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 disorder. Payment for a family member should be the same amount regardless of the number of family members who attend the family therapy session. Such coverage may be subject to deductibles, copayments and/or coinsurance in accordance with MHPAEA. *Note: Plans may cover more than 20 visits.* *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.* *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. 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.*	
PRESCRIPTION DRUGS			
Prescription Drugs Model Language Used? Yes ☐ No ☐	§ 3216(l) 45 CFR § 156.100 Model Language	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. This policy or contract form may have up to a three tier cost-sharing plan design. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Enteral Formulas Model Language Used? Yes ☐ No ☐	§3221(k)11 § 4303(y) OGC Opinion 10-12-03	This policy or contract form provides coverage for enteral formulas for home use, whether administered orally or via feeding tube, for which a physician or other licensed health care provider legally authorized to prescribe under Title 8 of the Education Law has issued a written order. The order must state that the formula is medically necessary and has been proven effective as a disease-specific	

	Model Language	treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic physical disability, mental retardation or death. Specific diseases that enteral formulas are effective for include, but are not limited to: inherited amino-acid or organic acid metabolism; Crohn's Disease; gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which if left untreated will cause malnutrition, chronic physical disability, mental retardation or death. Coverage for certain inherited diseases of amino acid and organic acid metabolism includes coverage of modified solid food products. Such coverage may be subject to deductibles, copayments and/or coinsurance.	
Off-Label Cancer Drug Usage Model Language Used? Yes ☐ No ☐	§ 3216(i)(12) § 4303(q) Model Language	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.	
Usual and Customary Cost of Prescribed Drugs Model Language Used? Yes ☐ No ☐	§ 3216(l) § 4325(h) PHL § 4406-c(6) Model Language	Copayments relating to prescription drugs shall not exceed the usual and customary cost of such prescribed drug.	
Prohibition for Tier IV Drugs	§ 3216(l) § 4303(gg) PHL § 4406-c(7)	The policy or contract form shall not impose cost-sharing (copayment, coinsurance and deductible) for any prescription drug that exceeds the cost-sharing for non-preferred brand drugs or its equivalent (or brand drugs if there is no non-preferred brand drug category).	
Eye Drops Model Language Used? Yes ☐ No ☐	§ 3216(l) § 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 ☐ No ☐	§ 3221(l)(12) § 4303(q-1) 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 apply to coverage for intravenous or injected anticancer medications.	
Mail Order Drugs for Policies or Contracts With a Provider Network Model Language Used? Yes ☐ No ☐	§ 3216(l) § 4303(hh) 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 ☐ No ☐	§ 3221(l)(16) § 4303(cc) 42 USC § 300gg-13 Model Language	This policy or contract form provides coverage for contraceptive drugs and devices or generic equivalents approved as substitutes by the FDA. Contraceptive coverage must be provided with no cost-sharing. *Note: Since the statute refers to contraceptive drugs and devices prescribed by a physician "or other licensed health care provider legally authorized to prescribe under title eight of the education law…," the policy or contract may not limit coverage to contraceptive drug and devices prescribed by a physician.*	
Formulary Exceptions	45 CFR § 156.122(c)	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. For standard formulary exception requests, the insurer must make a decision and notify the insured or the insured's designee and the prescribing health care professional no later than 72 hours after receipt of the request. If the insurer approves the request, the insurer must cover the prescription drug while the insured is taking the prescription drug, including any refills. An expedited formulary exception may be requested if the insured is suffering from a health condition that may seriously jeopardize the insured's health, life or ability to regain maximum function or if the insured is undergoing a current course of treatment using a non-formulary prescription drug. The insurer must make a decision and notify the insured or the insured's designee and the prescribing health care professional no later than 24 hours after receipt of the request. If the insurer approves the request, the insurer must cover the prescription drug while the insured suffers from the health condition that may seriously jeopardize the insured's health, life or ability to regain maximum function or for the duration of the insured's current course of treatment using the non-formulary prescription drug.	
WELLNESS	45 CFR § 156.100 § 3239		
Exercise Facility Reimbursement/Other Wellness Benefits Model Language Used? Yes ☐ No ☐ Is this benefit being substituted? Yes ☐ No ☐ *Note: If an insurer is*	§ 3216(l) § 3239 45 CFR § 156.100 Model Language	This policy or contract form partially reimburses the subscriber and the subscriber's covered spouse or each covered dependent for certain exercise facility fees or membership fees. All wellness benefits must comply with § 3239 of the Insurance Law. *Note: Plans may offer more comprehensive coverage or may substitute this benefit.*	

