

NEW YORK INSURANCE DEPARTMENT

Review Standards for

**Major Medical and Other Similar-Type Comprehensive Health Insurance
for Article 43 Corporations issuing Group Contracts**

As of 10/1/08

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:
 - Contract – Also complete all sections except the section entitled “Application Forms.”
 - Application – Also complete the section entitled “Application Forms.”
 - Rider or endorsement – Also complete all items relevant to the form being submitted in all sections.
- C. For filing of initial rates, complete the section entitled “Actuarial Section For Initial Rate Filings Only” in addition to completion of the applicable form sections identified above.
- D. For each item, enter in the last column the form number(s), page number(s) and paragraph(s) where the requirement is met in the filing or insert a bookmark connecting to the appropriate location in the filing.
- E. Do not make any changes or revisions to this checklist.

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LINE OF BUSINESS: Group Major Medical or Similar-Type
Comprehensive Health Insurance

CODES: H15G or H16G

TYPES OF INSURANCE

CODES

SUB-TYPES OF INSURANCE

H15G Group Health - Hospital/Surgical/Medical Expense

H15G.001 Any Size Group
H15G.002 Large Group Only
H15G.003 Small Group Only

H16G Group Health – Major Medical

H16G.001A Any Size Group - PPO
H16G.001B Any Size Group - POS
H16G.001C Any Size Group - Other
H16G.002A Large Group Only - PPO
H16G.002B Large Group Only - POS
H16G.002C Large Group Only - Other
H16G.003A Small Group Only - PPO
H16G.003D Small Group Only - POS
H16G.003G Small Group Only - Other

IF CHECKLIST IS NOT APPLICABLE, PLEASE EXPLAIN:

REVIEW REQUIREMENT	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD IN FILING
GENERAL REQUIREMENTS FOR ALL FILINGS	<i>Note: Unless otherwise noted, all references are to Insurance Law, Insurance Regulations, and Insurance Department Circular Letters and OGC opinions*</i>	<i>Note: This checklist is intended to provide guidance in the preparation of policy forms for submission and is not intended as a substitute for statute or regulation.</i>	Form/Page/ Paragraph Reference

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<p>Complete Contract Submission or Pages/Rider/Endorsement</p>		<p>This submission contains a complete contract form. Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If this submission contains insert pages, riders or endorsements, then the contract in its entirety complies with all the statutory and regulatory provisions stated below. Yes <input type="checkbox"/> No <input type="checkbox"/> (If no is checked, explain in the space provided above.)</p> <p>This rider, insert pages, or endorsements are being attached to a contract that was approved by the Department on _____, submission number _____.</p>	
<p>Form Requirements</p>	<p>11NYCRR52.31(b), (c), (d), (e), (f), (l)</p>	<p>Each form in the filing must meet the following requirements:</p> <ul style="list-style-type: none"> • This form contains no strikeouts. §52.31(b) • This form is submitted in duplicate. §52.31(c) • This form is designated by a form number made up of numerical digits and/or letters in the lower left-hand corner of the first page. §52.31(d) • This form is submitted in the form intended for actual use. §52.31(e) • All blank spaces are filled in with hypothetical data. §52.31(f) • If the form contains illustrative material, it does so only for items that may vary from case to case, such as names, dates, eligibility requirements, premiums and schedules for determining the amount of insurance for each person. §52.31(l) • Portions of other provisions, such as insuring clauses, benefit provisions, restrictions and termination of coverage provisions, may be submitted as variable, if suitably indicated by red ink, bracketing or underlining and an explanatory memorandum must be submitted that clearly indicates the nature and scope of the variations to be used. An explanatory memorandum may not use terms such as “will conform to law” or “as requested by contractholder” to describe the variable material. §52.31(l) 	
<p>Flesch Score</p>	<p>3102(c)</p>	<p>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.</p>	
<p>Letter of Submission</p>	<p>11 NYCRR 52.33 Circular Letter No. 33 (1999) Supplement 1 to CL No. 33 (1999)</p>	<p>The filing must include a letter of submission in duplicate, signed by a representative of the company authorized to submit forms for filing or approval, that contains the following:</p> <ul style="list-style-type: none"> • The identifying form number of each form submitted. §52.33(a) • If the form is a contract, the letter must indicate that the contract is submitted 	

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		<p>pursuant to 11 NYCRR 52.7. §52.33(b)</p> <ul style="list-style-type: none"> • Whether the form is new or supersedes an approved or filed form. § 52.33(c) • If the form supersedes an approved or filed form, the letter must state the form number and date of approval or filing of the superseded form and any material differences from the superseded form. § 52.33(d) • If the approval of the superseded form is still pending, the letter must include the form number, control number assigned by the Department and the submission date. § 52.33(d) • If the form had previously been submitted for preliminary review, the letter must include a reference to the previous submission and a statement setting out either that the form agrees precisely with the previous submission; or the differences from the form submitted for preliminary review. § 52.33(e) • If the form is submitted in accordance with 11 NYCRR 52.32(c), the letter must identify the prefiled group coverage. § 52.33(f) • If the form is other than a contract form, the letter must identify the form number and approval date of the contract or policies with which it will be used. If the form is for general use, the Department may accept a description of the type of contract with which it may be used in lieu of the form number and approval date. §52.33(g) • If the form is a contract, the letter must identify the form numbers and dates of approval of any applications previously approved to be used with the contract unless the application is required to be attached to the contract upon submission. §52.33(h) • If the 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 contract and a list of all optional pages, together with an explanation of their use. § 52.33(i) <p><i>Note: The Standard Transmittal Form may be submitted in lieu of the submission letter. See http://www.ins.state.ny.us to obtain a copy of the form.</i></p> <p><i>Note: Submission letters should advise as to whether the 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 contract.</i></p>	
Group Status and Recognition	§ 4235 §3201(b)(1) 11 NYCRR 59	The submission letter should include a statement that contract forms will be sold to a group specified in Insurance Law §4235(c)(1). However, a more detailed statement must be included where discretionary group status is sought under	

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		<p>Insurance Law §4235(c)(1)(M). See below. If the Standard Transmittal Form is submitted in lieu of the submission letter, all information regarding the group for which the submission is made, should be completed. The size of the group should be indicated (small, large or both). The letter should indicate whether the submission is for general use or is submitted on a one case basis. If the submission is for use on a one case basis, the group must be identified along with the subpart of Insurance Law §4235(c)(1) in which the group fits and a confirmation that the group meets all of the requirements of the identified subpart.</p> <p>Requests for discretionary group recognition, pursuant to Insurance Law §4235(c)(1)(M), must be accompanied by written documentation that demonstrates that the proposed group meets each and every element stated in the named statute. The documentation must also make clear that the request for discretionary group recognition is not a subterfuge, evasion technique, or a marketing tool to avoid compliance with other statutory or regulatory requirements and recognized marketing mechanisms. This provision is not intended to allow approval of groups recognized in the various subparagraphs of §4235(c)(1) or §4237(a)(3), but for which the proposed discretionary group does not meet one or more of the requisites specifically required or proscribed by §4235 or §4237. The request for allowance of a discretionary group must be granted before it may be used.</p> <p>Pursuant to §3201(b)(1) and Insurance Regulation 123, an accident and health certificate is deemed delivered in New York and subject to review and approval regardless of the actual place of delivery, if the contract is issued to certain groups. In these cases, the group certificate is reviewed for compliance with New York Law. The group contract that is delivered out-of-state is not reviewed.</p>	
<p>Prefiled Group Coverage</p>	<p>11 NYCRR 52.32</p>	<p>A copy of the letter of confirmation sent to the contractholder by the corporation must be submitted to the Department within 30 days after the date the corporation agrees to provide insurance and must include the following:</p> <ul style="list-style-type: none"> • The effective date of coverage. § 52.32(a)(1) • The nature and extent of the benefits or change in benefits as then known. § 52.32(a)(2) • That the contractual forms may be executed and issued for delivery only after filing with or approval by the Department. §52.32(a)(3) • That if the forms are not filed or approved or are disapproved, the parties will be returned to the status quo insofar as possible, or the coverage will be 	