<table>
<tr><td>substituting for this benefit, the benefit that is substituted must comply with §3239.

Are additional benefits being added to this EHB category?
Yes ☐ No ☐

If yes, please explain how this substitution or addition differs from the Model Language in the space provided below.</td><td></td><td></td><td></td></tr>
<tr><td colspan="4"><u>Benefit explanation:</u></td></tr>
<tr><td>VISION CARE</td><td></td><td></td><td></td></tr>
<tr><td>Pediatric Vision Care

Model Language Used?
Yes ☐ No ☐</td><td>§ 3216(l)
45 CFR § 156.100
Model Language</td><td>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 twelve month period, unless more frequent examinations are medically necessary as evidenced by appropriate documentation; and prescribed lenses & frames; and contact lenses.

Such coverage may be subject to deductibles, copayments and/or coinsurance.</td><td></td></tr>
<tr><td>DENTAL CARE</td><td></td><td></td><td></td></tr>
<tr><td>Pediatric Dental Care

Model Language Used?
Yes ☐ No ☐

Is dental coverage being provided by this filing?
Yes ☐ No ☐

If no, please explain how the insurer is meeting the requirement to offer the pediatric essential health benefit in the space provided below.</td><td>§ 3216(l)
45 CFR § 156.100
Model Language</td><td>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; 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.

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).

Note: The cosmetic orthodontics benefit is optional. Plans may impose no longer than a 12 month waiting period.

Embedded pediatric dental benefits must comply with all of the market reform and rating rules such</td><td></td></tr>
</table>

		guaranteed availability, rating tiers, rating regions, etc. For rating purposes, the pediatric dental benefit would be included in the insurer's single risk pool, medical loss ratio calculations and actuarial value calculations. Expenses related to an embedded pediatric dental benefit must also be included as part of the calculation of deductibles and out of pocket expense maximums. If the insurer offers a bundled stand-alone pediatric dental benefit, the following conditions must all be met: • The bundled dental benefit is identical to a stand-alone dental plan offered by the same dental carrier that is certified by the NYSOH but offered outside the NYSOH, including at the same premiums; • The policyholder or contractholder is informed that the dental benefit is being offered by a separate insurer, even if only one issuer collects the premiums; • The policyholder or contractholder is clearly informed of the medical plan design and the dental plan design and that the two plan designs have different deductibles, cost-sharing and out-of-pocket maximums; • The policyholder or contractholder is clearly informed that they can purchase any stand-alone dental plan, other than the bundled dental plan, that has been certified by the NYSOH but offered outside the NYSOH. • The pediatric dental benefit meets the 70% or 85% actuarial value and $700 out-of-pocket maximum for one covered child (or $1,400 if more than one child in the family is covered); • The stand-alone dental plan complies with all ACA provisions and CMS regulations pertaining to stand-alone dental plans; • Insurers should specifically describe the legal and business arrangement between the medical issuer and the dental issuer when submitting the forms and rates to the Department, and each insurer must separately submit its own forms and rates for approval. If the insurer is reasonably assured that an individual has obtained stand-alone pediatric dental coverage through an NYSOH-certified stand-alone dental plan offered outside the NYSOH the insurer does not need to provide the dental benefit when coverage is issued. Insurers may include a question in their application/enrollment form in order to verify whether an insured has obtained stand-alone pediatric dental coverage through an NYSOH-certified stand-alone dental plan offered outside the NYSOH.	
Benefit explanation:			
OPTIONAL ADDITIONAL BENEFITS			
Acupuncture	Model Language	This policy or contract form provides coverage for acupuncture.	
Family Vision Model Language Used? Yes ☐ No ☐	Model Language	This policy or contract form provides coverage for vision care including: emergency, preventive and routine vision care; including one (1) vision examination in any 12-month period; one (1) time per plan year, unless more frequent examinations are medically necessary as evidenced by appropriate documentation; prescribed lenses and frames; and contact lenses.	