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		<p>modified retroactively to meet all requirements necessary for approval. §52.32(a)(4)</p> <p><i>Note: At the time the corporation agrees to provide insurance, it cannot have been reasonably possible to obtain approval prior to the effective date of coverage because the contractholder requested the corporation provide immediate coverage. Also, the actual forms must be submitted for approval within six months from the date the corporation agrees to provide insurance. § 52.32(c). Failure to meet any of the conditions within the time specified shall be a violation of the Insurance Law, unless reasons for delay, including its probable extent, satisfactory to the Department are submitted to the Department within the respective times specified.</i></p>	
Table of Contents	§3102(c)(1)(G)	A table of contents is required for policies that are over 3,000 words or more than 3 pages regardless of the number of words.	
Discrimination	§2606 , §2607 , & §2608	This form does not contain any unfair discrimination provisions because of race, color, creed, national origin, disability (including treatment of mental disability), sex, and marital status.	
APPLICATION FORMS			Form/Page/ Paragraph Reference
Authorization	11NYCRR420.18(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)	The application contains the prescribed fraud warning statement.	
Pre-Existing Conditions	11NYCRR52.51(j)	If the application is used with a contract that contains a “pre-existing conditions” provision, the application must include a statement describing the provision.	
Prohibited Questions and Provisions	§3204 11NYCRR52.51	<p>The application does NOT contain:</p> <p>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.</p> <p>A provision that changes the terms of the contract to which it is attached.</p> <p>A statement that the applicant has not withheld any information or concealed any facts.</p> <p>An agreement that an untrue or false answer material to the risk will render the contract void.</p> <p>An agreement that acceptance of any contract issued upon the application will constitute a ratification of any changes or amendments made by the corporation</p>	

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		and inserted in the application, except to conform to §3204(d).	
POLICY FORM PROVISIONS			Form/Page/ Paragraph Reference
COVER PAGE			
Corporation name		This contract contains the name and full address of the issuing corporation on the front or back cover.	
Signature of Company Officer		The signature of company officer(s) appears prominently on the contract (such as on the cover).	
DEFINITIONS		<i>If definitions are included in the contract the definitions must comply with the following.</i>	
Continuous Hospital Confinement	11NYCRR52.2(f)	The definition of “continuous hospital confinement” complies with §52.2(f).	
Creditable Coverage	§4318(c) 11NYCRR52.20	The definition of “creditable coverage” complies with §4318(c) and §52.20.	
Emergency Condition	§4303(a)(2) §4900(c)	The definition of “emergency condition” complies with §4303(a)(2) and 4900(c).	
Enrollment Date	11NYCRR52.20	The definition of “enrollment date” complies with §4318(b) and §52.20.	
Hospital	11NYCRR52.2(m)	The definition of “Hospital” complies with §52.2(m).	
ELIGIBILITY			
Spouse	§4305(c)(1)	If dependent coverage is selected by the contractholder, this contract provides coverage for the lawful spouse, unless there is a divorce or annulment of the marriage.	
Dependents	§4305(c)(1)	If dependent coverage is selected by the contractholder, this contract provides coverage of dependents, and states the age restrictions for the insurance provided. <i>Note: Pursuant to §2608-a, an corporation 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 corporation’s service area.</i>	
Unmarried Students on Medical Leave of Absence	§4306-a	If this contract provides coverage for dependent children who are full-time students to a higher age than other dependent children, then coverage shall continue when such dependent takes a medical leave of absence from school due to illness for a period of 12 months from the last day of attendance at school, provided, however, that coverage of a dependent student is not required beyond the age at which coverage would otherwise terminate. To qualify for such coverage, the corporation may require that the medical necessity of the leave be certified to by the student’s attending physician who is licensed to practice in the	

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		state of New York.	
Unmarried Disabled Children	§4305(c)(1)	<p>If dependent coverage is selected by the contractholder, this contract 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.</p> <p><i>Note: Such coverage shall not terminate while the contract remains in effect and the dependent remains in such condition and is chiefly dependent on the insured for support and maintenance, if the insured has within 31 days of such dependent's attainment of the limiting age submitted proof of such dependent's incapacity.</i></p>	
Newborn Infants	§4305(c)(1)	<p>If dependent coverage is selected by the contractholder, this contract provides coverage of newborn infants, including newly born infants adopted by the insured if the insured takes physical custody of the infant upon the infant's release from the hospital and files a petition pursuant to §115-c of the domestic relations law within 30 days of birth; and provided further that no notice of revocation to the adoption has been filed and consent to the adoption has not been revoked, shall be effective from the moment of birth, except that in cases of adoption, coverage of the initial hospital stay shall not be required where a birth parent has insurance coverage available for the infant's care.</p> <p><i>Note: In the case of individual or two-person coverage, the corporation 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 30 days of the day of birth to make coverage effective from the moment of birth.</i></p>	
Adopted Children and Step-Children	11NYCRR52.18(e)(2); (3) §4305(c)(1)	<p>If dependent coverage is selected by the contractholder, this contract provides that adopted children and stepchildren dependent upon the insured are eligible for coverage on the same basis as natural children. Further, a family contract covering a proposed adoptive parent, on whom the child is dependent, shall provide that such child be eligible for coverage on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption.</p>	
Domestic Partners	§4305(c)(1) OGC Opinion 01-11-23	<p>This contract may cover domestic partners, who are financially interdependent on the employee or member, but such coverage is not required. If such coverage is provided, the contract shall require the applicant to provide the following:</p>	

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		<ul style="list-style-type: none"> • Registration as a domestic partner or an affidavit of domestic partnership • Proof of cohabitation • Proof of financial interdependency by evidence of two or more of the following: joint bank account; joint credit or charge card; joint obligation on a loan; status as authorized signatory on the partner's bank account, credit card or charge card; joint ownership or holding of investments; joint ownership of residence; joint ownership of real estate other than residence; listing of both partners as tenants on lease; shared rental payments; shared household expenses; shared household budget for purposes of receiving government benefits; joint ownership of major items of personal property; joint ownership of a motor vehicle; joint responsibility for child care; shared child-care expenses; execution of wills naming each other as executor and/or beneficiary; designation as beneficiary under the other's life insurance policy or retirement benefits account; mutual grant of durable power of attorney; mutual grant of authority to make health care decisions; affidavit by creditor or other individual able to testify to partners' financial interdependence; other items of sufficient proof to establish economic interdependency under the circumstances of the particular case. 	
New Family Members		The contract describes the requirements to add new family members to the contract.	
New Employees		New employees or members of the class must be added to the class for which they are eligible.	
Open Enrollment Period	11NYCRR52.70(e)(3)	<p>This contract must insure all persons without evidence of insurability, provided that coverage is elected during an initial period of eligibility of at least 30 days. Rules may be established limiting future enrollment to specific time periods. However, specified periods of open enrollment must be provided once every 12 months, for a period of not less than 30 days. No enrollment limitation shall apply to insureds who apply for coverage under the conditions described in Section 4305(k)(5).</p> <p><i>Note: If a certificateholder fails to timely enroll a newborn pursuant to the terms of the contract, the corporation may deny enrollment of the newborn only for the period of time prior to the certificateholder's untimely request for enrollment of the newborn.</i></p>	
MANDATORY COVERED BENEFITS			
Primary and Preventive	§4303(i)	This contract includes the following coverage for primary and preventive health	