Shoe Inserts Model Language Used? Yes ☐ No ☐	45 CFR § 156.100 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.	
Additional Benefits Provided in Policy or Contract, or By Rider Additional benefits provided? Yes ☐ No ☐ 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.	
Benefit explanation:			
MAKE AVAILABLE BENEFITS			
Care in a Nursing Home or Skilled Nursing Facility	§ 3221(l)(2) § 4303(d)	This policy or contract 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.	
Hospice Care Model Language Used? Yes ☐ No ☐	§ 3221(l)(10) § 4303(o) 45 CFR § 156.100 Model Language	This policy or contract form must make available hospice care to a member who has been certified by his or her primary attending physician as having a life expectancy of six (6) months or less which is provided by a hospice organization certified pursuant to Article 40 of the Public Health Law or under a similar certification process required by the state in which the hospice is located. Coverage will include inpatient hospice care in a hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210 days 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. 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. 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. *Note: Plans may cover more than 210 days or remove the limit.*	
Licensed Clinical Social Worker	§ 3221(l)(4) § 4303(i)	If this policy or contract 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 must make available and if requested by the policyholder, 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.).	
PERMISSIBLE EXCLUSIONS AND LIMITATIONS		*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.* *The following exclusions are permissible. A Plan does not need to include all the exclusions. However, if an exclusion is included, the language below must be used.*	Form/Page/Para Reference
Aviation Model Language Used? Yes ☐ No ☐	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 ☐ No ☐	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.	
Cosmetic Services Model Language Used? Yes ☐ No ☐	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.	
Coverage Outside of the United States, Canada or Mexico Model Language Used? Yes ☐ No ☐	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 ☐ No ☐	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.	§ 4303(z) § 3221(k)(12) Article 49	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	

Model Language Used? Yes ☐ No ☐	Model Language	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 ☐ No ☐	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 ☐ No ☐	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 includes 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 ☐ No ☐	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 ☐ No ☐	§ 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.	
Medicare or Other Governmental Program Model Language Used? Yes ☐ No ☐	11 NYCRR 52.16(c)(8) 52.26(c) Model Language	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). 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 ☐ No ☐	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 ☐ No ☐	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 ☐ No ☐	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	11 NYCRR	This policy or contract form excludes coverage for services performed by a member of the covered	

Member Model Language Used? Yes ☐ No ☐	52.16(c)(8) Model Language	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 ☐ No ☐	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 ☐ No ☐	§ 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 ☐ No ☐	11 NYCRR 52.16(c)(10) Model Language	This policy or contract form excludes coverage for the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the pediatric vision benefit.	
Workers' Compensation Model Language Used? Yes ☐ No ☐	11 NYCRR 52.16(c)(8) Model Language	This policy or contract form excludes coverage for services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.	
War Model Language Used? Yes ☐ No ☐	11 NYCRR 52.16(c)(4)(i) Model Language	This policy or contract form excludes coverage for an illness, treatment or medical condition due to war, declared or undeclared.	
CLAIM DETERMINATIONS			Form/Page/Para Reference
Notice of Claim	§ 3221(a)(8) § 3224-a(d) Model Language	The policy or contract form provides that the insured has to provide the insurer with written notice of claim as applicable. . The insured may also submit a claim electronically. However, failure to give notice within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such notice and the notice was provided as soon as reasonably possible.	
Submission of Claim Model Language Used? Yes ☐ No ☐	3221(a)(9) § 4306(n) Model Language	The policy or contract must provide that the insured has a minimum of 120 days to provide the insurer with proof of loss after the date of such loss. However, failure to give proof within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such proof and the proof was provided as soon as reasonably possible.	
GRIEVANCE, UTILIZATION REVIEW AND EXTERNAL APPEAL			Form/Page/Para Reference
Grievance Procedures Model Language Used? Yes ☐ No ☐	§ 3217-a(a)(7) § 3217-d(a) § 4306-C(a)	A policy or contract form that is a managed care product as defined in § 4801(c), or a comprehensive policy that utilizes a network of providers, or a HMO, includes a description of the grievance procedure to be used to resolve disputes between the insurer and the insured, including: • The right to file a grievance regarding any dispute between an insured and the insurer;	

	§ 4324(a)(7) § 4802 PHL § 4408(1)(g) PHL § 4408-a 10 NYCRR 98-1.14 42 USC §00gg-19 29 CFR 2560.503-1 45 CFR § 147.136 Model Language	• The right to file a grievance orally when the dispute is about referrals or covered benefits; • The toll-free telephone number which insureds may use to file an oral grievance; • The timeframes and circumstances for expedited and standard grievances; • The right to appeal a grievance determination and the procedures for filing such an appeal; • The timeframes and circumstances for expedited and standard appeals; • The right to designate a representative; • A notice that all disputes involving clinical decisions will be made by qualified clinical personnel; and, • That all notices of determination will include information about the basis of the decision and further appeal rights, if any.	
Utilization Review Policies and Procedures Model Language Used? Yes ☐ No ☐	§ 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: • The circumstances under which utilization review will be undertaken; • The toll-free telephone number of the utilization review agent; • The timeframes under which utilization review decisions must be made for prospective, retrospective and concurrent decisions; • The right to reconsideration; • The right to appeal, including the expedited and standard appeals processes and the timeframes for such appeals; • The right to designate a representative; • A notice that all denials of claims will be made by qualified clinical personnel and that all notices of denials will include information about the basis of the decision; • A notice of the right to an external appeal, together with a description, jointly promulgated by the Commissioner of Health and Superintendent, of the external appeal process and the timeframes for such appeals; and • Further appeal rights, if any.	
External Appeal Procedures Model Language Used? Yes ☐ No ☐	Article 49 PHL Article 49 45 CFR § 147.136 42 USC § 300gg-19 Model Language	This policy or contract form 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; experimental/investigational, including clinical trials and treatment for rare diseases; and for managed care health insurance contracts as defined as § 4801(c), and HMOs, 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. An HMO and a managed care health insurance contract as defined as § 4801(c) must provide for an external appeal of an out-of-network referral denial. Upon issuance or renewal, a comprehensive health insurance policy or contract that utilizes a network of providers must provide for an external appeal of an out-of-network referral denial or an out-of-network service denial.	