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Health Services	Circular Letter No. 3 (1994) Circular Letter No. 13 (2006)	<p>services for a dependent child from the date of birth through age 19:</p> <ul style="list-style-type: none"> • An initial hospital check-up and well child visits scheduled in accordance with the American Academy of Pediatrics. • At each visit, services in accordance with the American Academy of Pediatrics, including a medical history, complete physical examination, developmental assessment, anticipatory guidance, laboratory tests and necessary immunizations in accordance with the Advisory Committee on Immunization Practices. <p>Such coverage shall not be subject to annual deductibles and/or coinsurance.</p>	
Mammography Screening	§4303(p)	<p>This contract includes the following coverage for mammography screening for occult breast cancer:</p> <ul style="list-style-type: none"> • Upon the recommendation of a physician, a mammogram at any age for covered persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer. • A single, baseline mammogram for covered persons aged 35-39, inclusive. • An annual mammogram for covered persons aged 40 and older. • Mammography screening means an X-ray examination of the breast using dedicated equipment. <p>Such coverage may be subject to annual deductibles and coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the contract.</p> <p><i>Note: The contract should use the statutory language of “first degree relative” when describing when coverage is available for the covered person who has a first degree relative with a prior history of breast cancer. Language such as “mother, sister, daughter:” in lieu of “first degree relative” is impermissible.</i></p>	
Cervical Cytology Screening	§4303(t)	<p>This contract includes coverage for annual cervical cytology screening for cervical cancer and its precursor states for women aged eighteen 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 may be subject to annual deductibles and coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the contract.</p>	
Bone Mineral Density Measurements or Tests, Drugs and Devices	§4303(bb)	<p>This contract includes coverage for bone mineral density measurements or tests, and if the contract otherwise includes coverage for prescription drugs, drugs and devices approved by the FDA or generic equivalents as approved substitutes. Bone mineral density measurements or tests, drugs or devices shall include those</p>	

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		<p>covered and for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. Individuals qualifying for coverage, at a minimum, include individuals:</p> <ul style="list-style-type: none"> • Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or • With symptoms or conditions indicative of the presence or significant risk of osteoporosis; or • On a prescribed drug regimen posing a significant risk of osteoporosis; or • With lifestyle factors to a degree as posing a significant risk of osteoporosis; or, • With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis. <p>Such coverage may be subject to annual deductibles and coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the contract.</p>	
Prostate Cancer Screening	§4303(z-1)	<p>This contract includes coverage for the diagnostic screening for prostate cancer including:</p> <ul style="list-style-type: none"> • Standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer; and • An annual standard diagnostic examination for men age 50 and over who are asymptomatic and for men age 40 or older with a family history of prostate cancer or other prostate cancer risk factors. <p>Such coverage may be subject to annual deductibles and coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the contract.</p>	
Mastectomy Care	§4303(v) Women's Health and Cancer Rights Act of 1998, 29 USC 1185(b)	<p>This contract 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 contract, and any physical complications arising from the mastectomy, including lymphedema. Such coverage may be subject to annual deductibles and coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the contract.</p>	
Post Mastectomy Reconstruction	§4303(x) Women's Health and Cancer Rights Act of 1998, 29 USC 1185(b)	<p>This contract includes the following coverage for breast reconstruction surgery after a mastectomy: all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of</p>	

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		all stages of mastectomy, including lymphedemas, in the manner determined by the attending physician and the patient to be appropriate. Such coverage may be subject to annual deductibles and coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the contract.	
Emergency Services	§4303(a)(2) §4900(c) Circular Letter No.1 (2002)	<p>This contract includes coverage for the treatment of an emergency condition including a definition of emergency services, notice that emergency services are not subject to prior approval, and a description of the financial and other responsibilities of the insured regarding obtaining such services including when such services are received outside the corporation's service area.</p> <p><i>Note: Emergency condition means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, 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 in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy, or (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.</i></p>	
Preadmission Testing	§4303(a)(1)	This contract includes coverage for preadmission testing ordered by a physician performed in the out-patient facilities of a hospital as a planned preliminary to admission of the patient as an in-patient 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.	
Home Health Services	§4303(a)(3)	<p>This contract includes coverage of home care for not less than 40 visits in any calendar year or continuous twelve month period for each person covered under the 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 or more of the following:</p> <ul style="list-style-type: none"> • Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse. • Part-time or intermittent home health aide services which consist primarily of caring for the patient. • Physical, occupational or speech therapy if provided by the home health 	

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		<p>service or agency.</p> <ul style="list-style-type: none"> • Medical supplies, 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 home care visit. <p>Four hours of home health aide service shall be considered as one home care visit</p>	
Maternity Care	§4303(c)	<p>This contract includes coverage for maternity care, to the same extent as coverage provided for illness or disease under the contract.</p> <ul style="list-style-type: none"> • 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. • The mother has the option to be discharged earlier than the time periods listed above, and, in such cases, is entitled to one home care visit in addition to any home care provided under §4303(a)(3). Such home care is not subject to deductibles, coinsurance or co-payments. • Maternity coverage also includes coverage of the services of a midwife licensed pursuant to Article 140 of the Education Law, practicing consistent with a written agreement pursuant to §6951 of the Education Law and affiliated or practicing in conjunction with a facility licensed pursuant to Article 28 of the Public Health Law. • Maternity coverage also includes parent education, training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments. 	
Treatment of Correctable Medical Conditions that Cause Infertility/Infertility Treatments	§4303(s) OGC Opinion 05-11-10 11 NYCRR 52.18(a)(10)	<p>This contract shall not exclude coverage for hospital, surgical or medical care for the diagnosis and treatment of correctable medical conditions otherwise covered under the contract solely because the medical condition results in infertility.</p> <ul style="list-style-type: none"> • Coverage shall not exclude surgical or medical procedures which would correct malformation, disease or dysfunction resulting in infertility. • Coverage shall not exclude diagnostic tests and procedures including hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sonohysterogram, 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 contract. 	

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		<ul style="list-style-type: none"> 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 annual deductibles and coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the contract. <p>This mandate does not require coverage of the following treatments in connection with infertility: in vitro fertilization; gamete intrafallopian tube transfers; zygote intrafallopian tube transfers; the reversal of elective sterilizations; 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 contract.</p>	
Diabetes Equipment, Supplies and Self-Management Education	§4303(u) 10 NYCRR 60-3.1 (Health Dept. Reg.)	<p>This contract includes coverage for equipment, supplies and self-management education described in §4303(u) for the treatment of diabetes. Such coverage may be subject to annual deductibles and coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the contract.</p> <p><i>Note: This benefit must appear in the base contract and may not be addressed through a prescription drug rider unless the prescription drug rider would provide a more generous benefit than the base contract (i.e. lower cost sharing).</i></p> <p><i>Note: Since the statute refers to equipment, supplies and self-management education that is prescribed by a physician “or other licensed health care provide legally authorized to prescribe under title eight of the education law...,” the contract may not limit coverage to care prescribed by a physician.</i></p>	
Outpatient Substance Abuse Services	§4303(l)	<p>This contract includes coverage for at least 60 outpatient visits in any calendar year for the diagnosis and treatment of chemical dependence, of which up to twenty visits may be for family members. Such coverage may be limited to facilities in New York State, certified by the Office of Alcoholism and Substance Abuse Services (OASAS) or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs and, in other states, to those accredited by the joint commission on accreditation of hospitals as alcoholism or chemical dependence treatment programs. Such coverage may be subject to annual deductibles and coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the contract.</p> <p><i>Note: By the express terms of the statute, this benefit must be provided on a calendar year basis. It may not be provided on a contract or plan year basis.</i></p>	

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		<p><i>Note: The corporation 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 contract.</i></p> <p><i>Note: The coverage provided under this statute includes treatment as a family member pursuant to such family member's own contract provided such family member does not exceed the allowable number of family visits and is otherwise entitled to the coverage pursuant to this mandate.</i></p>	
Pre-Hospital Emergency Medical Services	§4303(aa)	<p>This contract includes coverage for pre-hospital emergency medical services for the treatment of an emergency condition when such services are provided by an ambulance service issued a certificate to operate pursuant to §3005 of the Public Health Law.</p> <p><i>Note: Pre-hospital emergency medical services means the prompt evaluation and treatment of an emergency condition, and/or non-air-borne transportation of the patient to the hospital where a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in (i) placing the health of the person afflicted with such condition 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.</i></p>	
Autism Spectrum Disorder	§4303(ee)	<p>This contract may not exclude coverage for diagnosis and treatment of medical conditions otherwise covered under the contract because the treatment is provided to diagnose or treat autism spectrum disorder. "Autism spectrum disorder" is defined as a neurobiological condition that includes autism, Asperger syndrome, Rett's syndrome, or pervasive developmental disorder.</p>	
Direct Access to OB/GYN Services	§4306-b §4324	<p>If this contract includes coverage for such obstetric/gynecologic services, this contract may not limit a female insured's direct access to primary and preventive obstetric and gynecologic services from a qualified participating provider of such services of her choice to less than 2 examinations annually and to any care related to pregnancy. In addition, a corporation shall not limit direct access to primary and preventive obstetric and gynecologic services required as a result of such annual examinations or as a result of an acute gynecologic condition, provided that such qualified provider discusses such services and treatment plan with the individual's primary care practitioner in accordance with the corporation's</p>	

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		requirements.	
Second Medical Opinion for Cancer Diagnosis	§4303(w)	<p>This contract 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.</p> <ul style="list-style-type: none"> • This benefit includes coverage for a second medical opinion from a non-participating specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer when the attending physician provides a written referral to the non-participating specialist, at no additional cost to the insured beyond what such insured would have paid for services from a participating specialist. • This benefit also includes coverage for a second medical opinion by a non-participating specialist where there is no referral from the attending physician and where the corporation has not pre-authorized the service. In such cases, the corporation is responsible for covering the medically necessary services at a usual, customary and reasonable rate. <p>Such coverage may be subject to annual deductibles and coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the contract.</p>	
Second Surgical Opinion	§4303(b) Circular Letter No. 29 (1979)	<p>This contract includes coverage for a second surgical opinion by a qualified physician on the need for surgery, subject to the following:</p> <ul style="list-style-type: none"> • A qualified physician must be a board-certified specialist who by reason of his specialty is an appropriate physician to consider the surgical procedure being proposed. • Obtaining the second surgical opinion is at the option of the insured. • The benefit is applicable to all in-patient surgical procedures of a non-emergency nature covered by the contract. • The benefit is payable only if the insured is examined in person by the physician rendering the second surgical opinion and a written report is submitted to the corporation. • If the board certified specialist who renders the second surgical opinion also performs the surgery, no second surgical opinion benefit is payable. <p><i>Note: The contract may contain a mandatory second surgical opinion provision only if such provision is consistent with Circular Letter No. 29 (1979).</i></p>	
Experimental/Investigatio	§4303(z)	This contract shall not exclude coverage of a health care service on the basis that	

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<p>nal Services Recommended by an External Appeal Agent</p>	<p>Article 49</p>	<p>it is experimental or investigational, or rendered as part of a clinical trial, if coverage of the service has been recommended by an external appeal agent pursuant to an external appeal performed according to Title II of Article 49.</p>	
<p>Chiropractic care</p>	<p>§4303(v)</p>	<p>This contract 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.</p> <p>Chiropractic care and services may be subject to reasonable deductible, copayment and coinsurance amounts, reasonable fee or benefit limits, and reasonable utilization review, provided that any such amounts, limits and review: shall not function to direct treatment in a manner discriminative against chiropractic care and individually and collectively shall be no more restrictive than those applicable under the contract to care or services provided by other health care professionals in the diagnosis, treatment and management of the same or similar conditions, injuries, complaints, disorders or ailments even if differing nomenclature is used to describe the condition, injury, complaint, disorder or ailment.</p> <p><i>Note: The Insurance Department interprets this mandate to mean that a contract 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 visit under the contract. Additionally, a 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 contract. This means, for example, that a contract may not require precertification or preauthorization of chiropractic care and services if it does not require the same for specialty office visits in general.</i></p>	
<p>Mental, Nervous and Emotional Disorders</p>	<p>§4303(g)&(h)</p>	<p>This contract includes coverage for the diagnosis and treatment of mental, nervous and emotional disorders, at least equal to the following:</p> <ul style="list-style-type: none"> • 30 days of inpatient treatment in any contract, plan or calendar year. • 20 outpatient visits in any contract, plan or calendar year for outpatient treatment in a facility issued an operating certificate by the Commissioner of Mental Health, a facility operated by the Office of Mental Health, a psychiatrist or psychologist, a licensed clinical social worker, or a professional corporation or university faculty practice corporation. 	

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		<ul style="list-style-type: none"> • Benefits for partial hospitalization program services shall be provided as an offset to covered inpatient days at a ratio of two partial hospitalization visits to one inpatient day treatment. • Coverage for adults and children with biologically based mental illnesses as defined in 4303(g)(2)(B) and for children with serious emotional disturbances, as defined in 4303(g)(3) must be comparable to other coverage provided under the contract. However, this provision is not mandatory for groups with fifty or fewer employees, but must be made available to the contractholder for purchase. <p>Such coverage may be subject to annual deductibles, co-pays and coinsurance as may be deemed appropriate by the Superintendent and shall be consistent with those imposed on other benefits under the contract.</p>	
Services Performed at Comprehensive Care Center for Eating Disorders	§4303(dd)	This contract may not exclude coverage for services covered under the 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.	
If prescription drugs are offered under this contract, then the following mandates apply:			
Enteral Formulas	§4303(y)	If coverage for prescription drugs is provided under the contract, then coverage must be provided for enteral formulas for home use for which a physician or other licensed health care provider legally authorized to prescribe under Title 8 of the Education Law has issued a written order. The order must state that the formula is medically necessary and has been proven effective as a disease-specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic physical disability, mental retardation or death. Specific diseases that enteral formulas are effective for include, but are not limited to: inherited amino-acid or organic acid metabolism; Crohn's Disease; gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which if left untreated will cause malnutrition, chronic physical disability, mental retardation or death. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall	

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		include coverage of modified solid food products, which is not required to exceed \$2,500 for any insured individual in any calendar year or continuous period of 12 months.	
Off-Label Cancer Drug Usage	§4303(g)	If coverage for prescription drugs is provided under the contract, then coverage may not be excluded 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 AMA Drug Evaluations; the American Hospital Formulary Service Drug Information; the U.S. Pharmacopeia Drug Information; or recommended by review article or editorial comment in a major peer reviewed professional journal.	
Contraceptive Drugs and Devices	§4303(cc)	<p>If coverage for prescription drugs is provided under the contract, then coverage for contraceptive drugs and devices must be included. Coverage for contraceptive drugs and devices must be included in policies and certificates only through the addition of a separate rider, subject to provisions in statute regarding religious employers.</p> <p>Such coverage may be subject to annual deductibles and coinsurance deemed appropriate by the Superintendent and as are consistent with those established for other drugs or devices covered under the contract.</p> <p><i>Note: Since the statute refers to contraceptive drugs and devices prescribed by a physician “or other licensed health care provide legally authorized to prescribe under title eight of the education law...,” the contract may not limit coverage to contraceptive drug and devices prescribed by a physician.</i></p>	
MAKE AVAILABLE BENEFITS		<i>The following benefits must be offered to contractholders annually, and must be included in the contract if the contractholder chooses to include it.</i>	
Hospice Care	§4303(o)	<p>This contract must make available at least 210 days of inpatient hospice care in a hospice or in a hospital and home care and outpatient services provided by the hospice, including drugs and medical supplies, and 5 visits for bereavement counseling. Such coverage may be subject to annual deductibles and coinsurance deemed appropriate by the Superintendent and as are consistent with those imposed on other benefits within the contract.</p> <p><i>Note: Hospice care is defined as the care and treatment of an insured who has been certified by the insured’s primary attending physician as having a life expectancy of six months or less which is provided by a hospice organization</i></p>	