TERMINATION OF COVERAGE Model Language Used? Yes ☐ No ☐	§ 4304(c) Model Language	*The following are the only termination provisions permissible under the Insurance Law.* *The Model Language must be used for each of the following termination provisions.*	Form/Page/Para Reference
Termination of Coverage	§ 3240(e) Model Language	Coverage will terminate under this policy or contract at the earliest of the following events. • The [date on; end of the month in] which the student ceases to meet eligibility requirements as defined by the [Contractholder; Policyholder, Insurer]. • Upon the Student's death, coverage will terminate unless the student has coverage for Dependents, in which case the coverage will terminate as of the last day of the month for which the premium has been paid. • [For spouses in cases of divorce, the date of the divorce.] • [For children, until the [day; end of the month; year] in which] the child turns [26] years of age.] {If the Plan includes coverage of children, the plan may include language that extends coverage until the day, end of the month or year in which the child turns 26. Plans may include age 29 if the make available option to extend coverage for young adults through age 29 is purchased.} • [For all other Dependents, the [day; end of the [month; year] in which] the Dependent ceases to be eligible.] {Drafting Note: Include this provision if the Plan includes coverage of Dependents. Plans may include language that extends coverage until the day, end of the month or year in which the dependent loses eligibility for coverage.} • The end of the month during which the student provides written notice requesting termination of coverage, or on such later date requested for such termination by the notice. • If a student has performed an act that constitutes fraud or made an intentional misrepresentation of material fact in writing on his or her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon delivery of the insurer's written notice of termination to the student. [However, if a student makes an intentional misrepresentation of material fact in writing on his or her enrollment application, coverage will be rescinded if the facts misrepresented would have prevented the issuance of coverage. Rescission means that the termination of coverage will have a retroactive effect of up to [one year; Your enrollment under the Certificate.] {Drafting Note: The language above related to rescission is optional.} • The date that the [Contractholder's Contract; Policyholder's Policy] is terminated. If the insurer terminates and/or decides to stop offering a particular class of group contracts or policies, without regard to claims experience or health related status, to which this Certificate belongs, the insurer will provide at least 90 days prior written notice to the [Contractholder; Policyholder] and Student. • If the insurer elects to terminate or cease offering student accident and health coverage in NY, the insurer will provide written notice to the [Contractholder; policyholder] and student at least 180 days prior to when the coverage will cease. • The [Contractholder; Policyholder] has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.	

		• For such other reasons that are acceptable to the superintendant and authorized by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and any later amendments or successor provisions, or by any federal regulations or rules that implement the provisions of the Act.	
LOSS OF COVERAGE			Form/Page/Para Reference
Extension of Benefits Model Language Used? Yes ☐ No ☐	§3221(k)(5) 11 NYCRR §52.21(j) 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. 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: • 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. 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. The insurer will not pay extended benefits: • 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.	

Temporary Suspension Rights for Armed Forces' Members Model Language Used? Yes ☐ No ☐	§ 3221(n) § 4304(i) Circular Letter No. 7 (2003) USERRA, 38 USC Model Language	This policy or contract form provides that: 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: • 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 is effective. 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.	
Continuation of Coverage	45 CFR§ 147.145(a) Model Language	This policy or contract form contains an optional continuation of coverage provision for up to 90 days. 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: • 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. Continued coverage will terminate at the earliest of the following applicable events: • [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. The date the Contract or Policy terminates. Please Note, if the Contract or Policy is replaced with similar	

		coverage, the student has the right to become covered under the new Contract or Policy for the balance of the period remaining for the student's continued coverage.	
			Form/Page/Para Reference
Assignment	Article 6 of the Financial Services Law; Chapter 60 of the Laws of 2014 Model Language	The policy or contract form must state whether or not assignment is permitted. This policy or contract must allow assignment of monies due to the insured's health care provider resulting from a surprise bill for covered services.	
Incontestability Model Language Used? Yes ☐ No ☐	§ 3221(a)(1) § 4306 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 ☐ No ☐	§ 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 subscriber and insurer.	
Action in Law or Equity Model Language Used? Yes ☐ No ☐	§ 3216(d)(1)(K) PHL § 4406-a Model Language	The policy or contract must provide that no action in law or equity shall be brought to recover on the policy or contract prior to the expiration of 60 days after proof of loss has been filed in accordance with the requirements of the policy or contract and that no such action shall be brought after the expiration of three (3) years following the time such proof of loss is required by the policy or contract.	
Subrogation Model Language Used? Yes ☐ No ☐	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).	
Unilateral Modification Model Language Used? Yes ☐ No ☐	11 NYCRR 52.17 (a)(25) Model Language	Unilateral modifications by an insurer to an existing policy or contract must be made with at least 45 days prior written notice to the subscriber. Unilateral modification by the insurer may be made only at the time of renewal. If the policy or contract form requires the subscriber to provide written notice to terminate coverage, the notice of the unilateral modification by the insurer must be provided to the subscriber no less than 14 days prior to the date by which the subscriber is required to provide notice to terminate coverage.	
Non-English Speaking Insureds Model Language Used? Yes ☐ No ☐	§ 3217-a(a)(15) § 4324(a)(15) PHL § 4408(1)(p) PHL § 4408(1)(p) Model Language	This policy or contract form includes a description of how the insurer addresses the needs of non-English speaking insureds.	
Reinstatement After Default	§ 3216(d)(1)(D) § 4306(f)	• 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	