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		<i>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.</i>	
Care in a Nursing Home or Skilled Nursing Facility	§4303(d)	This 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.	
Chemical Abuse and Dependence Diagnosis and Treatment	§4303(k)	<p>This contract must make available coverage for the diagnosis and treatment of chemical abuse and chemical dependence which includes the treatment of alcohol and substance abuse and dependence as follows:</p> <ul style="list-style-type: none"> • Inpatient benefits in a hospital or detoxification facility for the treatment of detoxification of not less than 7 days in any calendar year. • Inpatient rehabilitation benefits of not less than 30 days in any calendar year. • Such coverage may be limited to facilities in New York which are certified by OASAS and, in other states, to those which are accredited by the joint commission on accreditation of hospitals as alcoholism, substance abuse or chemical dependence treatment programs. <p>Such coverage may be subject to annual deductibles and coinsurance deemed appropriate by the Superintendent and as are consistent with other benefits within the contract.</p>	
Ambulatory Care	§4303(f)	<p>This contract must make available coverage for ambulatory care in hospital out-patient facilities, as a hospital is defined in Public Health Law §2801 or 42 U.S.C. §1395 and physicians' offices.</p> <p><i>Ambulatory care in hospital out-patient facilities includes services for diagnostic X-rays, laboratory and pathological examinations, physical, occupational and radiation therapy, and services and medications for nonexperimental cancer chemotherapy and cancer hormone therapy. However, physical therapy services are to be provided in connection for the same illness for which the insured had been hospitalized or in connection with surgical care, but do not need to be provided if commenced more than six months after discharge from a hospital or the date surgical care was rendered or after 365 days from the date of hospital discharge or the date surgical care was rendered.</i></p> <p><i>Ambulatory care in physician's offices includes diagnostic X-rays, radiation therapy, laboratory and pathological examinations, and services and medications used for nonexperimental cancer chemotherapy and cancer hormone therapy.</i></p> <p><i>Note: It is a violation of section 52.16(c) of Insurance Regulation 62 (11 NYCRR</i></p>	

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		<i>52) to subject certain services within a class of service to a higher level of cost sharing. For example, it is impermissible to subject high cost radiologic services such as PET scans or CAT scans or other similar services to an increased level of cost sharing as compared to less expensive radiologic services, such as x-rays.</i>	
Mental, Nervous and Emotional Disorders for Policies Issued to Small Groups	§4303(g) & (h)	This contract must make available to contractholders in the small group market coverage of mental, nervous and emotional disorders comparable to other coverage provided under the contract for adults and children with biologically based mental illnesses as defined by 4303(g)(2)(B). This contract must also make available to contractholders in the small group market comparable coverage for children with serious emotional disturbances, as defined by 4303(g)(3). Such mental health coverage may be subject to the terms and conditions otherwise applicable under the contract, such as network limitations and variations, exclusions, co-pays, coinsurance, deductibles or other specific cost sharing mechanisms.	
Licensed Clinical Social Worker	§4303(i)	If this 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 contract must make available and if requested by the contractholder, provide the same coverage to insureds for the such services when performed by a licensed clinical social worker, within the lawful scope of his or her practice, who is licensed pursuant to Article 154 of the Education Law (Education Law § 7700 et seq.).	
Registered Professional Nurse	§4303(m)	If this contract provides coverage for any service within the lawful scope of practice of a duly licensed registered professional nurse, the contract must make available reimbursement when such service is performed by a duly licensed registered professional nurse.	
MANDATORY STANDARD PROVISIONS		<i>Note: These provisions MUST be included in each contract. The provision must be no less favorable to the insured than the statutory provision.</i>	
Premium Payment		This contract includes a statement that all premiums due under the contract shall be remitted by the employer or employers of the person insured or by some other designated person acting on behalf of the association or group insured, to the corporation on or before the due date thereof, with such grace period as may be specified therein.	
Renewal	11NYCRR52.18(e)	This contract provides that except as specified in §4305(j), the corporation must renew or continue in force such coverage at the option of the contractholder.	

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		<p>The contract must specify the conditions under which the corporation may refuse to renew the contract.</p>	
<p>Right to New Contract After Termination (Conversion)</p>	<p>§4305(d)</p>	<p>This contract provides that if the employee or member insured under the group contract ceases to be covered because of termination of coverage of any member of the group because of: (1) termination for any reason whatsoever of his employment or membership, if he has been covered under the group contract for at least three months, or (2) termination for any reason whatsoever of the group contract itself, unless the group contract holder has replaced the group contract with similar and continuous coverage for the same group, whether insured or self-insured, such employee or member shall be entitled to be issued, without evidence of insurability, upon application and payment for the first premium with in forty-five days after termination of the coverage, an individual contract of insurance covering such member and his eligible dependents. The corporation is not required to issue a converted contract to any person who is covered by another individual contract providing similar coverage or if the person is covered by or eligible to be covered by a group contract or policy providing similar benefits or is provided with similar benefits required by any statute or provided by any welfare plan or program, which together with the converted contract would result in over –insurance according to standards on file with the superintendent of insurance relating to individual contracts. The effective date of the converted contract shall be the date of the termination of the individual’s insurance with the group contract.</p> <p>Conversion must also be made available, upon the death of the employee or member, to the surviving spouse and dependents, if they were covered under the group contract, and the former spouse of the employee or member upon the divorce or annulment of the marriage to the employee or member. Conversion must also be made available to a child covered under the contract who reaches the age limiting coverage under the group contract.</p> <p>The contract provides that the employee or member or his eligible dependents must request conversion within forty-five days of the termination of the group coverage, provided that if such employee or member receives written notice of the right to conversion more than fifteen days but less than ninety days after the date the group coverage was terminated, the time allowed to request conversion shall be extended for forty-five days after the giving of such notice. If such notice is not given within ninety days after the date the group coverage terminates, the time allowed for the exercise of the conversion privilege shall</p>	

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		<p>expire at the end of such ninety days.</p> <p><i>Note: The contract may not condition an eligible dependent's right to conversion on the employee or member being covered under the group contract for at least three months.</i></p>	
Continuation Coverage	<p>§4305(e) COBRA</p>	<p>This contract contains a provision regarding continuation coverage. §4305(e) provides continuation coverage in circumstances when Federal COBRA rights do not apply, such as where the group has less than twenty employees, the employee was terminated for misconduct or the group is a type that is not required to comply with COBRA.</p> <p>This contract provides that if all or any portion of the insurance on an employee or member insured under the policy ceases because of termination of employment or membership in the class or classes eligible for coverage under the policy, such employee or member shall be entitled without evidence of insurability upon application to continue the insurance for himself or herself and his or her eligible dependents.</p> <p>Continuation coverage is not available for:</p> <ul style="list-style-type: none"> • Any person who is covered, becomes covered or could be covered by Medicare; • An employee, member or dependent who is covered, becomes covered or could be covered as an employee, member or dependent by any other insured or uninsured arrangement which provides hospital, surgical or medical coverage for individuals in a group which does not contain any exclusion or limitation with respect to any pre-existing condition of such employee, member or dependent. <p>An employee or member who wishes continuation of coverage must request continuation in writing and remit the first premium payment within the 60 day period following the later of: the date of termination or the date the employee is sent notice by first class mail of the right of continuation by the group contractholder. The Insurance Law permits the contractholder to charge an additional 2% administrative fee for continued coverage.</p> <p>The continuation benefits terminate:</p> <ul style="list-style-type: none"> • On the date which the employee or member becomes entitled to coverage under Medicare. • On the date which the employee or member becomes covered by an insured 	

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		<p>or uninsured arrangement which provides hospital, surgical or medical coverage for individuals in a group which does not contain any exclusion or limitation with respect to any pre-existing condition.</p> <ul style="list-style-type: none"> • 18 months after the date the employee or member’s benefits would otherwise have terminated because of termination of employment or membership; or • 29 months after the date the employee or member’s benefits would otherwise have terminated in the case of an employee or member who is determined to have been disabled at the time of termination of employment or during the first sixty days of continuation of coverage. • The end of the period for which premiums were made if the employee or member fails to make timely payment; or • In the case of an eligible dependent, 36 months after the date such person’s benefits would otherwise have terminated by reason of the death of the employee or member, divorce or legal separation of the employee or member from his or her spouse, the employee or member becoming eligible for Medicare, or a dependent child ceasing to be a dependent child under the generally applicable requirements of the contract. • The date on which the group contract is terminated or, in the case of an employee, the date his employer terminated participation under the group contract, provided, however, that if the coverage ceasing because of such termination is replaced by similar coverage under another group contract, the employee or member shall have the right to become covered under the other group contract for the balance of the period he or she would have remained covered under the prior group contract had such a termination not occurred. 	
<p>Suspension of Coverage</p>	<p>§4305(g) & (h) Circular Letter No. 7 (2003) USERRA</p>	<p>This contract provides that:</p> <ul style="list-style-type: none"> • Any covered persons who are also members of a reserve component of the armed forces of the United States, including the National Guard, shall be entitled, upon request, to have their coverage suspended during a period of active duty. • The corporation will refund any unearned premiums for the period of the suspension. • Persons covered by this contract shall be entitled to resumption of coverage, upon written application and payment of the required premium within 60 days after the date of termination of the period of active duty. • Coverage shall be retroactive to the date of termination of the period of active duty. • No exclusion or waiting period may be imposed for any condition unless the 	

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		condition arose during the period of active duty and the condition has been determined by the secretary of veterans affairs to be a condition incurred in the line of duty or a waiting period had been imposed and was not completed at the time of suspension.	
Supplementary Coverage for Employees or Members who are also members of the reserve components of the armed services or the National Guard	§4305(g) & (h) Circular Letter No. 7 (2003)	If the contractholder does not choose to voluntarily maintain coverage for any employee or member when they enter active duty, then such member or employee shall be entitled to continuation or conversion coverage.	
Extension of Benefits	11NYCRR52.18(b)(4) 11NYCRR52.18(b)(5)	<p>This contract provides that upon termination of insurance, whether due to termination of employment, termination of eligibility, or termination of the policy, an extended benefit will be provided during total disability for hospital confinements commencing or surgery performed during the 31 days after termination of coverage.</p> <p>In addition, if the insured's coverage terminates by reason of termination of active employment, an extended benefit shall be provided during total disability, with respect to the sickness, injury or pregnancy which caused the disability, of at least 12 months subsequent to termination of insurance unless coverage is afforded for the total disability under another group health plan.</p>	
OPTIONAL STANDARD PROVISIONS			
Pre-existing Condition Limitation	§4318 11NYCRR52.20 11NYCRR52.16(f) 42 USC §§300gg et seq.	<p>This contract includes a pre-existing condition provision which:</p> <ul style="list-style-type: none"> • Defines a pre-existing condition as one which relates to a condition (whether physical or mental), regardless of the cause of the condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the enrollment date. • Excludes pre-existing conditions for a period of no more than 12 months from the enrollment date. • Credits the time the individual was covered under creditable coverage. • Does not treat genetic information as a pre-existing condition in the absence of a diagnosis of the condition related to such information. • Does not exclude coverage in the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under 	

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		<p>creditable coverage.</p> <ul style="list-style-type: none"> • Does not exclude coverage in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of adoption, is covered under creditable coverage. • Does not exclude coverage for pregnancy. • Does not exclude coverage in the case of an individual, and any dependent of such individual, who is eligible for a federal tax credit under the federal Trade Adjustment Assistance Reform Act of 2002 and who has 3 months or more of creditable coverage. <p><i>Note:</i> Groups over 300 may not impose a pre-existing condition provision.</p>	
Coordination of Benefits	11NYCRR52.23	If this contract contains a coordination of benefits provision, then it must comply with 11 NYCRR 52.23.	
Unilateral Modification	11NYCRR52.18(a)(8)	Unilateral modifications by a corporation to an existing contract must be made with at least 30 days prior written notice to the contractholder. Unilateral modification by the corporation may be made only at the time of renewal. If the contract requires the contractholder to provide written notice to terminate coverage, the notice of the unilateral modification by the corporation must be provided to such contractholder no less than 14 days prior to the date by which the contractholder is required to provide notice to terminate coverage.	
TERMINATION PROVISIONS		<i>The following are the only termination provisions permissible under the Insurance Law and the contract may, but is not required to include these termination provisions.</i>	
Notice of Termination	11NYCRR52.18(e)	Unless otherwise specified under the Insurance Law, notices of nonrenewal or termination shall provide at least 30 days prior written notice.	
Termination for Failure to Pay Premiums	§4305(j)(2)(A)	This contract includes a provision permitting the corporation to terminate the contract if the contractholder or a participating entity has failed to pay premiums or contributions in accordance with the terms of the contract or the corporation has not received timely premium payments.	
Termination for Fraud	§4305(j)(2)(B)	This contract includes a provision permitting the corporation to terminate the contract if the contractholder or a participating entity has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the contract.	
Termination for Failure to Comply With a Material Plan Provision	§4305(j)(2)(C)	This contract includes a provision permitting the corporation to terminate the contract if the contractholder has failed to comply with a material plan provision relating to employer contribution or group participation rules, as permitted in §4235.	

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Discontinuation of a Class of Contract	§4305(j)(2)(D) §4305(j)(3)(A)	This contract includes a provision permitting the corporation to discontinue this class of contract upon written notice to each contractholder, participant, and beneficiary not less than 90 days prior to the date of discontinuance. The corporation must offer contractholders the option to purchase all (or with respect to the large group market, any) other hospital, surgical, and medical expense coverage currently being offered by the corporation to a group in such market and in exercising the option to discontinue coverage of this class, the corporation must act uniformly without regard to the claims experience of those contractholders or any health status-related factor relating to any insureds covered or new insureds who may become eligible for such coverage.	
Discontinuation of all Contracts in the Small or Large Group Market	§4305(j)(2)(D) §4305(j)(3)(B)	This contract includes a provision permitting the corporation to discontinue all hospital, surgical and medical expense coverage in the small or large group market upon written notice to the superintendent and to each contractholder, participant, and beneficiary at least 180 days prior to the date of discontinuance.	
Termination for Failure to Meet Requirements of Group	§4305(j)(2)(E) §4235(c)(1)	This contract includes a provision permitting the corporation to terminate the contract if the contractholder ceases to meet the requirements of a group under §4235, or a participating employer, labor union, association or entity ceases membership in the group to which the contract was issued. Coverage terminated pursuant to this provision shall be done uniformly without regard to any health status factor relating to any individual.	
PERMISSIBLE EXCLUSIONS AND LIMITATIONS		<i>No contract shall limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:</i>	
Cosmetic Surgery	11NYCRR52.16(c)(5) 11NYCRR56	This contract excludes coverage for cosmetic surgery, except that cosmetic surgery does not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect. <i>Note: All exclusions for cosmetic surgery must be based on medical necessity, with the individual receiving all utilization review and external appeal rights under Article 49, except as otherwise provided in 11NYCRR56.</i>	
Foot Care	11NYCRR52.16(c)(6)	This contract excludes coverage for foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet.	
Dental Care or Treatment	11NYCRR52.16(c)(9)	This contract excludes coverage of dental care or treatment, except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital	