	Model Language	insurer's authorized agents or brokers shall reinstate the policy or contract.	
SCHEDULE OF BENEFITS Model Language Used? Yes ☐ No ☐	Model Language	This policy or contract must contain a Schedule of Benefits. All services subject to preauthorization and/or referral requirements must be clearly indicated in the Schedule of Benefits.	Form/Page/Para Reference
Prohibition on Lifetime Dollar Limits Model Language Used? Yes ☐ No ☐	§ 4306-e § 3217-f 42 USC § 300gg-11 45 CFR § 147.126 45 CFR § 147.145 Model Language	• The policy or contract form may not include a lifetime limit on essential health benefits. Essential health benefits are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorders, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including oral and vision care.	
Limitations on Annual Dollar Limits Model Language Used? Yes ☐ No ☐	§ 3217-f § 4306-e 42 USC § 300gg-11 45 CFR § 147.126 45 CFR § 147.145 Model Language	The policy or contract form may not impose "restricted" annual dollar limits for essential health benefits.	
Insured's Financial Responsibility for Payment	§ 3217-a(a)(5) § 4324(a)(5) PHL § 4408(1)(e)	This policy or contract form 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.	
ADDITIONAL RIDERS			
Out-of-Network Coverage Model Language Used? Yes ☐ No ☐ If out-of-network coverage is offered, please answer the following: Out-of-network coverage in the base policy/contract or by rider? Policy/Contract ☐ Rider ☐	Model Language	If out-of-network coverage has been selected, this policy or contract form provides benefits for covered services that are received from out-of-network providers and have not been approved by the insurer to be covered on an in-network basis. Out-of-network coverage may be provided in the base policy or contract, or by rider. *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.*	
Extended Dependent Coverage	§ 4304(d)(1)(B) § 4235(f)(i)(B) Model Language	For coverage that includes dependent children this policy or contract form must make available and if requested by the policyholder, provide coverage for unmarried children through the age of 29 (up to age 30); regardless of financial dependence; who are not insured by or eligible for coverage under an	

Model Language Used? Yes ☐ No ☐		employer-sponsored health benefit plan covering them as an employee or member, whether insured or self-insured; and who live, work or reside in New York State or the service area of the insurer. The company must comply with the notice requirements set forth in §§ 4235(f)(i)(B)or 4304(d)(1)(B).	
PROVIDER NETWORKS Has network been submitted to and/or approved by the Department of Health or the NYSOH? Yes ☐ No ☐ If yes, please indicate the name of the network, the network ID number, and the dates that the network was submitted to and/or approved by the Department of Health or the NYSOH. Network Name: Network ID #: Date Submitted: Date Approved:	§ 3201(c) § 3241(a)	If the insurance (other than HMO) policy or contract will be used in conjunction with a provider network, please identify in the adjacent box whether the insurer is using the same network that was submitted to and/or approved by the Department of Health and/or the NYSOH. Please indicate the network name and network ID number and include the date that the network was submitted to and/or approved by the Department of Health and/or the NYSOH. If the network differs in any respect from that which was submitted to and/or approved by the Department of Health and/or the NYSOH, please provide details on how the network differs in the Supporting Documentation Tab in SERFF. This includes, but is not limited to, detailing the providers and specialty types in each county that differ from the network that was submitted to and/or approved by the Department of Health and/or the NYSOH . In addition, the following items or information must be submitted as part of this filing: • 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 by county. *Note: The Department will not permit 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.*	
Provider Networks	§ 3201(c) § 3241	Insurers, including municipal cooperative health benefit plans and student health plans, that issue a health insurance policy or contract or a dental policy or contract with a network of providers must submit the network used to DFS for network adequacy review. Refer to the “Network Adequacy Standards and Guidance” document available on the Department’s website, http://www.dfs.ny.gov/insurance/ihealth.htm, for general instructions on the review of networks. The standards for review are the same as those used by the Department of Health and in general these standards include the following: ○ At least one hospital in each county; however, for Erie, Monroe, Nassau, Suffolk, Westchester, Bronx, Kings, New York and Queens the network will need to include at least 3 hospitals; ○ A choice of 3 primary care physicians (PCPs) in each county, and potentially more based	