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		disease or anomaly. <i>Note: It is impermissible to exclude treatment of temporomandibular joint dysfunction where the treatment is medical in nature, unless a medical necessity determination is made and the individual receives all utilization review and external appeal rights under Article 49.</i>	
Eye-glasses and Hearing Aids	11NYCRR52.16(c)(10)	This contract excludes coverage for eyeglasses, hearing aids and examination for the prescription or fitting thereof. <i>Note: It is impermissible to exclude lasik and other surgeries or treatments to the eyes, unless a medical necessity determination is made and the individual receives all utilization review and external appeal rights under Article 49.</i>	
Custodial Care	11NYCRR52.16(c)(11)	This contract excludes coverage for custodial care as defined in 11NYCRR52.16(l). <i>Note: All exclusions for custodial care that exceed the definition contained in 11NYCRR52.16(l) must be based on medical necessity, with the individual receiving all utilization review and external appeal rights.</i>	
Rest Cures	11NYCRR52.16(c)(11)	This contract excludes coverage for rest cures.	
War or Act of War, Participation in Felony, Riot or Insurrection, Service in the Armed Forces	11NYCRR52.16(c)(4)(i)	This contract excludes coverage for illness, accident, treatment or medical condition arising out of war or act of war (whether declared or undeclared), participation in a felony, riot or insurrection and service in the Armed Forces or units auxiliary thereto. <i>Note: Exclusions for terrorism are not included in this permissible exclusion.</i>	
Suicide, Attempted Suicide, Intentionally Self-Inflicted Injury	11NYCRR52.16(c)(4)(ii)	This contract excludes coverage for illness, accident, treatment or medical condition arising out of suicide, attempted suicide or intentionally self-inflicted injury.	
Aviation	11NYCRR52.16(c)(4)(iii)	This contract excludes coverage for illness, accident, treatment or medical condition arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.	
Mandatory No-Fault	11NYCRR52.16(c)(8)	This contract excludes benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable.	
Medicare or Other Governmental Program	11NYCRR52.16(c)(8)	This contract excludes coverage for treatment provided in a government hospital; benefits provided under Medicare or other governmental programs (except Medicaid); any state or federal workers' compensation, employers' liability or	

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		occupational disease law, unless where otherwise provided in State or Federal statute.	
Hospital Employees	11NYCRR52.16(c)(8)	This contract excludes coverage for services rendered and separately billed by employees of hospitals, laboratories or other institutions.	
Immediate Family	11NYCRR52.16(c)(8)	This contract excludes coverage for services performed by a member of the insured's immediate family.	
Services For Which No Charge Normally Made	11NYCRR52.16(c)(8)	This contract excludes coverage for services for which no charge is normally made.	
Outside the U.S.	11NYCRR52.16(c)(12)	This contract excludes coverage while the insured is outside the United States, its possessions or the countries of Canada or Mexico.	
PROVISIONS THAT MUST BE INCLUDED IN THE CONTRACT OR WRITTEN DISCLOSURE STATEMENT		<i>Corporations shall provide insureds and upon request prospective insureds the following written disclosure information, which may be incorporated into the contract. In the event of any inconsistency between any separate written disclosure statement and the contract, the terms of the contract shall be controlling.</i>	
Benefits and Exclusions	§4324(a)(1)	This contract includes a description of coverage provisions; health care benefits; benefit maximums, including benefit limitations; and exclusions of coverage.	
Definition of Medical Necessity	§4324(a)(1)	This contract includes a definition of "medical necessity" used in determining whether benefits will be covered.	
Prior Authorization Requirements	§4324(a)(2)	This contract includes a description of all prior authorization or other requirements for treatments and services.	
Utilization Review Policies and Procedures	§4324(a)(3) Article 49	This contract includes a description, consistent with Article 49, of the utilization review policies and procedures including: <ul style="list-style-type: none"> • The circumstances under which utilization review will be undertaken; • the toll-free telephone number of the utilization review agent; • the timeframes under which utilization review decisions must be made for prospective, retrospective and concurrent decisions; • the right to reconsideration; • the right to appeal, including the expedited and standard appeals processes and the timeframes for such appeals; • the right to designate a representative; • a notice that all denials of claims will be made by qualified clinical personnel and that all notices of denials will include information about the basis of the decision; • a notice of the right to an external appeal, together with a description, jointly promulgated by the commissioner of health and superintendent of insurance, 	

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		<p>of the external appeal process and the timeframes for such appeals; and</p> <ul style="list-style-type: none"> • further appeal rights, if any. 	
Reimbursement of Providers	§4324(a)(4)	This contract includes a description of the types of methodologies the corporation uses to reimburse providers.	
Insured's Financial Responsibility for Payment	§4324(a)(5)	This contract includes a description of the insured's financial responsibility for payment of premiums, coinsurance, co-payments, deductibles, 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.	
Non-Participating Providers and Non-Authorized Services	§4324(a)(6)	This contract 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 corporation's network of providers or by any provider without the required authorization or when a procedure, treatment or service is not a covered health care benefit.	
Grievance Procedures	§4324(a)(7)	<p>This contract includes a description of the grievance procedure to be used to resolve disputes between the corporation and the insured, including:</p> <ul style="list-style-type: none"> • the right to file a grievance regarding any dispute between an insured and the corporation; • 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. 	
Selecting, Accessing and Changing Participating Providers	§4324(a)(9) §4324(a)(10)	Where applicable, this contract 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.	
Referral to Non-Participating Providers	§4324(a)(11)	Where applicable, this contract includes notice that an insured enrolled in a managed care product as defined in §4801(c) may obtain a referral to a health	

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		care provider outside of the corporation's network or panel when the corporation does not have a health care provider with appropriate training and experience in the network or panel to meet the health care needs of the insured and the procedure by which the insured can obtain such referral.	
Standing Referrals	§4324(a)(12)	Where applicable, this contract includes notice that an insured enrolled in a managed care product as defined in §4801(c) with a condition which requires ongoing care from a specialist may request a standing referral to such specialist and the procedure for requesting and obtaining such standing referral.	
Specialty Care Provider as PCP	§4324(a)(13)	Where applicable, this contract includes notice that an insured enrolled in a managed care product as defined in §4801(c) 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 a specialist responsible for providing or coordinating the insured's medical care and the procedure for requesting and obtaining such a specialist.	
Specialty Care Center	§4324(a)(14)	Where applicable, this contract includes notice that an insured enrolled in a managed care product as defined in §4801(c) 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 the procedure by which such access may be obtained.	
Non-English Speaking Insureds	§4324(a)(15)	This contract includes a description of how the corporation addresses the needs of non-English speaking insureds.	
Contact Information	§4324(a)(16)	This contract includes all appropriate mailing addresses and telephone numbers to be utilized by insureds seeking information or authorization.	
PROVIDER NETWORKS		<p>If the contract will be used in conjunction with a provider network, then the following items or information must be submitted:</p> <ul style="list-style-type: none"> • 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. 	
For Contracts Being Issued to Small Groups	11NYCRR 360	Special rules apply to small groups that limit the way corporations may restrict or limit coverage. These rules are found in 11NYCRR360, and if this contract is	