		on enrollment and geographic accessibility; and ○ At least 2 of each specialist provider type, and potentially more based on enrollment and geographic accessibility.	
ACTUARIAL SECTION FOR <u>NEW PRODUCT</u> 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.* *Note: For rate changes to existing products, do NOT complete this section – complete the Existing Products-Rate Requirements section below.*	
ACTUARIAL MEMORANDUM	11 NYCRR 52.40(a)(1)	Actuarial qualifications: • 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	§ 3201 § 3240(h) 11 NYCRR 52.40(e)	• Expected claim costs. • Actuarial justification for claim costs and other assumptions. • Experience of a preceding issuer or issuers may be relied on to the extent available. • Provide rating methodology including experience rating formula. • Provide all elements of the formula, such as claims run-off, credibility and trend factors. • Provide the range of commission rates and other fees. • Non-claim expense components as a percentage of gross premium, including but not limited to administrative expenses, taxes and fees, risk and profit margins • Include support for the Actuarial Value and Metal Tiers for all plan designs. 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 and fees.	
Experience Pooling Options	§ 3240(g)	The issuer may choose to pool the student accident and health experience in a manner including • By policy form for all policyholders; • By policyholder; or By all policy forms for all policy holders.	
Reserve Basis	11 NYCRR 94	• Description of bases for unpaid claim liabilities and extra reserves (if any).	
Actuarial Certification	11 NYCRR 52.40(a)(1)	• 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	§ 3240(i)	The expected loss ratio is: ___________ %.	

Certification		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). • 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)	• 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. • 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).	
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.* • *Note: 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: • 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	11 NYCRR 52.40(e)
	§ 3240(h)
		• 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:
		    ○ Earned premium;
		    ○ Paid and incurred claims; and
		    ○ Incurred loss ratios.	

		• Derivation of the proposed rate revision in detail, including: o Demonstration that the expected future loss ratio and expected lifetime loss ratio are at least as large as the disclosed loss ratio o Actuarial justification of proposed rates revision (increase/decrease) • Non-claim expense components as a percentage of gross premium. • Impact on rates as a result of each of the changes with actuarial justification. • Include support for the Actuarial Value and Metal Tiers 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.	
Federal Rate Review Requirements	45 CFR Part 154	Submit the information included in the Preliminary Justification sent to CMS through the HIOS RRJ module to the State. Refer to the CMS Rate Review Student Health Plans FAQ from August 12, 2015.	
Actuarial Certification	11 NYCRR 52.40(a)(1)	• The filing is in compliance with all applicable laws and regulations of the State of New York. • The filing is in compliance with Actuarial Standard of Practice No. 8 "Regulatory Filings for Rates and Financial Projections for Health Plans". • The expected loss ratio meets the minimum requirements of the State of New York. • The benefits are reasonable in relation to the premiums charged. • The rates are not unfairly discriminatory.	
Expected Loss Ratio Certification	§ 3240(i)	The expected loss ratio is: ____________ %. 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). • 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)	• 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. • 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).	