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(groups of 2-50)		being issued in the small group market, they must be followed.	
Major Medical Insurance	11NYCRR52.7	<i>If the contract being issued is major medical insurance, the following benefits must be included.</i>	
Benefit Maximums	11NYCRR52.7	The contract must provide coverage for each insured, to a maximum of not less than \$100,000.	
Copayments	11NYCRR52.7	Copayments may not exceed 25%.	
Deductible	11NYCRR52.7	<p>A deductible stated on a per-person, per-family, per-illness, per-benefit period, or per-year basis, or a combination of such bases, not to exceed five percent of the lowest overall maximum limit under the contract, unless the contract is written to complement underlying hospital and medical insurance, in which case the deductible may be increased by the amount of the benefits provided by such underlying insurance for at least:</p> <ul style="list-style-type: none"> • Daily room and board as defined in 52.5(a). • Miscellaneous hospital services as defined in 52.5(b) provided that the maximum limitation shall not apply. • Surgical services as defined in 52.6(a). • Anesthetic services as defined in 52.6(b). • In-hospital medical services as defined in 52.6(c). • Mental health care consisting of 30 outpatient visits per year at no less than \$30 per visit and a yearly maximum of no less than \$1,500 and outpatient crisis intervention services consisting of at least three psychiatric emergency visits per year for which benefits shall be no less than \$60 per visit. 	
Out-of-Hospital Care	11NYCRR52.7(g)	The contract includes coverage for out-of-hospital care consisting of physicians' services rendered on an ambulatory basis for diagnosis and treatment of sickness or injury, including the cost of drugs and medications available only on the prescription of a physician, and diagnostic X-ray, laboratory services, radiation therapy, chemotherapy and hemodialysis ordered by a physician.	
Prosthetic Appliances and Durable Medical Equipment	11NYCRR52.7(h)	The contract includes coverage for prosthetic appliances meaning artificial limbs or other prosthetic appliances (including replacements thereof which are functionally necessary) and the rental or purchase of durable medical equipment required for therapeutic use, including repairs and necessary maintenance of the purchased equipment, not otherwise provided for under a manufacturer's warranty.	
ACTUARIAL SECTION FOR NEW PRODUCT RATE FILINGS ONLY		<p><i>Complete this section for all new product forms filings except those filings where a rate filing is unnecessary because: (select one)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> <i>The submission contains only application forms, disclosure statements, and/or advertising, OR</i> <input type="checkbox"/> <i>The submission is an out-of-state filing pursuant to Section</i> 	

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		<p style="text-align: center;"><i>3201(b)(2), OR</i></p> <p style="text-align: center;"><input type="checkbox"/> <i>The form submission has no premium rate implications and a letter or actuarial memorandum is enclosed that states and justifies this as appropriate.</i></p> <p style="text-align: center;"><i>For rate changes to existing products, do NOT complete this section – complete the Existing Products-Rate Requirements section below.</i></p>	Form/Page/ Paragraph Reference
ACTUARIAL MEMORANDUM	11NYCRR52.40(a)(1)	Actuarial qualifications: a. Member of the Society of Actuaries; and b. Meet the “Qualification Standards of Actuarial Opinion” as adopted by the American Academy of Actuaries.	
Justification of Rates	§3103 & §4303 11NYCRR52.40(e) 11NYCRR52.40(g) 11NYCRR360.10 11NYCRR360.11 11NYCRR52.45(f) 11NYCRR59.5(b)	<p>Small Group:</p> <p>a. Provide community rated rating methodology and assumptions used in calculating rates – description of sources, assumptions, formulas, and actuarial justification thereof.</p> <p>b. Provide rating methodology and assumptions used in rate calculation for mental health coverage provided pursuant to §4303(g) and (h).</p> <p>c. Actuarial justification for the use of claim costs and other assumptions.</p> <p>d. Non-claim expense components as a percentage of gross premium.</p> <p>e. Expected loss ratio(s).</p> <p>f. Demonstration that applicable minimum loss ratio of 11NYCRR52.45 or 11NYCRR59.5 will be met.</p> <p>Large Group:</p> <p>a. Development of manual rates including sources, actuarial assumptions, formulas used and actuarial justification thereof.</p> <p>b. Provide rating methodology including experience rating formula (both new business and renewals), including all elements of the formula, (claims run-off, credibility, trend factors, etc.).</p> <p>c. Provide rating methodology and assumptions used in rate calculation for mental health coverage provided pursuant to §4303(g) and (h).</p> <p>d. Non-claim expense components as a percentage of gross premium.</p> <p>e. Expected loss ratio(s).</p> <p>f. Demonstration that applicable minimum loss ratio of 11NYCRR52.45 or 11NYCRR59.5 will be met.</p>	
Loss Ratios	11NYCRR52.45(f) 11NYCRR59.5(b)	Expected loss ratio(s) – with actuarial justification	
Reserve Basis	11NYCRR94	Description of bases for unpaid claim liabilities and extra reserves (if any).	
Actuarial Certification	11NYCRR52.40(a)(1)	a. The filing is in compliance with all applicable laws and regulations of the	

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		<p>State of New York.</p> <p>b. The filing is in compliance with Actuarial Standard of Practice No. 8 “Regulatory Filings for Rates and Financial Projections for Health Plans” as adopted by the Actuarial Standards Board.</p> <p>c. The expected loss ratio meets the minimum requirements of the State of New York.</p> <p>d. The benefits are reasonable in relation to the premiums charged.</p> <p>e. The rates are not unfairly discriminatory.</p> <p>f. All reserves are in compliance with 11NYCRR94.</p>	
Expected Loss Ratio Certification		The expected loss ratio is: ██████████	
GROUP RATE MANUAL	11NYCRR52.40(e)(2)(i) 11NYCRR52.40(e)(3) 11NYCRR52.40(g) 11NYCRR52.45(f) 11NYCRR59.5(b)	<p>a. Table of contents.</p> <p>b. Rate pages.</p> <p>c. Corporation name on each consecutively numbered rate page.</p> <p>d. Identification by form number of each policy, rider, or endorsement to which the rates apply.</p> <p>e. Brief description of benefits, types of coverage, limitations, exclusions, and issue limits.</p> <p>f. Description of rating classes, factors and premium discounts.</p> <p>g. Examples of rate calculations.</p> <p>h. Schedules of commissions and fees.</p> <p>i. Underwriting guidelines and/or underwriting manual.</p> <p>j. Expected loss ratio(s).</p> <p>k. Experience rating formulas (both new business and renewals).</p>	
ACTUARIAL SECTION FOR EXISTING PRODUCT RATE FILINGS ONLY		<p><i>Complete this section for all filings of changes in rates (e.g., rate increases/decreases or changes in rate calculation rules or procedures), commissions or underwriting to existing products.</i></p> <p><i>(For new products, do NOT complete this section – complete the New Products-Rate Requirements section above instead.)</i></p>	
ACTUARIAL MEMORANDUM	11NYCRR52.40(a)(1)	<p>Actuarial qualifications:</p> <p>a. Member of the Society of Actuaries; and</p> <p>b. Meet the “Qualification Standards of Actuarial Opinion” as adopted by the American Academy of Actuaries.</p>	
Justification of Rates	11NYCRR52.40(e) 11NYCRR52.40(g)(3) 11NYCRR52.45 11NYCRR59.5(b)	<p>a. Description of proposed changes in coverage, rates, commissions, underwriting rules, etc.</p> <p>b. History of previous New York rate revisions.</p>	

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		<ul style="list-style-type: none"> c. Provide New York and nationwide claims experience respectively, including: <ul style="list-style-type: none"> (i) Earned premium; (ii) Paid and incurred claims; and (iii) Incurred loss ratios. d. Actuarial justification of proposed rate revisions (increase/decrease). e. Non-claim expense components as a percentage of gross premium. f. Impact on rates as a result of each of the changes with actuarial justification. g. Expected loss ratio(s) after the proposed changes. h. Demonstration that applicable minimum loss ratio of 11NYCRR52.45 or i. 11 NYCRR59.5 will be met. 	
Actuarial Certification	11NYCRR52.40(a)(1)	<ul style="list-style-type: none"> a. The filing is in compliance with all applicable laws and regulations of the State of New York. b. The filing is in compliance with Actuarial Standard of Practice No. 8 “Regulatory Filings for Rates and Financial Projections for Health Plans”. c. The expected loss ratio meets the minimum requirements of the State of New York. d. The benefits are reasonable in relation to the premiums charged. e. The rates are not unfairly discriminatory. f. All reserves are in compliance with 11 NYCRR94. 	
Expected Loss Ratio Certification		The expected loss ratio is: %.	
REVISED RATE MANUAL PAGES	11NYCRR52.40(e)(2)(i) 11NYCRR52.40(e)(3) 11NYCCR52.40(g) 11NYCRR52.45(f) 11NYCRR59.5(b)	<ul style="list-style-type: none"> a. Revise each item listed in “Group Rate Manual” above, as appropriate, to reflect all changes in coverages, rates, commissions, underwriting rules, etc. 	